



# Data Trends


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

issue numbers 94-106  
december, 2004

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*Data Trends* are produced by the Research and Training Center for Children's Mental Health in Tampa, Florida to increase the dissemination of current research findings in the area of children's mental health services. Each issue of *Data Trends* summarizes 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.

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Source: Walrath, C. M., Mandell, D. S., Holden, E. W., & Santiago, R. (2004). Assessing the strengths of children referred for community-based mental health services. *Mental Health Services Research* 6(1), 1-8.

**Keywords:** CCMHSP, CAFAS, BERS, impairment, strengths, children's mental health

Do youth with higher levels of functional impairment have fewer strengths when compared with youth having low or moderate levels of impairment? Are the concepts of impairment and strength at opposite ends of a continuum, or are they two unrelated concepts? These are some of the questions explored by the authors of this study of strengths in children and adolescents with emotional and behavioral disorders. Results suggest that there is a *relationship* between impairment and strengths, but they are *separate concepts*. This supports the position that it is important to promote the acquisition of strengths as part of the package of services provided to youth with functional impairment.

Data on youth receiving services between 1997-2002 were collected from the national evaluation of the Comprehensive Community Mental Health Services for Children and their Families Program. Of this group, 56% were selected for the current study ( $N = 1,838$ ) because their records included complete data for all variables of interest. There were no statistically significant differences found between the selected youth and those who were not selected. Youth in the current study were between 5 and 17.5 years of age at intake, and were from 23 communities throughout the United States (i.e., urban, small city, rural, and Native American). Over half of the youth were Non-Hispanic White (54%), male (66%), and over the age of 11 (73%). Eleven percent of the youth had mild impairment, followed by moderate (30%), marked (30%), and severe (29%) impairment.

Impairment ratings were determined with the Child and Adolescent Functional Assessment Scale (CAFAS), and strengths were measured with the Behavioral and Emotional Strength Rating Scale (BERS). Analysis revealed a significant difference in the average BERS Strength Quotient among youth having mild, moderate, marked and severe impairment. Higher impairment scores were associated with lower strength scores, but strength scores (even among the most severely impaired youth in the sample) reflected near-average and average overall strengths. Regardless of level of impairment, youth scored highest for affective strength, followed by intrapersonal, family involvement, interpersonal, and school-related strength (see Table 1).

Table 1. Domain-Specific Strengths* and Overall Functional Impairment ( $N = 1,838$ )				
Domain-specific Strengths (BERS)	Overall Functional Impairment (CAFAS)			
	Mild/minimal ( $n = 202$ ) M (SE)	Moderate ( $n = 556$ ) M (SE)	Marked ( $n = 555$ ) M (SE)	Severe ( $n = 525$ ) M (SE)
Family involvement	10.21 (0.18)	8.88 (0.11)	7.75 (0.11)	6.83 (0.11)
Interpersonal	9.83 (0.11)	7.80 (0.11)	6.64 (0.11)	6.04 (0.11)
Intrapersonal	10.69 (0.20)	9.16 (0.12)	8.45 (0.12)	7.40 (0.12)
School functioning	8.98 (0.18)	7.55 (0.11)	6.73 (0.11)	5.99 (0.11)
Affective	11.31 (0.27)	10.16 (0.14)	9.04 (0.14)	8.41 (0.14)

\* BERS average strengths =  $-3 \leq 10 \leq +3$

With regard to demographic characteristics, males, youth under the age of 11, and minority/ethnic youth had significantly higher strength ratings compared to girls, older youth, and Non-Hispanic Whites. However, the fact that all youth in the sample had near-average or average BERS overall strength scores was not negatively influenced by demographic characteristics.

Because youth with all levels of impairment exhibited near-average or average strengths, the authors suggest that strength and impairment are separate concepts. Additionally, the moderate correlation found between the CAFAS and the BERS "provides further evidence for the convergent validity of the BERS" (p. 6).

Clinical implications of the study suggest that measuring both the impairment levels and strengths of youth upon intake into services can provide a more holistic picture of the youth in order to set treatment goals accordingly. "Clinical assessments should expand beyond problem-based measures to include measures of strengths, thereby not only gauging the needs of children but also working to empower families and discover the foundation upon which to build interventions" (p. 7).

Source: Heflinger, C. A., Simpkins, C. G., Scholle, S. H., & Kelleher, K. J. (2004). Parent/caregiver satisfaction with their child's Medicaid plan and behavioral health providers. *Mental Health Services Research*, 6(1), 23-32.

**Keywords:** parental satisfaction, managed care, fee-for-service, Medicaid

To date, few studies have been conducted assessing parental satisfaction with children's health care in managed care plans. Consumer satisfaction is of growing importance for managed care companies and is frequently displayed in health plan report cards, as well as in benchmarking and monitoring procedures. However, little is known about the satisfaction of parents of children with chronic conditions. This study is one of the first of its kind to focus on children with serious emotional disorders and examine the influence of managed care on parent/caregiver satisfaction ratings about their children's (a) behavioral health provider, and (b) behavioral health insurance plan through the Medicaid programs in three states. The study results reveal parents of children with serious emotional disorders in Medicaid fee-for-service (FFS) plans were significantly more satisfied with their plans than those parents in Medicaid managed care (MC) plans.

The researchers analyzed data from three of six states participating in the Children with Serious Emotional Disorders section of the Managed Care for Vulnerable Populations Study funded by SAMHSA. All three states, Mississippi, Pennsylvania, and Tennessee, had similar behavioral health benefits in their plans, but the plans were administered differently. Mississippi's Medicaid program was FFS for behavioral health services and almost all physical health services. Preauthorization was required only for inpatient hospitalization. In Pennsylvania, there were two groups of children with Medicaid included in the study: those in the traditional FFS plan and those who had voluntarily chosen a MC plan, including both physical and behavioral health services. Tennessee mandated all Medicaid beneficiaries into the MC plan for both physical and behavioral health.

Data were collected in 1997-98 by face-to-face interviews with parents/caregivers of children with serious emotional disorders. A total of 715 participants were included in the sample: 52% from Pennsylvania, 23% from Tennessee, and 24% from Mississippi. The sample consisted of parents of children aged 4-17 (mean age=12.4) diagnosed with a serious emotional disorder. Seventy percent of the children were male and 25% were African American. These children exhibited high levels of behavioral health symptoms, as measured by the Child Behavior Checklist and Columbia Impairment Scale. Children were excluded from participating in the study if their only diagnosis for Medicaid service had been adjustment disorder or mental retardation.

The respondents were the primary caregivers for the children, primarily mothers or other female family members. Their average age was 40 years with a mean educational level of 12<sup>th</sup> grade. Parents/caregivers reported a high level of depressive symptoms, according to scores on the Center for Epidemiological Studies Depression Scale. Ratings of caregiver strain were also found to be elevated.

