Data Trends

Summaries of Current Research Findings
in the Children's Mental Health Field

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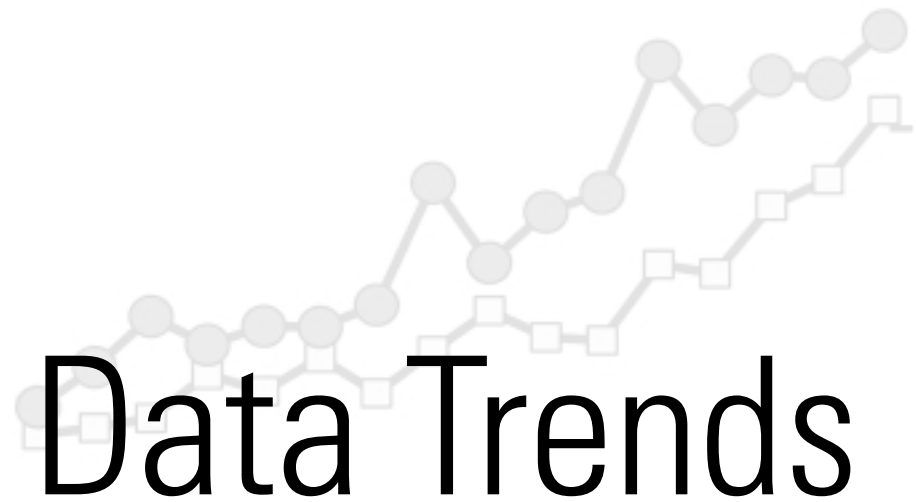Krista Kutash, Ph.D.
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Summaries of research on mental health services for children and adolescents and their families

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Data Trends are produced to increase the dissemination of current research findings in the area of children's mental health services. Each issues of Data Trends summarizes, in a single page, a current publication in the children's mental health area to alert the field to current findings and activities. A citation is given for each summary so the readers will be able to retrieve the original document for further examination.

The enclosed *Data Trends* were produced by the Research and Training Center for Children's Mental Health in Tampa, Florida.

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Source: Burns, B. J., Hoagwood, K., & Mrazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review 2*(4), 199-254.

This article provides an exhaustive summary of "what we know" about the effectiveness of mental health treatment for children and their families in the United States, and lays out some recommendations for future work. In preparation for the recently issued Surgeon General's Report on Mental Health, these authors conducted a review of all of the published empirical literature on efficacy and effectiveness dating from the 1960s to the present. The majority of information gathered by Burns et al. was not able to be included in the Surgeon General's report, so the authors prepared this comprehensive article presenting their findings and recommendations.

The brief summary included in this *Data Trends* is necessarily selective. It is recommended that interested individuals read this important article in its entirety.

The authors offer a wealth of research and reference information (the reference list alone totals over 360 entries), and divide the article into five areas: 1) prevention; 2) traditional forms of treatment; 3) intensive community-based interventions; 4) crisis and support services, and 5) treatment for two prevalent disorders that were a major focus of the Surgeon General's report (major depressive disorder, and attention-deficit hyperactivity disorder). The article includes general conclusions and recommendations for future directions.

The authors begin with reviewing some of the methodological shortcomings of existing research. This includes their findings that the length of follow-up in studies is brief, outcome measures have typically been limited to measures of clinical status, and many studies reflect interventions which do not typify clinical practice. An important context for the reviewer is the authors' point that, "empirically validated treatments have been tested on children and families who do not generally represent clinic-referred children" (p. 200).

Overall, the authors report that "the strongest evidence base supportive of positive outcomes for children and families exists for five forms of services and treatments: home-based services, therapeutic foster care, some forms of case management, and both pharmaceutical and psychosocial treatments for specific syndromes" (p. 238). It is important to note that the conclusion on home-based services is based largely on the research of multi-systemic therapy. Also, it is noteworthy that the studies on case management that are reviewed typically include the use of wraparound processes. When talking about wraparound specifically, the authors state that although the studies of its effectiveness tend to utilize uncontrolled designs, the studies "provide encouraging evidence of the effectiveness of the case management approach utilized in the wraparound process" (p. 219).

With regard to more traditional outpatient treatment, the authors suggest that the evidence base is clearest with regard to psychosocial treatments that focus on teaching problem-solving strategies, on parent management training, and on strengthening parent-child interpersonal skills. They also point to progress through the use of cognitive behavioral strategies for anxiety disorders.

The authors offer a very strong statement in support of the importance of family engagement in treatment. They report that, "the effectiveness of services, no matter what they are, may hinge less on the particular type of service than on how, when, and why families or caregivers are engaged in the delivery of care. While traditional forms of care approached mental health treatment in a hierarchical top down approach (with the clinician maintaining some distance from the recipients of treatment), this approach is not reflected in newer forms of service delivery. It is becoming increasingly clear that family engagement is a key component not only of participation in care, but also in the effective implementation of it" (p. 238). This is a very strong and important

statement about the importance of family engagement to come out of a review of the empirical literature on treatment efficacy and effectiveness.

Further, Burns et al. call for the development of a research agenda for the future that involves the contribution of multiple stakeholders, including children and families, clinicians, clinical educators, policymakers, and clinical and services researchers. They indicate that, "harnessing the contributions of these multiple stakeholders and the perspectives that they represent requires a democratization in the public sphere" (p. 241). This is a call for action that hopefully will be heeded.

Finally, the authors call for further efficacy and effectiveness research, additional service system research, and more research on actual practice. They identify the area of practice research as one of the most underdeveloped areas.

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Summaries of research on mental health services for children and adolescents and their families

Source: Henggeler, S. W., Rowland, M.D., Randall, J. et al. 1999. Home-based multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis: Clinical outcomes. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(11*)*, 1331-1339.

   Schoenwald, S. K., Ward, D. M., Henggeler, S. W., & Rowland, M. D. 2000. Multisystemic therapy versus hospitalization for crisis stabilization of youth: Placement outcomes 4 months postreferral. *Mental Health Services Research, 2*(1)*,* 3-12.

Two recent articles by Scott Henggeler and his colleagues present the results of a study in which multisystemic therapy was compared to hospitalization for youth in psychiatric crisis. These are important articles both because of the significance of the topic and the encouraging results that have been obtained so far by Henggeler using multisystemic therapy (MST).