Parents/caregivers rated global items regarding their satisfaction with a) their child's most frequently used behavioral health service provider in the six months before the interview and b) their child's behavioral health plan. Specific questions were also included, such as asking parents/caregivers to give grades of A-F to *number of providers available, convenience of location, range of services covered, and overall quality of behavioral health services under their plan.*

Multiple regression modeling techniques were used to examine satisfaction ratings and explore the differences between FFS and MC plans, while controlling for issues such as demographic characteristics, clinical measures that have been previously related to satisfaction ratings, and child mental health service use in the past six months.

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# DATA TRENDS

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

**No. 95 (continued)**

Results show that parents/caregivers for children with serious emotional disorders were significantly less satisfied with their Medicaid managed care programs than those in fee-for-service programs. Provider satisfaction did not differ greatly on the basis of health plan type, in part because in at least one site (Pennsylvania), the providers were the same for both MC and FFS.

- Parent/caregiver age was positively associated with provider satisfaction and plan satisfaction
- Family income had a negative association with provider satisfaction and plan satisfaction
- Parents/caregivers with higher levels of depression/caregiver burden were significantly less satisfied with their children's providers
- Parents/caregivers rated higher satisfaction for more intensive levels of care (i.e., inpatient/residential and day treatment)
- Parents/caregivers of Black children gave higher satisfaction ratings for the plan than parents/caregivers of children of other races
- Parents/caregivers in Pennsylvania reported lower levels of satisfaction with their children's providers than those in the other two states

These findings highlight the importance of consumer ratings of health care systems. The results of this study are particularly important because of the paucity of information on consumer satisfaction with this group – parents/caregivers of children with serious emotional disorders. The authors suggest that “a focus on the experiences of special populations such as these children should be a part of ongoing monitoring and oversight activities” (p. 30).

Source: Shaffer, D., Scott, M., Wilcox, H., Maslow, C., Hicks, R., Lucas, C. P., Garfinkel, R., & Greenwald, S. (2004). The Columbia SuicideScreen: Validity and reliability of a screen for youth suicide and depression. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(1), 71-79.

**Keywords:** suicide, adolescents, Columbia SuicideScreen, Beck Depression Inventory

According to the National Institute of Mental Health, suicide by youth ages 15-24 was the third leading cause of death among adolescents in 2002. It is also estimated that there may be 8-25 attempts for every adolescent suicide death. These statistics reveal the importance of identifying youth who are at risk of suicide and to provide them with treatment. This article reports on the validity and test-retest reliability of the Columbia SuicideScreen (CSS). The CSS is a brief, 11-item self-report instrument designed to assess known risk factors for suicide among adolescents. The instrument was found to have "good sensitivity and reasonable specificity" (p. 71). However, youth who screen positive on the CSS for being at risk of suicide should be evaluated with a second instrument in order to reduce the number of false-positives (i.e. students who are not at risk of suicide) identified by the CSS.

Participants were drawn from a convenience sample of 9<sup>th</sup>-12<sup>th</sup> grade students attending eight New York high schools ( $N = 1,729$ ). Each grade represented about 25% of the sample. The mean age of the sample was 15.4 years ( $SD = 1.4$ ), and over half of the students were female (57%). Caucasians comprised 56% of the sample, followed by African-Americans (18%), Hispanics (13%), and other ethnicities (13%).

All students completed the CSS and Beck Depression Inventory (BDI) during school hours. To avoid an emphasis on suicidality, items from the CSS and BDI were embedded within a larger health survey. With regard to the CSS, students were deemed at risk of suicide if they endorsed any of the following key risk items: (a) any suicidal ideation within the last three months; (b) any suicide attempt at any time; (c) three out of five emotional items (i.e., unhappy, withdrawal, irritability, anxiety, substance abuse); or (d) if they asked to speak to a professional about their emotional problems. Of the total sample, 28% ( $n = 489$ ) of the students endorsed one of the items and therefore met criteria for being at risk of suicide.

In order to assess the validity of the CSS, 73% ( $n = 356$ ) of students who were identified as being at risk of suicide were group matched (by grade, gender, and ethnicity) with 285 students who were not at risk. The Diagnostic Interview for Children (DISC-2.3) was then administered to each group, and students needing further evaluation or treatment were identified at this time. The DISC-2.3 for risk of suicide includes: suicidal ideation or prior attempt, and a DSM-III-R diagnosis for major depression, dysthymia, or substance abuse. The level of risk of suicide detected by the DISC-2.3 was used to establish the criterion validity of the CSS.

Results indicate that the CSS algorithm for *suicidal ideation* or *previous attempt*, along with intermediate or higher scores for *unhappy*, *withdrawal*, *irritability* or *anxiety*, provided the best concordance with the DISC-2.3 criterion. The most balanced algorithm had a sensitivity of 0.75, a specificity of 0.83, and a positive predictive value ranging from 16-33% (p. 75). Thus, in comparison to the BDI, the CSS was more sensitive to detecting adolescents who are at risk of suicide, and was more specific in its ability to reduce the number of false-positives. The CSS was also more sensitive than the BDI in predicting suicide as measured by the DISC-2.3 validity criterion.

The power of the CSS to detect adolescents who are at risk of suicide, along with their specific risk factors, may be due to the longer time frame (three months) covered by the CSS in comparison to the BDI (one week). Further, the CSS asks about both suicidal ideation and suicidal behaviors, and the BDI does not. However, like other suicide risk instruments, the CSS "has the potential for having high sensitivity at the

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expense of specificity.” (p. 75). Thus, even though the specificity of the CSS was “generally better than for other instruments,” (p. 75), the authors recommend a second-stage evaluation to increase specificity.

Test-retest reliability was determined with 85 students who were re-administered the CSS and BDI eight days after their first administration. Test-retest reliabilities were 0.48(ê) for suicidal ideation, and 0.58(ê) for suicide attempt. With the exception of ethnicity, this sample of students did not differ significantly from the overall sample. There were more Hispanic and African-American students in the test-re-test sample than in the original sample. Compared to the BDI, the CSS had slightly lower test-retest reliability, but had greater sensitivity and specificity against the DISC-2.3 validity criterion.

In conclusion, the CSS shows promise as an instrument that can detect suicidal ideation and other at-risk factors for suicide among teenagers as a first step toward identifying students who need evaluation or treatment. A second-stage evaluation should increase the ability of clinicians and researchers to accurately detect these teens. Further, the CSS can be administered in a school setting, which should increase the odds of identification and treatment of high school youth.



Source: Stephens, R. L., Holden, E. W., & Hernandez, M. (2004). System-of-Care Practice Review Scores as predictors of behavioral symptomatology and functional impairment. *Journal of Child and Family Studies*, 13(2), 179-191.

**Keywords:** SOCPR, fidelity, national evaluation, direct services

The System-of-Care Practice Review (SOCPR) measures the extent to which service delivery systems embody system-of-care principles. In the current study, the authors assess the degree of adherence to those principles at the direct service level, and investigate whether adherence impacts children's mental health outcomes. Three system-of-care sites funded by the Center for Mental Health Services (CMHS) were matched with three comparison communities offering traditional services. After 12 months of services, the authors found a "counterintuitive" (p. 188) association between adherence to system-of-care principles and lower symptomatology and impairment scores for the control group only. However, children and families served by CMHS-funded system-of-care sites gave higher ratings, overall, to their service delivery experiences than did participants in the comparison communities.

The SOCPR is one of the measures in the longitudinal component of the national evaluation of the Comprehensive Community Mental Health Services for Children and their Families Program. Eligibility criteria for the SOCPR are the same as those for the national evaluation (see Hernandez et al., 2001), with the additional requirement that children and their families have received services long enough to ensure familiarity with a range of service experiences. A subset of families ( $N = 75$ ) participating in the national evaluation was selected for the SOCPR: 36 children and families receiving services at three well-developed CMHS-funded system-of-care sites (SOC) were matched as a group with 39 families receiving services from three comparison communities (COMP). Over half of the children in the SOC and COMP groups were male (56% and 63%, respectively), and the average age for children in both groups was about 10-11 years. There were two significant differences between the samples; the COMP group had more African American participants and more families with low annual incomes.

The SOCPR protocol combines a qualitative case study methodology (i.e., document review, observation, multiple interviews, etc.) with a quantitative method for aggregating data. Part of the protocol assess the child and parent's experiences with their services according to the following system-of-care domains: (a) *child-centered and family focused*—individualized, full participants, case management; (b) *community-based*—early intervention, access to services, level of restrictiveness, integration and coordination; (c) *cultural competence*—sensitivity and responsiveness, awareness, agency culture, informal supports; and (d) *impact*—improvement, appropriateness of services. Respondents rated these domains on a scale of 1, *strongly disagree*, to 7, *strongly agree*. Child symptomatology and impairment were identified with the Child Behavior Checklist (CBCL) and the Child and Adolescent Functional Assessment Scale (CAFAS), respectively. The SOCPR, CBCL, and CAFAS were administered at intake into services and every six months thereafter for up to two years. The authors report on results through the first 12 months.

At intake into services, children in both groups scored in the clinical range on the CBCL and CAFAS. In comparison to the COMP group, mean CBCL total problem scores fell significantly below the clinical range for the SOC group at 12 months. A similar pattern occurred between the two groups for CAFAS total scores, but the difference was not statistically significant. At 12 months, higher SOCPR scores were significantly associated with lower CBCL and CAFAS scores among COMP families only. Thus, even though children in the SOC group improved, and their families reported higher levels of adherence to system-of-care

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values than the COMP group, correlations between SOCPR Total scores and the two outcome measures were significant for children in the comparison communities only. Notably, families in the COMP group who gave high ratings on the SOCPR tended to have children with fewer behavioral and emotional problems at intake than did children in the SOC group.

These results provide support for the ability of the SOCPR to detect fidelity to system-of-care principles at the direct service level. However, the unexpected association between fidelity and outcomes among children in the COMP group (rather than the SOC group) may be explained by the low variation in SOCPR scores provided by the SOC sample; this group consistently provided high ratings for the system-of-care domains, with all scores ranging from 4-7. In contrast, rankings from the COMP sample varied widely, with rankings from 1-7. Thus, “the restricted range of scores and reduced variability of experiences within the funded communities may have accounted for the absence of significant relationships that were found within the relatively small number of [participating] families” (p. 189).

In conclusion, children and their families in the SOC group consistently reported high levels of fidelity to system-of-care principles in their service experiences. While children in the COMP group showed improved emotional, behavioral, and impairment scores at 12 months, children in the SOC group also improved. The association between fidelity to system-of-care principles and improved outcomes found for children in the COMP group was not anticipated, but it was explained. As discussed in this study, and in Hernandez et al. (2001), the ability of the SOCPR to detect fidelity to system-of-care principles is an important step toward understanding the relationship between such principles and outcomes. A revised SOCPR is currently underway, and should provide more specific details about the delivery of evidence-based interventions at the local level.

## References:

Hernandez, M., Gomez, A., Lipien, L., Greenbaum, P. E., Armstrong, K., & Gonzalez, P. (2001). Use of the System-of-Care Practice Review in the national evaluation: Evaluating the fidelity of Practice to system-of-care principles. *Journal of Emotional and Behavioral Disorders*, 9(1), 43-52.

Source: Walrath, C., Miech, R., Holden, E. W., Manteuffel, B., Santiago, R., & Leaf, P. (2003). Child functioning in rural and nonrural areas: Does it compare when using the service program as the level of analysis? *Journal of Behavioral Health Services & Research*, 30:4, 452-461.

**Keywords:** rural, urban, functional impairment, CAFAS

The research question for this study asked whether impairment scores for children in the federal system-of-care program differ between children who live in rural areas and children who live in either small cities or in urban cities. Thus, analyses were conducted at the regional level rather than at the individual level. The authors compared aggregated functional impairment scores between each group of children; after controlling for age, gender and race, few differences were found between the rural and nonrural samples. Further, age proved to be a more influential predictor of impairment than geographic area.

All participants for the study were recruited from 26 system-of-care sites located throughout the United States. Each site self-identified as being located in either a rural or nonrural (i.e., a small city or urban city) area; data from the 2000 Census verified each response. This process resulted in the selection of eight rural sites and 18 nonrural sites; about one-third of participating children were from rural areas ( $n = 4013$ ), and the rest were from nonrural areas ( $n = 9666$ ). Children from rural areas were on average 11.23 ( $SD = 3.83$ ) years old, while children from nonrural areas were about a year older, at 12.34 ( $SD = 3.69$ ). Almost half of the children in the rural sample (45%) were 12 years of age or younger, as were 56% of children from the nonrural sample. Gender distributions in each sample were about the same; females comprised 35% of the rural and 34% of the nonrural samples. There were more Caucasian children in the rural (64.9%) than in the nonrural (47.8%) sample, and African-American children comprised 11% of the rural, and 18.7% of the nonrural sample.

At intake into services, the Child and Adolescent Functional Assessment Scale (CAFAS) was completed for each child; aggregated scores are provided in Table 1, with higher scores indicating greater impairment (see *Data Trends* #25 for a theoretical discussion of functional impairment). At first glance, it would seem that youth from nonrural areas have higher degrees of impairment when compared to youth from rural areas. Yet a series of analyses revealed otherwise.

The first analysis identified the nonrural sample as having a significantly higher CAFAS Total score; subscales for *school*, *community*, and *substance use* were also significantly higher among the nonrural sample than the rural sample. No significant differences between groups were found for the *behavior toward others*, *home*, *mood*, *self-harmful behavior*, and *thinking* subscales. Next, controls for age, gender, and race were factored into the model, revealing considerable changes between each analysis. For example, CAFAS Total score and the subscales for *community* and *substance use* were no longer statistically significant between the rural and nonrural groups. However, differences

**Table 1. Site-level functional impairment by region (N = 26 sites)**

Functional impairment, M (SD)	Rural ( $n = 4013$ )	Nonrural ( $n = 9666$ )
Eight score total CAFAS	87.05 (9.61)	92.45 (13.44)
School	17.84 (1.74)	19.56 (1.83)
Home	17.83 (2.20)	17.30 (2.90)
Community	7.83 (1.47)	9.63 (3.16)
Behavior Toward Others	15.98 (1.72)	16.22 (2.34)
Moods and Emotions	14.12 (1.91)	14.22 (3.10)
Self-harmful Behavior	5.63 (1.75)	6.33 (2.90)
Substance Use	3.39 (1.79)	4.65 (3.18)
Thinking	4.44 (0.96)	4.54 (1.50)

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between groups revealed significant improvement in the *home* subscale score for the nonrural sample. No new differences in the *behavior toward others*, *mood*, *self-harmful behavior* and *thinking* subscales were revealed between regions when this analysis was performed.