Most of the research done prior to this study by Henggeler focused on children with delinquency and/or substance abuse problems. This study therefore represents a major change in the population of concern. Participants were 116 children aged 10 through 17 in Charleston County, South Carolina who were Medicaid-funded or without health insurance, and who were judged to be in need of psychiatric hospitalization because of the presence of systems of suicidal ideation, homicidal ideation, psychosis, or threat of harm to self or others due to mental illness. Families with children who met eligibility criteria for participation and who agreed to participate (116 families out of 134 agreed to participate) were randomly assigned either to psychiatric hospitalization or to multisystemic therapy.

It is important to note that MST underwent considerable modification for purposes of serving this population of concern. For example, at the time of intake a comprehensive plan to safely resolve the crisis was developed. The basic MST treatment team was enhanced by a child and adolescent psychiatrist, psychiatric residents, and crisis caseworkers, and supervision was initially increased from weekly to daily. Also, caseloads of therapists were reduced from five families per clinician to three families, thereby enhancing the intensity of the intervention. Also, a therapeutic foster care capability was added to MST.

It is also noteworthy that participants in the MST condition were hospitalized when the MST team felt it was needed. In fact, 44% of the youths in the MST condition were hospitalized at some point. During the hospitalization, the MST treatment rather than the hospital staff maintained clinical responsibility for the youth, and extensive efforts were made to insulate the MST youth from other activities on the inpatient unit.

The first of the two articles (Henggeler at al., 1999) presents the clinical outcomes. The results are favorable for the MST condition although in a relatively modest way. For example, of nine measures of youth functioning, two were significant in favor of MST, one was significant in favor of hospitalization, and for six there were no significant differences. The two significant differences in favor of MST were the externalizing scale of the CBCL as completed by the teacher, and the externalizing scale of the CBCL as completed by the caregiver. The one difference in favor of hospitalization was on self-esteem. Of five outcome measures on family functioning, there were two that were statistically significant in favor of MST (adaptability as reported by youth on the FACES-III, and cohesion as reported by caregivers on FACES-III), and three for which there were no significant differences. Out of five measures of youth social functioning, the only significant difference between conditions was on days out of school, which was in favor of MST. Both measures of consumer satisfaction (one from the youth and one from a caregiver) showed greater satisfaction by recipients of MST.

Overall, therefore, out of 19 measures of youth, family, or youth social functioning, there were five differences between conditions in favor of MST, one in favor of hospitalization, and 13 for which there was so significant difference between groups. On both measures of consumer satisfaction, the MST group was rated more positively than the hospitalization group. No data on effect sizes are given, although only three of the seven measures that favored MST were at the .01 level or greater.

The second article (Schoenwald, Ward, Henggeler, & Rowland, 2000) presents the findings on placement and cost. On overall number of days hospitalized, there is a clear and large difference in favor of MST, which reduced the number of hospital days used by 72% in comparison to the hospitalization group. Most of this difference was immediately after entry into the study.

The authors indicate that a "preliminary" accounting of the costs of MST with this population of concern indicated a cost of $5,954 per youth for a four month period. The estimated daily cost of MST was $47, which the authors report to be 52% higher than those incurred when MST is used with serious juvenile offender populations. This is important information for the children's mental health field. The average cost in the hospitalization condition was $6,174, just about the same as for the MST condition.

Overall, it is first of all very encouraging that Henggeler et al. modified and adjusted their MST model to better meet the needs of a population of children with severe psychiatric needs. The authors indicate, in fact, that "even with the extensive track record of MST in successfully treating adolescents with serious clinical difficulties, the complexity and severity of the problems presented by the youths in psychiatric crisis and their families was significantly greater than expected" (Henggeler et al., 1999, p. 1337). Second, it is also encouraging that on measures of clinical outcome the differences were primarily in favor of MST, and both on measures of consumer satisfaction and use of hospital days the differences were clearly in favor of MST. Third, however, it should be noted that the differences in clinical outcomes appear to be relatively modest (it would be easier to judge the importance of the differences in clinical outcomes if effect sizes had been presented by the authors), and that the costs for the two interventions were virtually the same. Therefore while the results are largely positive, indicating the potential value of this expanded MST model for youth in psychiatric crisis, there is still a need for further study and perhaps program development to enhance the effect sizes.

Also, at this point the results that are presented are only for the first four months after entry into the study. The authors indicate that they are gathering more long-term data, and that these data will be forthcoming soon.

Finally, it is noteworthy that perhaps no other group of program developers/researchers devote as much time and care to trying to develop and evaluate interventions for children with special challenges and their families as Henggeler and his colleagues. The children's mental health field clearly needs to identify mechanisms to encourage and support many others in doing the type of systematic program development and evaluation work that has been the trademark of Henggeler et al. Without such encouragement and support, progress at the clinical level is likely to be very slow.

Source: Hodges, K., Doucette-Gates, A., Cheong-Seok, K. (2000). Predicting service utilization with the Child and Adolescent Functional Assessment Scale in a sample of youths with serious emotional disturbance served by Center for Mental Health Services-funded demonstrations. *The Journal of Behavioral Health Services & Research* *27*(1), 47-59.

This study reports on data gathered as part of the evaluation of the Comprehensive Community and Mental Health Services for Children and their Families Program. The Child and Adolescent Functional Assessment Scale (CAFAS) is a measure commonly used to determine the presence and severity of serious emotional disturbance (SED) in children and adolescents. This article reports on a study to see if there is a correlation between CAFAS scores at intake and the subsequent length and level of restrictiveness of care that a youngster receives for treatment of SED.

Prior research from the Fort Bragg Evaluation has suggested that children and adolescents with greater impairment as measured by the CAFAS would require greater and more intensive care. However, those youths were generally from middle-income, two-parent military families and had less impairment than the youngsters sampled in the present study.

The CMHS-funded sites and CMHS-funded national evaluation are ongoing initiatives, with data collection at intake, 6 months, 12 months, and annually thereafter while children actively receive mental health services. Therefore, data collected by the evaluation are significant for their demographic and longitudinal scope.

Data for the present study indicate that the majority of caregivers were single females living below the poverty level. About two-thirds of the youngsters were male. About half of the children were adolescent (age 13 and above), and the rest were preadolescent. Youths meeting criteria for SED were referred for services through a variety of service agencies (see text box).

Changes in CAFAS scores from intake to 6 months were analyzed for the present study. Data were analyzed for over 1,500 youth according to levels of restrictiveness of care received as part of their treatment for SED. Youths who were very impaired as measured by the CAFAS scores at intake were more likely to receive services in residential units or in intermediate care settings. Youths who were less impaired were more likely to remain in a family setting during the six month period after intake.