To determine whether age, gender, or race had the most influence on these results, a third analysis was conducted. Compared to the controls for gender and race, age had the strongest influence on the aggregated scores. Specifically, among the nonrural group the control for age eliminated statistical differences on the CAFAS Total score, and on the *community* and *substance use* subscales. Controlling for age continued to reveal low levels of impairment among the nonrural sample for the *home* subscale, but scores for the *school* subscale remained high for these children.

In summary, the first analysis indicated that children in the nonrural sample displayed more impairment on the CAFAS Total score and on three out of eight subscales when compared to children in the rural sample. After further analysis, impairment scores for nonrural children reduced to nonsignificance for the CAFAS Total score and for three subscales, but significantly increased for the *home* subscale. After controlling for age in the third analysis, children from nonrural areas remained significantly less impaired on the *home* subscale, but more impaired on the *school* subscale when compared with the rural group. With the exception of the *home* and *school* subscales, these analyses brought impairment scores for rural and nonrural children into close range with each other, suggesting that children in these groups are “more similar than different” (p. 460). The study also supports a case-mix methodology, in which researchers consider the demographic composition of a group or community rather than its geographic region.

Generally, risk-factors associated with city life (e.g., an abundance of crime, substance abuse, densely populated low-income neighborhoods, etc.) imply an influence on the development or exacerbation of impairment problems among children who live in cities. While this may be the case for nonrural children, results of this study discourage the inference that rural children need fewer supports and services than nonrural children. Rather, both rural and nonrural children have similarly high levels of impairment. These results “remind policymakers and funding agents that youth in rural areas need equity in both access and resources for mental health services” (p. 452).

Source: Slade, E. P. (2003). The relationship between school characteristics and the availability of mental health and related health services in middle and high schools in the United States. *The Journal of Behavioral Health Services & Research*, 30:4, 382-392.

**Keywords:** schools, counseling, mental health, substance abuse, Add Health, Medicaid

School-based mental health services can help identify, refer, and provide mental health counseling for troubled adolescents. Yet few nationally representative studies have investigated the extent to which schools offer on-site mental health counseling services to their students. This study identifies local-level factors associated with the availability of in-school mental health counseling and other health care services for students in grades 7-12. Results suggest that approximately half of all schools surveyed offer mental health counseling. Large schools, schools in urban areas, and schools with high percentages of students enrolled in Medicaid were more likely to provide mental health services than other schools.

For this study, a nationally representative sample of 125 middle and high schools was selected from the National Longitudinal Study of Adolescent Health database, Add Health (see *Data Trends* #70). Results of two surveys adapted from the Add Health database, county-wide demographic data (i.e., state funding, poverty rates, household income), and school characteristics (e.g., size, location) were also used in this analysis. In addition, school administrators were asked four questions about whether their school provided: (a) on-site counseling for emotional and behavioral problems, (b) on-site physical exams, (c) substance abuse counseling, or (d) all of the above. Using these data, multivariate estimates explored the extent to which mental health counseling, physical examinations, and substance abuse counseling are available in schools throughout the U.S. Selected results of the study are summarized below.

### All three services

- About 1 in 10 schools offered all three services to their students.
- Larger schools, urban schools, and schools having a high percentage of students enrolled in Medicaid or without insurance were the most likely to offer all three services.
- Schools having a large percentage of minority students were much less likely to offer all three services; small schools and schools in the South were also unlikely to offer these services when compared to other schools.
- No association was found between the availability of state funding for mental health services, physical examinations, or substance abuse counseling.

### Mental health counseling

- Overall, 48% of schools surveyed provided mental health counseling.
- Schools with a high percentage of minority students were likely to provide mental health counseling (this relationship approached significance, with  $p = .103$ ), and some schools reported up to 80% minority representation. Most schools having a large percentage of minority students were located in urban areas.
- Students attending schools in the Northeast and in the West were more likely to receive mental health counseling if they lived in an urban area. Regardless of urbanicity, schools in these areas provided more mental health counseling than did Midwestern and Southern schools; 86% of schools in the Northeast and 69% of schools in the West provided mental health counseling. In comparison, 46% of schools in the South, and 28% of schools in the Midwest provided this service.

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- Coming from an economically disadvantaged home (i.e., low annual income, uninsured children) was not significantly associated with the availability of mental health counseling in schools.
- A significant, positive association was found between urbanicity and Medicaid enrollment and the availability of mental health counseling.

## **Physical examinations**

- Slightly more than half (53%) of the schools in this study offered physical examinations.
- Sixty-three percent of suburban schools, and 50% of rural schools offered physical examinations.
- Schools with a high percentage of uninsured students were significantly less likely to offer physical examinations.
- Urbanicity was not significantly related to physical examinations.

## **Substance abuse counseling**

- About 40% of schools offered substance abuse counseling.
- Suburban schools were less likely to offer mental health counseling, and more likely to offer counseling for substance abuse problems.
- Medium-size schools were unlikely to offer substance abuse counseling.
- Urbanicity was not significantly related to substance abuse counseling.

In conclusion, the strongest positive association found was between mental health counseling and the percentage of students on Medicaid. Another strong, positive association became evident for students with no health insurance and the provision of all three services. Thus, schools with high proportions of students on Medicaid or who are uninsured are making strides toward providing students with mental health services. However, the costs associated with in-school health services may discourage school administrators from establishing on-site clinics or programs for students. This reluctance among school administrators may be explained by the complex and lengthy process involved in becoming a Medicaid provider.

While this study provides further insight into the disparities that exist among schools and on-site mental health counseling, findings regarding mental health and substance abuse counseling programs should be interpreted with caution. Administrators who reported on their school's mental health and substance abuse counseling programs may have had different ideas about what constitutes "counseling" for students (e.g., part-time social worker v. an in-school clinic). Further, the data in this study do not provide insight into the type and quality of services provided in schools. Nonetheless, the author raises new questions about in-school services and the student populations they serve, and calls for further research into the type and quality of in-school services and their funding sources.



Source: Rogers, K. N., Fernandez, M., Thurber, L., & Smitley, A. (2004). Exploring differential attrition rates among system of care evaluation participants. *Journal of Community Psychology*, 32(2), 167-176.

**Keywords:** national evaluation, attrition

The authors investigated differential attrition rates among a sample of children and their families who participated in the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program. About a quarter of children and their families dropped out of the evaluation. Children of families who dropped out had less severe externalizing and impairment scores than children who remained in the evaluation.