Sources of referral. Data collected by Macro, International, Inc.:	
Mental health	23%
Social services	17%
Corrections or court	12%
Parent	99%
Other	17%

It is suggested by the authors that CAFAS scores at intake can aid policymakers and planners in allocation of funds based on anticipated out-of-family treatment and restrictiveness of care (e.g., cost and setting) for groups of youth. However, youths in the present study cannot be assumed to be representative of all youngsters with SED because only children and adolescents in treatment for six months were sampled. Furthermore, care should be exercised with scores for individual youth, as scores at intake should not be the only indicator for which type or intensity of treatment is deemed best for a particular youngster. The predictive utility of this measurement may, however, be beneficial to individuals as they progress through treatment in restrictive care settings. The authors suggest that frequent assessment with the CAFAS might help determine when a youngster has improved enough to be released into less restrictive care settings.

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Source: The Importance of Trust in Medical Care, "a review of recent writings by David Mechanic, available from the National Program Office of the Robert Wood Johnson Foundation Investigator Awards in Health Policy Research at the Academy for Health Services Research and Health Policy, 202/296-6700, e-mail: info@ahsrhp.org

This review of recent writings by a leading researcher and policy analyst in the health care area, David Mechanic of Rutgers University, has great applicability to the children's mental health field although it doesn't deal directly with it.

The review summarizes a series of nine articles by Mechanic on "trust" in medical care. It is significant in and of itself that a leading researcher, who is well known for his work in adult mental health, should choose this topic as a focus of study.

Mechanic makes the point that in health care, trust is the "glue" that makes care work. He says that as medical practice has changed in the managed care era with power shifting away from physicians to entrepreneurs and managers, there has been a sizable erosion of patient trust for their physicians. Research done with three groups of patients – those with breast cancer, Lyme disease, or mental illness – found that interpersonal competence is the most important aspect of trust from the patient's perspective. Patients characterized trust as an iterative process that developed over time, and were highly concerned about whether physicians advocated on their behalf. Patients also expressed great concern about the technical competence of their physicians.

While this work does not deal directly with children with emotional problems, their families, and the practitioners who they see, it is certainly relevant to the field. It has potential implications for staff selection and training, for the establishment of organizational and fiscal arrangements to facilitate trusting relationships, and for research on treatment effectiveness. It is consistent with the apparent growth in the use of independent case managers in the children's mental health field, particularly when the case manager role does not involve rationing of resources but does involve a strong element of advocacy for the children and families that they serve. The focus on trust also has great implications for the development of partnerships in general between parents and professionals, between various service sectors, and between individuals at neighborhood, county, and state levels.

Source: Promoting Resilience: Helping Young Children and Parents Affected by Substance Abuse, Domestic Violence, and Depression in the Context of Welfare Reform,Ó by Jane Knitzer, is available from the National Center for Children in Poverty, the Joseph L. Mailman School of Public Health, 154 Haven Avenue, New York, NY 10032-1180, 212 304-7100, e-mail: nccp@columbia.edu or website: www.nccp.org

The National Center for Children in Poverty, in its spring, 2000 newsletter, has included a very useful summary of an earlier report on welfare reform and young children. The report, entitled "Promoting Resilience: Helping Young Children and Parents Affected by Substance Abuse, Domestic Violence, and Depression in the Context of Welfare Reform," was authored by Jane Knitzer, a long-time leader in the children's mental health field and now deputy director of the National Center for Children in Poverty.

The report indicates that from 16-37 percent of welfare recipients have been reported to abuse drugs or alcohol, 20 percent are likely to face domestic violence in a 12-month period, and two to three times as many low-income mothers as other mothers are likely to experience depression. This creates a group of children who are at special risk for poor health, difficulty with relationships, and insufficient learning and mastery of social competence. It also creates a special challenge to the service community.

Knitzer indicates that, "by bringing together early childhood resources, TANF agencies, and agencies dealing with substance abuse, domestic violence, and mental illness, communities can create strategies that address both generation's needs simultaneously, more effectively, and more cost-efficiently than is often done now." She reports that while resilience-promoting, collaborative strategies are not being adequately used now, the building blocks for two-generation support systems are present in every community. She indicates that the aim should be to weave together adult focused services addressing both employment and parenting, and child focused services including early intervention, health care, and quality early care and education. The report indicates that TANF dollars are one possible source of funds to develop targeted intensive strategies.

This brief article, and the overall report on promoting resilience, call attention to an important and often overlooked issue in welfare reform – the impact on young children. They also suggest strategies for capitalizing on welfare reform, and the dollars available through TANF, to develop collaborations that have a two-generation focus and can promote resilience in vulnerable children.

Source: Weisz, John R. (Spring, 2000). Lab-clinic differences and what we can do about them: 1. The clinic-based treatment development model. *Clinical Child Psychology Newsletter, 15*(1)*,* 1-3, 10.

In a very thoughtful article, John Weisz, whose reviews of the results of outpatient treatment with children over the past ten years have been very influential in emphasizing the gap between what we know works under highly controlled conditions and what we know works in real day-to-day clinical practice, shares his new insights on this issue. Much of his new insights are based on his current research, which involves taking empirically-tested cognitive-behavioral treatments for youth anxiety and depression into community clinics in Los Angeles, and training and supervising clinic therapists as they try to apply these treatments with children referred through normal channels.

Weisz reports that while the therapists with whom they are working are dedicated and hard-working, they find it hard to fit manualized treatments into their clinic routines, their demanding workloads, and, perhaps most important, into the "complex array of life circumstances their clients present." Previously Weisz has pointed out that youngsters served in typical community settings are often different from those seen in many university studies. For example, they have more co-occurring conditions, and they and their families are under greater financial and social stress. Now, based on his current work, Weisz indicates that, "my colleagues and I were wrong, some years ago, when we wrote about difference between lab and clinic...we under-estimated the differences." As a result, Weisz indicates that treatment protocols that have been developed through research in specialized settings with volunteer populations "can face big challenges when used in typical clinical practice."

Weisz advocates moving from the Biomedical Intervention Testing Model, which originated in drug treatment research, to guide the process of developing treatments that are effective under real world conditions, to a "Clinic-Based Treatment Development Model." In this model, while original work may be done under controlled conditions, the treatments are studied in "single-case applications in practice settings with progressive adaptations to the protocol" before full-scale tests of their effectiveness are conducted. The use of single-case pilot tests with children referred through normal channels represents an important addition to traditional models, and, Weisz argues, provides important information for subsequent modification of the protocol.

Weisz concludes by asking whether we are more likely to obtain valid answers about treatment outcome from research with recruited samples seen under lab conditions, or from samples of individuals referred through normal channels seen under genuine clinical practice conditions. He indicates that "we may find that the most useful information, and ultimately the most useable and effective treatments, will come from immersing our treatment development and research in the complexity of real life."