There were 303 children and their families who participated in this study of attrition from the national evaluation (see *Data Trends* #31 for more information about the national evaluation). The children were receiving services from three North Carolina system-of-care sites; they were between the ages of 5-18, had a serious emotional or behavioral disorder, and were at-risk for out of home placement. The evaluation followed each family for 6-36 months, depending on when they entered the program. Interviews were conducted at baseline, and every six months thereafter until the 36<sup>th</sup> month; measures included the Descriptive Information Questionnaire, the Child and Adolescent Functional Assessment Scale (CAFAS) and the Child Behavior Checklist (CBCL).

A total of 78 (26%) families dropped out of the evaluation. European American families comprised 50% of the drop out sample, followed by African American (40%), Asian (5%), and Hispanic/Other (5%). The most common three reasons for dropping out of the evaluation were *refusal* (32%), *moved* (25%), or *could not be contacted* (20%). Notably, almost half (46%) of the families dropped out after completing the baseline interview only. Compared to the children who remained in the study, those who dropped out did not have as many mental health problems; they had significantly lower levels of clinical impairment for externalizing problems, and lower functioning in school, community, and thinking.

When child and family characteristics and levels of functioning were correlated with the number of completed interviews, it was found that parents with higher levels of education were significantly less likely than other parents to drop out of the evaluation. Furthermore, the child's rate of improvement did not influence attrition rates.

In conclusion, attrition is a common problem for researchers and clinicians. When children and families drop out of a longitudinal study, results may not reflect an accurate rate of change among those who remain in the study. Most importantly, children and families who drop out will not receive the additional services available to them. The authors of one study found that children and adolescents are the most likely of all age groups to attrit from services (see *Data Trends* #60). Understanding why attrition occurs is complex. Rogers et al. speculate that some of the children who dropped out of the current study may have completed treatment during the course of the study; in such cases families may not have been motivated to continue in the evaluation. Other reasons may include cultural differences, disagreement over the effectiveness of the treatment

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# DATA TRENDS

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itself, problems within the family, and economic or insurance problems. The authors provide the following recommendations to reduce attrition from the evaluation. These suggestions are also relevant to retaining children and families in treatment.

- Ask families and children specific questions about why refuse to participate in the evaluation.
- Increase efforts to locate families.
- Expand travel efforts (within reason) to collect data from families who have changed addresses.
- Reassess incentive procedures.
- Disseminate community-specific outcome reports to local agencies and participating families.
- Extend efforts to increase family participation in the evaluation.
- Investigate predictors of attrition and adjust service delivery systems and/or treatments.

Source: Yeh, M., Hough, R. L., McCabe, K., Lau, A., & Garland, A. (2004). Parental beliefs about the causes of child problems: Exploring racial/ethnic patterns. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(5), 605-612.

**Keywords:** etiology, cultural competence, sociology, POC Survey

Parents who seek services for their children may have beliefs about the causes of emotional and behavioral problems that are not consistent with current research findings. These beliefs may hinder parental help-seeking, especially among underserved minority groups. Thus, the authors explored perceptions held by parents with racial/ethnic backgrounds about the causes of mental illness in their children. Results indicate that African-American, Asian Pacific Islander, and Latino parents were less likely than Non-Hispanic White parents to attribute mental health problems in their children to a combination of biological, psychological, and sociological factors. Significant differences between racial/ethnic groups were also found.

For this study, a subsample of 1,338 parents were selected from the Patterns of Care (POC) Survey. The current sample included 270 African American (AA), 372 Latino, 109 Asian Pacific Islander (API), and 587 Non-Hispanic White (NHW) parents; their children were receiving services in San Diego County. *Data Trends* #35, #55, and #86 summarize studies of diagnoses, referral patterns, and barriers to care among participants in the POC survey, respectively.

For the current study, parents endorsed up to 11 global items on the Beliefs About the Cause of Child Problems—Parent Version, a measurement designed for the POC survey. These items were grouped under three categories: 1) *Biopsychosocial* (i.e., a combination of biological, psychological, and sociological factors). This category includes five items understood to influence mental health problems and toward which treatment is typically directed: *physical causes*, *personality*, *relational issues*, *familial issues*, and *trauma*; 2) *Sociological*. This category includes *friends*, *American culture*, *prejudice*, and *economic problems*; and 3) *Spiritual causes* (e.g., spirit possession), and *Nature disharmony* (i.e., disruption of the child's vital energy flow) comprise the final category.

A series of analyses uncovered a tendency among each racial/ethnic group to endorse each item in the biopsychosocial category significantly *less* often than did the NHW group. Of items in the sociological category, significant differences were found between minority and NHW parents for *American culture* and *prejudice* (see the textbox for major findings and implications).

Results also revealed significant differences between racial/ethnic groups for both the biopsychosocial and sociological categories. African American parents identified *physical* causes more often than API and Latino parents. Compared to API parents, AA respondents were also more likely to report that *personality* and *familial* factors caused mental health problems. Latino parents believed that *familial* problems adversely affected mental health more often than did API parents. When compared to Latino and AA parents, API respondents were more likely to endorse *American culture* as the cause of their children's problems. Further, more AA parents identified *prejudice* than did Latino parents.

#### Summary of Major Findings

- Parents from minority backgrounds were less likely to endorse items related to biopsychosocial causes than Non-Hispanic White parents were;
- Parents from minority backgrounds were more likely than Non-Hispanic White parents to endorse sociological differences, particularly those related to characteristics of American culture, and issues related to prejudice;
- There were some differences between parents in the different racial and ethnic groups, highlighting the need to understand the beliefs of each group rather than viewing all parents from minority backgrounds as having a similar view.

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The results of this study may help further our understanding of help-seeking patterns among AA, API, and Latino parents and their beliefs about the causes of child mental health problems. As suggested by the authors, if ethnic minority parents have explanatory beliefs about child problems that are less consistent with biopsychosocial causes, they may be unlikely to comply with the majority of treatments available to them.

The clinical implications of this study call for strategies that acknowledge and work directly with parental beliefs about the causes of mental illness. The authors recommend that clinicians and administrators direct some of their outreach efforts toward informing parents about possible relationships between sociological factors and the full range of what we know about possible causes for emotional and behavioral problems (p. 611). They also suggest that mental health services address problems that are sociological in nature—such as prejudice, or American culture for newly immigrated families—which may contribute to children’s emotional and behavioral problems.

Source: Garland, A. F., Lewczyk-Boxmeyer, C. M., Gabayan, E. N., & Hawley, K. M. (2004). Multiple stakeholder agreement on desired outcomes for adolescents' mental health services. *Psychiatric Services*, 55(6), 671-676.

**Keywords:** parent-child-therapist agreement, psychotherapy, desired outcomes

What kinds of changes do adolescents want to see in themselves and their environment as a result of their treatment for mental health problems? Are these desires similar to those held by their primary caregiver and therapist? In the first study to compare desired outcomes across all three groups, Garland et al. explored these questions. Desired outcomes were compared for each group and by agreement across groups. Results indicate that agreement between groups on outcomes was relatively poor.