While this conclusion may not seem surprising to individuals accustomed to working under genuine practice conditions, it represents an important statement from a highly-respected researcher who has specialized in treatment efficacy and effectiveness issues.

Source: Conduct Problems Prevention Research Group (1999). Initial impact of the Fast Track prevention trial for conduct problems: I. The high-risk sample. *Journal of Consulting and Clinical Psychology, 67*(5), 631-647.

Conduct Problems Prevention Research Group (1999). Initial impact of the Fast Track prevention trial for conduct problems: II. Classroom Effects. *Journal of Consulting and Clinical Psychology, 67*(5), 648-657.

For many years mental health professionals have promoted prevention as the missing link in a continuum of services for children and their families. This series of articles reports on some ongoing work in the area of prevention targeting very young children. The Fast Track intervention is a highly coordinated program designed to improve the social, emotional, and cognitive skills of children who are at high risk for long-term behavioral problems. The program is based upon a model of antisocial development that suggests behavioral problems are multiply determined and that factors contributing to aggressive behavior have a cumulative effect on a child's social and academic development. Accordingly, the program is designed to address the social and emotional environment of high-risk children through a multi-level intervention (conducted at the "universal" level and at various "specialized" levels). Research results suggest that the Fast Track intervention improved the social, emotional, and reading skills of these high-risk children.

The first article provides an overall, but detailed, summary of the Fast Track intervention and research results. The accompanying article concentrates on one interesting and crucial component of the Fast Track intervention, the Promoting Alternative THinking Strategies (PATHS) curriculum. The PATHS curriculum was delivered at the universal (in-class) level, and was designed to promote the emotion-regulation and prosocial skills of all (i.e., high-risk and non-high-risk) children in the regular education classroom. The authors note that the article on the PATHS curriculum presents "the first reported study of a universal social competence intervention implemented at the elementary grade that used the classroom, rather than the student, as the unit of analysis" (p. 655).

The Fast Track intervention study included 891 first grade children (nested within 401 classrooms) who were at high-risk of developing long-term behavioral and academic problems. The children attended school in four districts having high crime and poverty rates (Durham NC, Nashville TN, Seattle WA, and central Pennsylvania). All children were in regular education classes at the beginning of the first grade year, and were selected through teacher and parent reports of their disruptive behavior in kindergarten and at home. Of the 891 high-risk children identified, 445 received the intervention program at both levels. The remaining 446 children attended schools that had been randomized into a control group category, and did not receive either level of intervention.

The Fast Track intervention model was designed to help the target group of high-risk children (N=445) to develop non-aggressive peer relationships in school, to reduce the stress level of the overall classroom environment, and to educate their parents about appropriate disciplinary measures and positive parenting skills. In order to achieve these multiple goals, the Fast Track intervention "operated" at two levels: 1) in the classroom where both the target children and their non-high risk peers received the PATHS curriculum to build emotional and prosocial skills, and 2) at the specialized level designed solely for the target group of high-risk children. The specialized level included after school "enrichment sessions" for the children and their parents, semi-weekly tutoring sessions during school hours, and home visitations made by enrichment session coordinators (please see the insert for a breakdown of enrichment session activities).

continued…

Breakdown of Time Spent in Two-Hour Enrichment Sessions

First Hour:

Children: Met in "friendship groups" (social skills training groups) of 5-6 children. Facilitated sessions focused on reviewing and practicing skills in emotional understanding and communication, friendship building, self-control, and social problem solving.

Parents: Met in facilitated groups to discuss parenting strategies that would support child-school adjustment and improve child behavior. Primary content areas included: positive family-school relationships, parental self-control, appropriate expectations for child's behavior, improved parent-child interaction to decrease disruptive behavior.

Second Hour:

Parent-child pairs (thirty minutes): Participated in positive cooperative activities and practiced positive parenting skills with staff support. Activities included: games, crafts, and joint reading activities.

Academic tutoring (thirty minutes): In this last thirty minute session, children received academic skills tutoring (designed to promote reading skills) while their parents observed.

The after school enrichment sessions were coordinated with the PATHS curriculum in order to ensure that high-risk children and their parents were exposed to the curriculum contents before they were introduced in class. In this way, the children received a "head start" toward the skills they would learn in class with their peers. The program was presented to parents with a positive, skills-enhancing focus, and parents were paid for each session they attended. Childcare and transportation were also provided. Over 99% of parents attended at least one session, and 72% attended over half of the sessions.

In addition to the enrichment sessions, high-risk children received additional tutoring for reading and social skills development during school hours. The same paraprofessionals from the enrichment sessions tutored the children during school hours, thus ensuring that the children had contact with a supportive adult on a regular basis throughout the year. The enrichment session paraprofessionals also conducted bi-weekly visits to the children's homes. The visits were designed to develop trusting relationships with the parents and children and to promote general problem-solving skills for the entire family (e.g., marital conflict, housing issues). Most of the participants received at least six home visits.

At the end of the school year, an extensive variety of measures were used to assess the intervention. Results of the measures were compared between the high-risk children who received the intervention, and the control group of high-risk children who did not receive the intervention. Findings revealed that the intervention-group children improved in emotional and social coping skills, and made "distinct" progress with basic reading skills. The authors conclude, "these improvements in skills were accompanied by more positive peer relations at school, as well as better language arts grades" (p. 643). Parents of the high-risk children demonstrated more positive involvement with their children and more appropriate disciplinary practices. Parents also reported a greater sense of satisfaction with their parenting and self-efficacy. The Fast Track preventive intervention is designed to continue through grade 10. The trials reported in these articles for grade one are encouraging. The Conduct Problems Prevention Research Group has illustrated that a successful, large scale, and comprehensive school-based intervention is indeed possible.

Source: Bickman, L., Lambert, E. W., Andrade, A. R., & Penaloza, R. V. (2000). The Fort Bragg continuum of care for children and adolescents: Mental health outcomes over 5 years. *Journal of Consulting and Clinical Psychology* *68*(4), 710-716.

In this study, Bickman and his colleagues present data collected during the Fort Bragg Evaluation Demonstration (FBED), along with new data collected at a five year follow-up. Based on their analyses, they conclude that there were no differences between groups. They go on to report that "the current national policy of large investments in system of care infrastructure is unlikely to affect children in the manner intended," and "we need to focus on the services or treatment themselves to improve outcome."