Participants included 170 adolescents between the ages of 11-18 ( $M = 13.5$ ,  $SD = 2$ ), their primary caretaker (usually a mother;  $n = 170$ ), and their therapist ( $n = 57$ ). Therapists most frequently reported practicing family systems therapy or eclectic psychotherapy.

Interviews with the adolescent, caregiver, and therapist were conducted after one or two outpatient therapy sessions. The interviews consisted of open-ended questions in which each respondent identified the three most important outcomes that he or she desired. These responses were then coded and organized under five domains: (a) *symptoms* (e.g., reduce anger, improve moods); (b) *functioning* (e.g., have more friends); (c) *consumer perspective* (e.g., have a good experience in therapy); (d) *environment* (e.g., a peaceful home life), and; (e) *system* (e.g., appropriate school placement).

Comparisons between the groups for agreement on each outcome were moderate to poor. Results indicated that *reduce anger and aggression* was endorsed significantly most often by all groups. Other significant results for comparisons between groups are listed in the text box.

**Significant results of comparisons between groups for agreement on outcomes**

- Adolescents and therapists reported *environment* more often than caregivers;
- Adolescents and therapists endorsed *improve family relationships* more often than caregivers;
- Caregivers endorsed *obey parents* and *improve self-esteem* more often than adolescents;
- Caregivers and therapists endorsed *symptoms* and *functioning* more often than adolescents;
- Therapists reported *talk about feelings* more often than adolescents and caregivers, and;
- Few respondents endorsed outcomes in the *consumer perspective* or *systems* domains.

At the individual level, comparisons between a specific adolescent and his or her caregiver and therapist were poor. Although no triads agreed on the same three outcomes, 38% of all triads agreed on one outcome. Agreement was more likely to occur between dyads than between all three respondents; 70% of parent-therapist dyads agreed on at least one outcome, followed by parent-adolescent dyads (64%), and adolescent-therapist dyads (62%). Further analysis revealed that triads were significantly most likely to agree with each other when the adolescent had an anxiety disorder, and significantly least likely to agree if the therapist used a cognitive-behavioral approach to treatment.

The authors note that these results must be interpreted with caution. It is possible that respondents might have agreed on the same outcomes generally, but that they prioritized them differently. Citing the qualitative method as a limitation to the study design, the authors appended a "forced-method" survey to the end of the interview. Respondents were again asked to choose their three most important desired outcomes. Results did not differ substantially from the open-ended method.

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The implications of this study are important on multiple levels. At the individual level, the adolescents studied were “very willing” (p. 675) to participate in the interview process and to identify the areas that they wanted to improve upon through therapy. According to the authors, this willingness discourages the perception that adolescents are unlikely to enter into treatment voluntarily; paying attention to the goals and expectations of youth and their families may improve their engagement in services.

At the level of research and policy, the authors suggest that we take a closer look at the “ecological validity of outcome measures, including the variability in meanings and the prioritization of outcomes for various stakeholders [to] improve the clinical utility of outcome measurement in the field, which could ultimately improve the effectiveness of mental health services” (p. 676).



Source: Harrison, M. E., McKay, M. M., & Bannon, W. M. (2004). Inner-city child mental health service use: The real question is why youth and families do not use services. *Community Mental Health Journal*, 40(2), 119-131.

**Keywords:** mental health services use, need for services, service providers, barriers

Due to the stresses of poverty and urban living, many children of color who reside in low income, urban neighborhoods may be at risk for emotional and behavioral problems. Yet empirical studies show that these children and their families receive relatively few mental health services, possibly due to inadequate supports and/or cultural differences. In order to better understand the gap between service need among this population and service use, the authors investigated parental *help-seeking behaviors* and *utilization* or *non-utilization* of services. Miscommunication between parents and service providers was the most often cited reason for non-utilization of services.

Respondents ( $N = 253$ ) were parents of children consecutively referred to a community-based mental health clinic in a Midwestern, urban city. Children were an average age of 9.8 years ( $SD = 4.14$ ), and most were African American (79%), followed by Latino (12%), and Caucasian/Other (7%). A battery of questionnaires identified (a) parenting skills (e.g., discipline effectiveness); (b) child psychopathology; (c) steps families took prior to service use and the helpfulness of informal supports; (d) factors associated with service use; and (e) barriers to accessing services. Parents were contacted to participate in the study after their children were referred to the service agency. Families who kept at least one appointment for services were interviewed periodically after the child's first appointment, for 16 weeks (families who dropped out of treatment were asked about their reasons for doing so). Families who kept no appointment after scheduling services were contacted by phone to determine why they had not come to the clinic for services.

There were 171 (68%) families who kept at least one appointment, and 82 (32%) families who kept no appointments (there were no significant demographic differences between these groups). The severity of child psychopathology did not influence the degree of service use or non-use by families. Selected results of the three main goals of this study are provided below.

- *Help-seeking behavior*: most parents sought help from a school counselor or from family members prior to seeking services;
- *Utilization of services*: effective discipline and social support were two factors that significantly influenced the use of services, while having a positive attitude to mental health approached significance; and
- *Non-utilization of services*: miscommunication, or because the therapist had not called the family back, was the most often reported reason for not keeping an initial appointment, followed by feeling too overwhelmed to keep an appointment. However, when contacted by phone, nearly three-quarters of families who had not kept an appointment reported that they would still like to receive services for their child.

Results of this study provide additional confirmation of the gap between unmet need and service use among low income, urban families of color. Yet these results also suggest some strengths that clinicians and researchers can build upon. As mentioned by the authors, parents were using informal supports prior to their child's referral, and most found those supports very helpful. Thus, understanding family strengths may contribute to greater participation in services. For example, most parents in this study wanted their child to receive services (even if they had not kept an appointment)—this knowledge, combined with community outreach efforts about mental health services and programs, may help attract and retain children and their families in services. Finally these results suggest that community-based clinics may want to evaluate their in-house policies and procedures to ensure that they do not discourage families from seeking services.

Source: Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. [And Commentary, J. S. Lyons & L. Rogers, The U.S. child welfare system: A de facto public behavioral health care system]. *Journal of the American Academy of Child and Adolescent Psychiatry* 43(8), 960-973.

**Keywords:** child welfare, unmet mental health need, cross-agency collaboration

Results of this study indicate that approximately half of the children who come into contact with the child welfare system have need for mental health services. Findings reflect the critical need for child welfare workers to screen youth for emotional and behavioral problems when they first enter the child welfare system. However, as pointed out by Lyons and Rogers, child welfare is one system among many child-serving agencies currently overburdened by an influx of children who need mental health services. The authors of this article, and its commentators, underscore the importance of cross-agency involvement among child- and adult-serving sectors to identify and meet the mental health needs of youth and their families. Barriers to establishing such partnerships are also discussed.