The conclusion about Fort Bragg is based on six general outcome measures and four measures (two derived from the Child Behavior Checklist and two derived from the Youth Self-Report). In actuality, there was a statistically significant difference in favor of the FBED on one of the six general outcome measures – the Youth Self-Report. Interestingly enough, this difference also occurred at 12 months and was maintained throughout this time although the effect size is modest. Bickman et al. discount this because it was the only one that was significant and so they believe that it should not be counted since the likelihood of getting one significant difference when ten measures are used is unacceptably high.

It is also noteworthy that neither of the two measures that were used in the original data analysis at 12 months, and that produced significant differences in favor of FBED, were used in this study (the Global Level of Functioning scale, and the Child and Adolescent Function Assessment Scale). Both have been replaced by the Vanderbilt Functioning Index (both a parent and child version) that were actually developed using Fort Bragg data, and on which Fort Bragg kids did not do well (partly because they used more services and the Vanderbilt scale is based partly on service utilization). Nor does this article present data specifically on those children with serious emotional disturbance, although a footnote to the article indicates that an analysis was done of this sub-group, and "did not suggest superior outcomes at either site for any of the subgroups."

It is important to remember as well that this article about five-year outcomes suffers from the same problems that affected the overall study. For example, there were indications that the system was overwhelmed early in the project when most subjects were being admitted to the evaluation, and that implementation of the intervention was not good in this early stage. There are also indications that the populations of kids in the demonstration and comparison sites were not comparable, and the financing system created incentives for high cost. Overall, however, it is not surprising that there were no large differences at five years when there weren't large differences at 12 and 18 months.

Despite these problems, however, the FBED study, as well as the Starke County study, both appropriately reinforce the importance of focusing on improving practice as well as strengthening the system infrastructure. In fact, this focus on improving practice has been widely recognized and is being acted upon by CMHS and in the broader mental health field.

It is important, in response to the findings from Bickman's research, for the field to acknowledge how vital the practice part of a system of care is, and to continue to work on it. It is also important to recognize that there have been significant changes in the organization of systems of care since Fort Bragg, and that the system they studied (which was never a multi-agency collaborative effort anyway and did not have a strong family component either) is not reflective of current systems.

It is perhaps particularly noteworthy in this regard that systems of care are increasingly keeping larger and larger portions of their money flexible so that they might buy individualized services for children and families, rather than buying slots in existing programs that might or might not meet the needs. It is also noteworthy that systems of care are striving to use more evidence-based interventions, and that the evidence in support of the effectiveness of case management and wraparound, while not yet compelling, is encouraging, and has been so described in a recent article by Burns, Hoagwood, and Mrazek (1999). They indicate that, "Overall, these studies, although they utilize uncontrolled designs, provide encouraging evidence of the effectiveness of the case management approach utilized in the wraparound process.…Although the evidence base is small, there are indications that case management is an effective intervention for youth with severe emotional disorders" (p. 219).

In summary, this latest article by Bickman et al. is an extension of the same findings and conclusions that they reached earlier about Fort Bragg (and Starke County). While the Fort Bragg study can continue to be criticized on a number of grounds, perhaps the most important points are that the system of care movement has taken seriously the admonition that there needs to be a greater focus on the practice level, that systems of care are not a static phenomenon but are constantly evolving, and are looking for ways to strengthen practice, including using interventions that are supported by research.

Reference: Burns, B. J., Hoagwood, K., & Mrazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review, 2,* 199-254.

Source: Canino, G., Costello, J. E., & Angold, A. (1999). Assessing functional impairment and social adaptation for child mental health services research: A review of measures. *Mental Health Services Research* 1(2), pp. 93-108.

Psychological functioning is generally understood to exist along a continuum, making it difficult to distinguish between psychopathology and impaired functioning. However, it is becoming increasingly apparent that a measurable distinction needs to be made between the two constructs. Recent empirical evidence is beginning to show a difference between impairment and psychiatric disorder that may be useful in treatment planning and prevention. Furthermore, eligibility for mental health services, particularly in the public sector, often requires some level of impairment to be present.

The authors contribute to this discussion with an in-depth review of twelve commonly used instruments to assess "where we are" in the measurement of impairment in functioning (please see insert), and conclude that while each measure has its strengths, no one measure is appropriate for every purpose. They note, "some of the measures reviewed (e.g., CAFAS, SAICA) appear to be more appropriate for use in clinical settings, whereas others (e.g., CAPA and DISC Impairment Ratings) appear to be more appropriate for research purposes" (p. 105).

Impairment Measures Reviewed

Measures of Global Impairment
C-GAS (Children's Global Assessment Scale)
    Clinical C-GAS
    Lay C-GAS
CIS (Columbia Impairment Scale)
VFI (Vanderbilt Functioning Indexes, Parent and Youth)
Domain-specific or Multidimensional Scales
CBCL (Child Behavior Checklist)
SAICA (Social Adjustment Inventory for Children and
    Adolescents)
Vineland Scales
Vineland Screener
CAFAS (Child and Adolescent Functional Assessment Scale)
BERS (Behavioral and Emotional Rating Scale)
ISCS (Instrumental and Social Competence Scale)
    Instrumental Scale
    Competence Scale
Measures of Symptom-specific Impairment
CAPA (Child and Adolescent Psychiatric Assessment)
    Incapacity Ratings
DISC (Diagnostic Interview Schedule for Children)
    Impairment Measures

This article may be of interest to professionals who are called upon to measure or make determinations of impairment—not only for its useful review of measures, but for its theoretical content as well. Accordingly, the following paragraphs: 1) discuss the role that impairment may play in eligibility requirements for receipt of services, and 2) organize the theoretical content of the article into four topic areas.

Eligibility requirements. Many state and federal agencies and managed care companies now require the presence of a significant degree of impairment in functioning in order for a child or adolescent to be eligible for services. For example the federal definition of a Serious Emotional Disturbance (SED) requires a diagnosis of a DSM-defined psychiatric disorder resulting in functional impairment that "substantially interferes with or limits the child's role or functioning in family, school, or community" (p. 94). However, the DSM-IV does not provide a definition of what constitutes disability or functioning in its criterion for diagnosis of a mental disorder.

The DSM-IV criterion merely states that mental disorder requires the presence of "a clinically significant behavioral or psychological syndrome or pattern…associated with present distress or disability." (p. 93). The authors point out that so far neither federally funded agencies nor managed care companies have provided any concrete requirements or suggestions for specific measures to determine the point, or threshold, at which a child with a diagnosis becomes functionally impaired. Accordingly, "it has been left to mental health professionals to define and measure the construct" (p. 95).