Data for the current study were from the National Survey of Child and Adolescent Well-Being (NSCAW), a nationally representative sample of youth whose caregivers/families were investigated by child welfare agencies between October 1999 and December 2000 for child maltreatment; the authors report on children between the ages of 2-14 years ( $N = 3,803$ ). Youth, their caregivers and child welfare workers were interviewed within six months of each completed investigation to determine mental health need at the time of the investigation, and rates of service use 12 months prior to the investigation.

Child Behavior Checklist (CBCL) scores indicated that 48% of the sample had need for mental health services, and among those, only 11% had received services in the previous year. For very young children (ages 2-5), 33% had a need for services and only 7% actually received them. Overall, 16% of the entire sample received mental health services, and 84% did not. Youth with greater clinical need received services at a significantly higher rate than youth with less clinical need. All youth were more likely to receive services for sexual abuse than for neglect, and this finding was significant for very young children. Further, all youth were significantly more likely to receive mental health services if they had a parent with severe mental illness, or if they had been exposed to numerous risk factors. Almost all youth (90%) were living at home at the time of the investigation; of this group, children between the ages of 6-14 were significantly less likely to receive services than youth who were living outside of the home.

Importantly, 53% of the entire sample had previously come to the attention of a child welfare agency for allegations of child maltreatment. The authors ask: "Will their next appearance in the child welfare system result in a placement?" (p. 967). Over one-third of the youth in this study were exposed to impaired parenting skills, and two-thirds were victims of alleged neglect; these findings, combined with mental health services need and use by these children, indicate the urgent need for multi-agency partnerships. As suggested by the authors, these partnerships should also include agencies that serve the needs of parents (e.g., parenting, mental health, substance abuse, etc.).

In their commentary, Lyons and Rogers point out that if half of the children in the child welfare system have emotional and behavioral problems in the clinical range, then the child welfare system is a de facto behavioral health care system. As such, the child welfare system has a responsibility to identify youth with

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mental health needs and to secure treatment for them, not simply through referrals, but to the extent that “all aspects of the child welfare system...should be planned within the context of designing systems that are responsive [to the needs of these children]” (p. 971). Moreover, systems involved with children and families that overlap with other child-centered systems (e.g., child welfare, education, social services, juvenile justice, and mental health) should coordinate services in such a way that the welfare of the children and their families served by these systems are addressed at every level of operation. Where Burns et al. suggest that their findings “beg for clear identification of the barriers to receiving mental health care,” (p. 967) Lyons extends this call to an identification of barriers to inter-agency coordination among child-centered systems (which may parallel barriers among adult-serving systems; see text box).

### **Cross-system barriers to multi-agency cooperation:**

- Services are often provided only in the system that the child/family enters, despite the family having multiple issues. Many people have referred to this as the “silos” in the service system;
- Finger pointing: The different child-serving systems, based on funding issues, regulations, and expertise, will take the position that their particular system is not responsible, but that another system should be accountable for the care of the child;
- Care is left uncoordinated in case of the multiple needs of particularly challenging children and families;
- Services are not uniformly monitored for quality and outcomes, leading to ineffective, underutilized services;
- Due to failures to sufficiently fund accessible community-based services, many children end up in the high-need, expensive services. In the absence of an effective community-based system, the waiting lists for these high-end services grow into bottlenecks that give the illusion that the system needs more high-end services;
- Most systems lack an infrastructure to identify and monitor children in high-end services and, consequently, to assist in a “step-down” process to reintegrate the child back into his or her family and community; and
- Services are not efficiently used because there are few mechanisms in place that assist the appropriate matching of children’s needs and strengths to services, treatments, and levels of care.

Lyons & Rogers, p. 972.

Source: Lau, A. S., Garland, A. F., Yeh, M., McCabe, K. M. Wood, P. A., & Hough, R. L. (2004). Race/ethnicity and inter-informant agreement in assessing adolescent psychopathology. *Journal of Emotional and Behavioral Disorders*, 12(3) 145-156.

**Keywords:** POC Survey, inter-informant agreement, cultural competence

Identifying children who have mental health problems commonly relies upon the perceptions of parents, teachers, and the youth themselves. However, the perception of mental health need across these three informants may be different. Cognizant of this problem, the authors compared inter-informant agreement between youth-parent, parent-teacher, and youth-teacher dyads to determine whether perceptions about the child's emotional and behavioral problems differed by race/ethnicity. Findings indicate that teachers exhibited more racial and ethnic bias than youth or parents; parents were frequently unable to gauge whether the child had internalizing or externalizing problems; and generational differences between immigrant parents and their children may affect informant responses.

This study involved adolescents ( $N = 600$ ) who were an average age of 14 years ( $M = 14.9$ ;  $SD = 2.2$ ), and had received services within the year from one or more child-serving agencies (e.g., mental health, juvenile justice, child welfare, alcohol and drug rehabilitation, special education). Most youth were Caucasian (42%); followed by Hispanic (27%); African American (23%), and Asian Pacific Islander (8%). Over half (67%) of the sample was male. Over half of Asian Pacific Islander (61%) and Hispanic (59%) families had immigrated to the United States. The authors analyzed scores from the parent, teacher, and youth versions of the Child Behavior Checklist and controlled for age, gender, and family income.

Results indicate that no racial or ethnic bias significantly affected youth self-reports. However, teacher responses suggested the presence of bias in their perceptions, such that they associated *externalizing* behaviors with African-American youth (especially males). The perception that African-American youth have greater externalizing problems than their Caucasian peers "may partially account for [African American] overrepresentation" in the special education (p. 152) and juvenile justice sectors (p. 154). Teachers also characterized Asian/Pacific Islander youth with more *internalizing* than externalizing problems.

Results further suggest that parents frequently over- or under-estimated their child's need for mental health services. Caucasian parents reported *more* problems, and minority parents reported *fewer* problems than their children endorsed. Agreement between the youth and parent was higher for Caucasian than for Hispanic and Asian Pacific Islanders. The authors suggest that internalizing and externalizing problems may manifest differently in the classroom than they do in the home, possibly explaining discrepancies among respondent endorsements of internalizing and externalizing behaviors. For example, in contrast to teacher endorsements, African-American parents often reported internalizing problems in their children. Also, parents who immigrated to the United States and who "shoulder the burden" (p. 152) of immigration and discrimination may have difficulty identifying emotional and behavioral problems in their more acclimated children. Additionally, in an attempt to conform to competing cultural norms, youth from immigrant families might shield their parents from their emotional and behavioral problems.

In conclusion, parents and teachers are often key informants about the emotional and behavioral problems exhibited by youth; their responses and perceptions are often affected by their own ideas about what constitutes a mental health need. As discussed in their literature review, the authors assert that cross-cultural assessments with multiple respondents may also suffer from cultural, linguistic, and conceptual differences between respondents. The combined use of multiple respondents and culturally competent measures may reduce the instances of racial and ethnic discrepancies among informants. A previous cross-cultural study of parental beliefs about the causes of mental health problems (see *Data Trends* #101), and a study comparing parent, teacher, and youth self-reports on desired outcomes (see *Data Trends* #102) add support to the results of the current study.