Theoretical concerns. Asking, "what is it that agencies and researchers want to evaluate, and what kinds of measures are out there," the authors note that each measure under review is strong in one or more areas, but falls short in others. After reading the review of the instruments, it becomes clear to the reader that beyond the standard requirements of good measurement practices that Canino et al. address (such as validity and reliability), difficulties associated specifically with the measurement of impairment fall into four general areas of concern: 1) conceptual clarity, 2) degree of impairment, 3) cultural sensitivity and developmental differences, and 4) reliability of the informant or interviewer. Each area is discussed below.

I) Conceptual clarity. In the absence of an official definition, confusion can result over what is meant by "functional," "functionally impaired," or "competent." Some instruments measure the lack of functioning (impairment) while others measure achievement (competence) in functioning. Because functioning and symptomatology can overlap, it is difficult to devise an instrument that can determine where one construct "ends" and another "begins." The authors ask, for example, "When is lack of friends at school poor peer relations and when it is social phobia?" Accordingly, some measures suffer from a lack of clarity of questions or items used to differentiate between symptomatology and impairment.

II) Degree of impairment. While functioning can be thought of as "the ability to adapt to varying demands posed by the child's home, school, neighborhood, and peers"(p. 94), it is possible that a child's functioning may be highly impaired in one area and relatively functional in another. Therefore, the difficulties inherent in distinguishing between impairment and diagnosis are further compounded when degrees of functioning must also be ascertained (e.g., between adaptive, impaired, or severely impaired functioning), and in what areas.

III). Cultural sensitivity and developmental differences. Functional adaptation is typically associated with a child's performance in conformity with the expectations of his or her reference group (Hoagwood et al., 1996). Tests must therefore be sensitive to a child's cultural background in order "to avoid bias and misinterpretations of research results from studies using standard methods developed in a single sociocultural context" (p. 105). A number of measurements were found to be culturally bound. Furthermore, as with all childhood measures, tests for impairment must be considered in relation to the child's individual developmental stage. Not all tests under review were able to address differences in development.

IV). Reliability of the informant or interviewer. Some instruments do not collect new information but rely upon what is already known about the child (e.g., by a social worker who knows the child). In such cases, assessment can hinge upon the cultural perceptions of the interviewer of what constitutes normal behavior, and/or on how much or how little the interviewer knows the child.

In summary, this article contributes to an essential area in the children's mental health field by addressing the complex issue of impairment.

Source: Pires, S. A., Stroul, B., & Armstrong, M. L. (Spring 2000). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—1999 Impact Analysis.* Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida.

The Health Care Reform Tracking Project was initiated in 1995 to track and analyze public sector managed care initiatives as they affect children and adolescents with mental health and substance abuse disorders (referred to as "behavioral health") and their families. To date, the Tracking Project has completed two all-state surveys of managed care reforms (the 1995 State Survey and the 1997-98 State Survey) and has completed two Impact Analyses of selected states for in-depth analyses of state policy choices and implementation strategies. The 1999 Impact Analysis involved site visits to a new sample of 8 states, including Colorado, Indiana, Maryland, Nebraska, New Mexico, Oklahoma, Pennsylvania, and Vermont. A maturational analysis of the 1997 sample also was conducted through telephone interviews with key informants in order to assess changes and refinements made to those managed care systems since the site visits for the 1997 study.

The 1999 Impact Analysis report presents findings with respect to the new sample of states as well as the results of the maturational analysis and special analyses focusing on issues related to the child welfare system, substance abuse services, and the perspectives of family respondents. Where appropriate, results of the 1997-98 State Survey are incorporated and findings are compared with earlier Tracking Project results.

The authors conclude that the Tracking Project to date reflects a "good news, bad news" picture. On the positive side, more states—particularly those with carve outs—are moving toward changes in their policy decisions and purchasing specifications that would appear to benefit adolescents and children with behavioral health problems and their families. These include:

- Broadening medical necessity criteria and the array of covered services,

- Incorporating family involvement, cultural competence, level of care criteria and interagency collaboration into purchasing specifications,

- Involving key stakeholders more in planning and redesign,

- Providing more training for managed care organization staff regarding the needs of the population served by behavioral health services,

- Beginning to create more home and community-based services and alternatives to inpatient hospitalization, and

- Working more collaboratively across child-serving systems to problem solve.

On the other hand,

- Stakeholder reports indicate a major disconnect between state policies and contractual requirements and what actually is occurring at the implementation level,

- Home and community-based services are reported to be in short supply, access is difficult, and waiting lists persist in spite of contractual access standards,

- Reports of cost shifting and fragmentation of services (especially for children with serious behavioral health disorders) are widespread,

continued…

- Knowledge reportedly is lacking about how to operationalize family involvement and cultural competence at policy and service levels, and
- As in 1997, stakeholders in 1999 identified more disadvantages for children with behavioral health disorders in states with integrated physical/behavioral health managed care approaches than in states with behavioral health carve outs.

Overall, stakeholder perceptions vary according to their role in managed care initiatives. There seems to be a level of optimism over policy changes at state levels, and particularly in states with carve outs, but a degree of pessimism continues to prevail over implementation problems.

Souce: Koplan, J. P., Fleming, D. W. Current and future public health challenges. *Journal of the American Medical Association. 2000; 284:* 1696-1698.

Children and mental health are getting increased attention in the public health world! A recent article in the prestigious *Journal of the American Medical Association* by two senior members of the Centers for Disease Control and Prevention, lists ten current and future public health challenges. The third of these ten is children's emotional and intellectual development.

Koplan and Fleming indicate that, "Attention to children's physical development must be matched with a parallel focus on their emotional and intellectual development. Although vaccinations and other health advances have made infancy and childhood less perilous, an essential challenge is to encourage home, pre-school, and community environments, interactions, and relationships that permit each child to achieve his or her full potential."

It is noteworthy that the eighth challenge on the list is to "recognize and address the contributions of mental health to overall health and well-being." The authors indicate that, "the challenges are to identify risk factors, improve access to treatment (including removing the stigma from seeking help), and promote good mental health in all communities."

This article was published just two weeks after the Surgeon General's Conference on Children's Mental Health, and during the same week that the Surgeon General conducted a Congressional briefing on children's mental health.

The complete list of 10 challenges is:

1. Institute a rational health care system;
2. Eliminate health disparities
3. Focus on children's emotional and intellectual development
4. Achieve a longer "healthspan"
5. Integrate physical activity and healthy eating into daily lives
6. Clean up and protect the environment
7. Prepare to respond to emerging infectious diseases
8. Recognize and address the contributions of mental health to overall health and well-being
9. Reduce the toll of violence in society
10. Use new scientific knowledge and technological advances wisely

Previous research has shown that a relationship exists between high-risk neighborhood environment and the development of mental health problems in children and adolescents. While the casual observer may conclude that the actual rates of poverty, violence, and other conditions associated with high-risk neighborhoods will have a direct effect on mental health problems, the authors show that the relationship between neighborhood environment and mental health is very complex.

Stiffman et al. distinguish between objective ("real") environment and perceived (psychological) environment, and consider the mitigating role played by family and peers (environmental support) in the development of mental health problems in such adolescents.

Findings indicated that objective environment did not have a direct influence on mental health. Rather, the way an adolescent perceived his or her environment was directly related to the development of mental health problems.

Mental health problems were likely to develop when the youths perceived their neighborhoods negatively (i.e., as "deteriorating"). Yet adolescents receiving support from their families and who associated with non-misbehaving peers reported fewer negative perceptions of their neighborhoods than did youths who did not receive very much environmental support.

Youths with internalizing mental health problems benefited from family and peer support to a greater extent than did youths with externalizing problems. However, chronic exposure to violence increased the chances that youths would perceive their neighborhoods negatively; in which case family and peer support were less likely to have a positive influence on mental health.

The Youth Services Project (YSP) was funded by the National Institute of Mental Health (NIMH) in 1994. The study involved 792 adolescents in urban St. Louis who were recruited from various child-serving agencies (i.e., health, juvenile justice, child welfare, and education systems). The youths were between the ages of 14-18 (see sidebar for demographics).

Demographics of adolescents interviewed (N=792)

Adolescents (age range 14-18 yrs):

Mean age	15.3
Caucasian	13%
African-American	86%
Male	43%
Female	57%

Head of household or living situation:

Family headed by mother:	42%
Mother and other adults	11%
Two-parent families	14%
In foster or group care	14%
With non-parent relatives	12%

Employment of primary financial support provider:

On welfare	13%
Semi-skilled	39%
Blue collar	16%
White collar	20%
Professional	9%

Many of the adolescents interviewed had mental health or behavioral health problems: 12-16% met diagnostic criteria, and 22-58% reported three or more symptoms. Two-thirds of the youths reported that they had engaged in some form of violent behavior within the prior six months. Mental health status was determined through youth self-reports using the Diagnostic Interview Schedule for Children-Revised (DISC-R), and DSM-IV criteria.

Perceived environment was measured by combining information gleaned from the DISC-R interviews with youths' ratings of their neighborhoods. Emphasis was placed on how the youths "saw" their neighborhood. For example, youths were asked whether there were "a lot" of deteriorated buildings, or only "some" (see sidebar for perceived environment).

A picture of the *objective environment* was captured by combining 1990 census data with addresses of adolescents interviewed, and with police district records. Interestingly, there was good concordance between youths' self-reports and police records. That is, children reporting higher incidences of violent behavior in their communities did indeed live in high-crime areas.

Environmental support was approximated by adolescent self-reports about their family, peer groups, and structured activities (e.g., through clubs and organizations). Analysis showed that only family environment and peer behavior had a significant, mitigating effect on youths' perceptions of their neighborhood environment. The authors note that the measurement of environmental support was the "weakest portion" of the model.

Overall, limitations of the study revolve around the sample size. All respondents were from public service sectors in one Midwestern city and may not be representative of urban or inner-city adolescents. The fact that youths were asked to report on their own violent behavior or illegal activities is also problematic. Furthermore, it is not known whether youth involved in violent behavior would be more or less prone to notice violence around them.

However, the study is commendable for its use of structural equation modeling to examine relationships between each type of environment and mental health status from several different angles. For example, perceived environment and mental health status were each tested as dependent variables because it is not clear whether perception influences mental health or mental health influences perception.

In conclusion, the authors note three significant insights for further research and treatment: 1) the youths' perceptions of their environments are based in reality; 2) it is important to understand the way that youths perceive their neighborhoods in order to treat them for mental health and behavioral problems, and 3) environmental support plays a key role in mitigating the negative impact of high-risk neighborhoods. "The next logical research step would be the development, implementation, and evaluation of a theory-based intervention simultaneously targeting community environment, youths' perceptions, and environmental support" (p. 85).

Source: Rosenblatt, J., Rosenblatt, A., Biggs, E. E. (2000). Criminal behavior and emotional disorder: Comparing youth served by the mental health and juvenile justice systems. *Journal of Behavioral Health Services & Research, 27*(2), 227-237.

This article focuses on the types of crimes adolescents with serious emotional or behavioral disorders (SED) are arrested for and how often are they arrested for these crimes, along with differences in DSM-IV diagnoses between these youth and youth with SED who have not been arrested for crimes.

The authors shed additional light on these complex issues by examining public mental health (MH) and juvenile justice (JJ) datasets on youth served in a CMHS system of care (Sonoma County, California) between April, 1995 and June, 1998. Combined, these datasets included data on 4,924 adolescents. Findings indicate that one-fifth of adolescents receiving MH services in Sonoma County had a history of multiple arrests over a three year period. Child and Adolescent Functional Assessment Scale (CAFAS) and Child Behavior Checklist (CBCL) scales indicated that MH-using youth with a history of arrests had more externalizing problems than MH-using youth who had not been arrested.

The number of youth who received both MH and JJ services was 684. That is, 20% of all adolescents receiving MH services were arrested during the study period. Or, viewed from the perspective of the JJ system, 31% of all youth arrested during the study period had some prior contact with the MH system.

Table 1. Demographic and arrest data on MH using and non-MH using youth during study period (N=4,924).			
	Total youth served by public MH or JJ systems N=4,924		
	Youth served by public mental health service system N=3,367		**Arrested youth not served by the public mental health system N=1,557**
	Youth without arrests N=2,683	Youth with arrests N=684	
Avg age at MH intake	13.9	14.8	n/a
Avg age at JJ intake		15.5	15.8
Euro-American	69%	73%	data unavailable
Male	60%	60%	60%
Avg no. arrests per youth	n/a	2.81	1.6
Misdemeanors	n/a	65%	59%
"Other" lesser crimes	n/a	44.3%	37.4%

Data for this study were utilized in two ways. Table 1 illustrates the total data set (N=4,924) and average number of arrests by MH-using and non-MH using youth, along with other demographic information. Unfortunately, no ethnic data was available from the JJ database.

Table 2 illustrates diagnostic differences between two matched and randomly paired subsets consisting of: 1) MH-using youth who had *not* been arrested ; and 2) MH-using youth who had been arrested.

Findings from this smaller, representative sample revealed that youth with arrest records had higher rates of oppositional defiant disorder (ODD) and conduct disorder (CD), and lower rates of anxiety disorders than did MH-using youth who had not been arrested during the period of the study.