Source: James, S., Landsverk, J., Slymen, D. J., Leslie, L. K. (2004). Predictors of outpatient mental health service use—The role of foster care placement change. *Mental Health Services Research*, 6(3), 127-141.

**Keywords:** foster care, placement type, placement change, externalizing problems

In the first study of its kind known to the authors, this research contributes to the literature on mental health service use among children and adolescents in foster care. The authors examined rates of outpatient mental health service use by youth in foster care who, as a consequence of their behavioral problems, had to change foster homes. The study found that as the number of placement changes due to behavioral problems increased, so did the number of outpatient mental health visits.

Participants ( $N = 570$ ) ranged in age from 2-16 years ( $M = 7.3$ ;  $SD = 3.9$ ), and were chosen from the Foster Care Mental Health study in San Diego. For the current study, most of the children were female (54%), and minority groups comprised over half of the sample (55%). At the onset of the study, youth had been in foster care for at least five months; for 71% of the sample, this was their first placement. Neglect (65%) and/or Caretaker absence (46%) were the two most common reasons for being placed in foster care initially. The Child Behavior Checklist (CBCL) was administered about seven months after the youth entered foster care, and 50% of the sample scored in the clinical range. Outpatient services were defined as "Any mental health service provided by Medicaid" (p. 131) that met at least one of the following criteria: (a) a mental health provider (e.g., psychiatrist or psychologist) delivered the services; (b) services took place in a mental health clinic; (c) mental health claims data were coded for psychiatric/psychological visits or group therapy sessions, or for other psychiatric/psychological services.

During the course of the study, 54% of all youth changed foster homes either once or twice, while 30% changed foster homes between 3-5 times. After adjusting for gender, race/ethnicity, age, maltreatment type, behavioral functioning, placement type and prior placements, the authors found that Caucasians received more mental health visits per year than their peers, followed by African Americans. Age also predicted more visits, with the highest rate of service use by preadolescents. CBCL Total scores were a strong predictor of high rates of mental health service use; these children were twice as likely to receive outpatient treatment than those who did not score in that range. Conversely, youth who were Hispanic, were placed in kinship care for any amount of time, or were placed outside of the home due to Caretaker absence or Neglect were significantly less likely to receive mental health services than other children.

The behavior of the child and his or her placement change appear to be significantly related to service use. Twenty-five percent ( $n = 144$ ) of all children in the sample were placed in foster care due to behavior-related problems. On average, youth had been in foster care for four months before experiencing their first behavior-related placement; after that placement, they received 48% more outpatient services. Among youth who were moved more than once due to behavioral problems, their mental health service use significantly increased by 89% within three months of their new behavioral-related placement. Additionally, whether placement changes occurred due to behavioral problems or other reasons, the number of times a youth was moved from one home to another was a significant predictor of high rates of outpatient service use.

According to the authors, this study provides preliminary insight into the relationship between behavior- and non-behavior-related placement changes and mental health service use. Although the authors suggest that multiple placements may be related to behavioral problems among this population, their study does not include an investigation of why multiple, behavior-related placements occurred, or whether the youth's outpatient services produced positive outcomes. Overall, it is not clear whether youth placed for behavioral problems received the quality and/or rate of services they needed. Further, it is not known whether they continued to have externalizing problems due to the disruptive placement, the foster care home environment, or other factors. Recognizing these problems, the authors recommend that researchers investigate predictors of placement change, as well as interventions to reduce their occurrence. They write, "[t]here is great need for prospective studies, both quantitative as well as qualitative, which would investigate what reactions or symptoms children in foster care exhibit in response to placement change and how children as well as caregivers experience and adjust to placement change" (p. 137).



# DATA TRENDS

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

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## Articles reviewed in *Data Trends* Summaries, by issue number:

Issues 1-16, summarized January – December, 1999

Issues 17-30, summarized January – December, 2000

Issues 31-48, summarized January – December, 2001

Issues 49-70, summarized January – December, 2002

Issues 71-93, summarized January – December, 2003

Issues 94-106, summarized January – December, 2004

Each of these summaries can be accessed through Data Trends, at: <http://rtckids.fmhi.usf.edu>

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## Summarized during calendar year 1999

- Issue 1: Rosenblatt, A. (1998). Assessing the child and family outcomes of systems of care for youth with serious emotional disturbance (pp. 329-362). In Epstein, M. H., Kutash, K., & Duchnowski, A. (Eds). *Outcomes for children and youth with behavioral and emotional disorders and their families*. Austin, TX: PRO-ED.
- Issue 2: Zametkin, A. J., & Ernst, M. (1999). Problems in the management of Attention-Deficit-Hyperactivity Disorder. *The New England Journal of Medicine*, 340(1), 40-46.
- Issue 3: Walrath, C. M., Nickerson, K. J., Crowel, R. L., & Leaf, P. J. (1998). Serving children with serious emotional disturbance in a system of care: Do mental health and non-mental health agency referrals look the same? *Journal of Emotional and Behavioral Disorders*, 6(4), 205-213.
- Issue 4: Rosenblatt, J. A., Robertson, L., Bates, M., Wood, M., Furlong, M. J., & Sosna, T. (1998). Troubled or troubling? Characteristics of youth referred to a system of care without system-level referral constraints. *Journal of Emotional and Behavioral Disorders*, 6(1), 42-64.
- Issue 5: Rosenblatt, J. A., & Furlong, M. J. (1998). Outcomes in a system of care for youths with emotional and behavioral disorders: An examination of differential change across clinical profiles. *Journal of Child and Family Studies*, 7(2), 217-232.
- Issue 6: Jerrell, J. M. (1998). Utilization analysis for children's mental health services. *Journal of Behavioral Health Services & Research*, 25(1), 35-42.
- Issue 7: Burns, B. J. (1999). A call for a mental health services agenda for youth with serious emotional disturbance. *Mental Health Services Research*, 1(1), 5-20.
- Issue 8: Hodges, K., Doucette-Gates, A., & Liao, Q. (1999). The relationship between the child and adolescent functional assessment scale (CAFAS) and indicators of functioning. *Journal of Child and Family Studies*, 8(1), 109-122.
- Issue 9: Foster, E. M. (1998). Does the continuum of care improve the timing of follow-up services? *Journal of the American Academy of Child and Adolescent Psychiatry*, 37(8), 805-814.
- Issue 10: Halfon, Neal & Paul W. Newacheck. (1999). Prevalence and impact of parent-reported disabling mental health conditions among U.S. children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(5), 600-609, and Commentary by E. Jane Costello, 610-613.
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# DATA TRENDS

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

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- Issue 11: Geller, J. L., Brown, J. M., Fisher, W. H., Grudzinskas, A. J., & Manning, T. D. (1998). A national survey of "consumer empowerment" at the state level." *Psychiatric Services*, 49(4), 498-503.
- Issue 12: Vander Stoep, A., Williams, M., Jones, R., Green, L., & Trupin, E. (1999). Families as full research partners: What's in it for us? *The Journal of Behavioral Health Services & Research*, 26(3), 329-344.
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