Table 2. Functional status of MH service users with and without arrest records during study period		
	With arrest (n=94)	Without arrest (n=94)
ODD/CD diagnosis (p = .04)	33%	20%
Anxiety diagnosis (p = .01)	4.3%	14.9%
ADHD diagnosis	6.4%	7.4%
Mood disorder diagnosis	37.2%	41.5%

There was no significant difference between groups for Attention deficit hyperactivity disorder (ADHD) and mood disorder. CAFAS and CBCL scores showed high rates of impairment for adolescents having a history of mental and emotional disorders and who were arrested during this study period; as a group, this was particularly the case for CAFAS subscales on School/Work Role, Home Role, Community Role, Behavior Toward Others/Self, and Substance Abuse.

Implications of this study should be considered with reference to its limitations. Because data were only collected on JJ-using youth during the 38 month period of the study, adolescents with prior arrests were not included in the analysis.

Additionally, arrest data does not include acts for which youth were subsequently convicted, and certainly does not cover crimes for which no arrest was made. However, analysis of the data on JJ-using youth who had also received MH services during the study period (31%), suggests that, "because traditional services in the JJ system have tended to either ignore MH needs or inappropriately treat youth with multifaceted problems, 31% is probably a low estimate of the MH needs of youth arrested for crimes in the current study" (p. 233).

Although data indicate that the majority of arrests for MH-using youth were misdemeanors, this finding may simply reflect the possibility that those adolescents who commit serious crimes have not been identified as being in need of MH services. "These youths may have the same need for MH services as youth committing less serious crimes, yet due to the nature of their arrests, they are viewed as in need of punishment rather than rehabilitation" (p. 235).

With the above limitations in mind, implications of the study become more salient. Findings that one-third of arrested youth have had previous contact with the MH service system "serves to underline the importance" of collaborative services between the JJ system and MH services.

Furthermore, implications of the representative sample suggest that the majority of MH-using youth arrested during the study period were diagnosed with externalizing problems. Collaboration between the two systems must emphasize clinical programs that are effective with externalizing problems. According to the authors, "most interventions with adolescent offenders have not proven successful." Noting that "MH service systems may be ill-equipped in their current form to serve youth with antisocial or violent behavior," (p. 235), the authors suggest that Multisystemic Therapy (MST) may be an efficacious clinical practice for these youth.

In conclusion, this article is valuable in two respects: first and foremost, it provides "evidence of a high degree of interrelationship between the JJ and public MH systems in a county in which MH services are delivered as part of an overall strategy for developing a system of care for youth with severe emotional disturbance" (p. 235). Second, the authors review prior research on MH-using youth in the JJ system, and provide an excellent list of references for further study of this important and timely topic.

Source: Lopez, S. R. & Guarnaccia, P. J. J. (2000). Cultural psychopathology: Uncovering the social world of mental illness. *Annual Review of Psychology*, 51, 571-598.

This exhaustive review of research in the field of cultural psychopathology includes an interesting section on childhood disorders. The authors define cultural psychopathology as "an interdisciplinary research approach integrating anthropological methods and conceptualizations with traditional psychiatric and psychological approaches" (p. 1).

The section on childhood psychopathology highlights work conducted by Weisz and colleagues on differences between Thai youth in Thailand and American youth in the United States. According to Weisz, "the fact that others determine whether children's behavior is problematic indicates the importance of the social world in defining mental illness and disorders of children and adolescents" (Weisz, in Lopez et al., p. 18).

Two studies by Weisz et al. support the hypothesis that culture "influences the ways in which youth express psychological distress" (p. 18). In both studies, over 90% of Thai children came from a Buddhist household, where self-control and emotional restraint are highly valued behaviors (Weisz et al., 1993). Accordingly, both studies found that Thai youth exhibited more internalizing problem behaviors (e. g., anxiety and depression), when compared to American youth. However, the second study indicated that Thai youth also exhibited aggressive behaviors at a rate similar to that of youths in the United States Thus, no cross-cultural differences could be found with regard to externalizing problems, but differences were found with regard to internalizing problems.

From these two studies, Weisz et al. conclude that "Thai cultural factors …may contribute to the development of overcontrolled [internalizing] problems without significantly suppressing undercontrolled [externalizing] problems" (Weisz et al., 1993 p. 396). That is, "over and undercontrolled problems do not constitute a hydraulic system…forces that may facilitate the development of one problem type do not necessarily suppress the other" (Weisz et al., 1993, p. 401). Interviews with Thai youth help shed light on the complex interaction between culture and behavior: One youth admitted, "We should control ourselves in order to make us happy. Although I know this fact, it is hard for me to control myself" (Weisz et al., 1993, p. 396).

A third study by Weisz et al. (1995) compared Thai schoolteacher ratings with US schoolteacher ratings of problem behaviors in their classrooms. They found that Thai schoolteachers rated more externalizing and internalizing problem behaviors by their schoolchildren than did American teachers. In order to check these findings, Weisz et al. "devised an innovative observational methodology to assess whether it was something about the children or the teachers that contributed to this finding" (p. 19). Independent observers returned to the same schools in the US and in Thailand to rate the same groups of children and teachers; one of the observers was a bilingual Thai psychologist who received his graduate training in the United States. The observers found that "ratings were reliable across both national sites," leading Weisz et al. to conclude that "Thai teachers have a much lower threshold than US teachers for identifying problem behaviors in their students" (p. 20).

Lopez et al. provide further examples of "the possibility that culture shapes the type and degree of problem behaviors of children and adolescents" (p. 20) with brief discussions of the work done by developmental researchers in numerous countries. They also discuss the ecocultural model of accommodation developed by Weisner, Gallimore and colleagues with regard to developmental disabilities.

For anyone interested in ways that cultural psychopathology can inform research in children's mental health, this review is a "must read." The authors discuss the growth of the field from Kleinmann's work in the late 1970s to current trends in the field today, and list over 160 references. Brief discussions of families and children appear in other sections of the review as well (e.g., families' role in schizophrenia, and "US Ethnic Minority Groups"). Full text of this review is available on the internet to those with individual or university access to the *Annual Review of Psychology* [http://psych.annualreviews.org/] or the OVID Mental Health Collection database.

Reference: Weisz, J. R., Somsong S., Chaiyasit, W., Weiss, B., Achenbach, T. M., & Eastman, K. L. (1993). Behavioral and emotional problems among Thai and American adolescents: Parent reports for ages 12-16. *Journal of Abnormal Psychology, 102*(3), 395-402.

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