ISSN 1537-0399

Data Trends

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

issue numbers 107-124
december, 2005

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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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The Research and Training Center for Children's Mental Health is funded by the National Institute on Disability and Rehabilitation Research of the U.S. Department of Education and the Center for Mental Health Services under grant number H133B040024. The opinions contained in this publication are those of the grantee and do not necessarily reflect those of the U.S. Department of Education or the Center for Mental Health Services.

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

January 2005
No. 107

Hurlburt, M. S., Leslie, L. K., Landsverk, J., Barth, R. P., Burns, B. J., Gibbons, R. D., Slymen, D. J., et al. (2004). Contextual predictors of mental health service use among children open to child welfare. *Archives of General Psychiatry: 61*, 1217-1224.

Keywords: child welfare, foster care, mental health services, interagency coordination, CBCL

The authors investigated the strength of interagency coordination and its relationship to outpatient mental health service use by children in the child welfare system. They also explored the association between the number of mental health service providers and receipt of services. Results indicate that most children in need of services do not receive them, especially including younger children, children who remain in their homes, and Hispanic children. African-American children were more likely to receive services only in regions having strong interagency linkages.

Data identifying eligible children were from the National Survey of Child and Adolescent Well-Being (NSCAW); children from 92 counties nationwide were selected for the current study (N = 2, 823). They were between the ages of 0-14; of the sample, 862 were removed from their homes, and 1,961 were in foster care, kinship foster care, or a group home. Half of the sample was male. Most youth were Caucasian (47%); African Americans comprised the next largest ethnic/racial group (32%), and Hispanics accounted for 13% of the sample. Emotional neglect was the most common reason for opening a child welfare case, followed by physical abuse.

Initial interviews were conducted with child welfare workers and the caregiver, and follow-up interviews occurred 12 months later with the caregiver only. A battery of instruments gathered information on: (a) child demographics and placement status; (b) type of maltreatment; (c) family risk factors that resulted in contact with the child welfare system; (d) insurance status; (e) internalizing and externalizing behaviors as identified by the Child Behavior Checklist; (f) use of specialty mental health services (i.e., community mental health clinics; clinic-based providers; day treatment; psychiatrists, social workers and other professionals); (g) the linkages, or "strength of ties existing between child welfare and mental health agencies at the local level" (p. 1219); and (h) the number of agencies per county that offer specialty mental health services. With this data, a series of bivariate and multivariate analyses were performed. Selected results are listed below:

- Of the entire sample, 43% of youth had CBCL scores in the clinical range, and 28.3% received outpatient specialty mental health services,
- Children with CBCL scores in the clinical range were 4 times more likely to receive mental health services than children whose scores were not in the clinical range,
- As interagency linkages increased, children in the clinical range received more services, and children in the non-clinical range experienced a decrease in services "This [latter] relation was moderated by a strong and significant interaction of interagency linkage with CBCL scores" (p. 1220),
- Children living outside of the home were more likely to receive mental health services than children living at home,
- Younger children were less likely to receive services than older children,
- Compared with rates of service use among Caucasians, African American children were 0.61 times, and Hispanics were 0.51 times, as likely to use services, and
- Compared to counties with weak interagency relationships, African Americans were more likely to receive services in counties with strong interagency linkages.

Continued...

In conclusion, the combined effects of available services and the strength of interagency linkages appear to be associated with receipt of services. For example, strong interagency linkages predicted more service use by African-American children. Thus, the authors write: “The two most significant results of this analysis concern the interactions of CBCL score, and race/ethnicity with the strength of interagency linkages between the local child welfare and mental health service systems” (p. 1223). These findings support a previous analysis of NSCAW data conducted by the authors (see *Data Trends* 104), and suggest a greater need for interagency coordination between the mental health services system and the child welfare system.

DATA TRENDS **March, 2005**
Summaries of research on mental health services for children and adolescents and their families **No. 108**

Boothroyd, R. A., & Armstrong, M. I. (2005). Comorbidity and unmet service needs among Medicaid-enrolled children with identified disabilities. *Journal of Emotional and Behavioral Disorders, 13*(1), 43-51.

Keywords: SSI, TANF, children's mental health, comorbidity, unmet need

The authors investigated rates of current mental health and health disabilities among children receiving SSI for either of these problems and compared rates with children receiving Temporary Aid to Needy Families (TANF). They also identified rates of comorbidity and unmet need for children receiving SSI for either disability compared to TANF children. In general, 41% of children with mental health problems were found to have a health problem, and over half of children with a health problem had mental health problems (62%). Further, children with mental health problems who also had health problems were more likely to have unmet service need than children not receiving assistance for mental health or health problems (TANF).

The children (*N* = 1,145) were from two urban areas in Florida and were classified into three groups: (a) youth who lived in families receiving TANF, but not SSI, for mental health or health related problems (*n* = 764); (b) children receiving SSI for a mental health problem (*n* = 220; SSI-MH); and (c) children receiving SSI for a health problem (*n* = 161; SSI-H). Approximately 80% of all children were white or Black, and fewer children (i.e., 8%-17%) were Hispanic. Data were collected from a mail survey completed by caregivers that drew 25 questions from the Child Health Questionnaire (CHQ); the Pediatric Symptom Checklist (PSC) was also utilized. Current health and mental health problems were defined relative to composite scores on the CHQ and PSC for the TANF control group.

Table 1. Estimated prevalence rates by SSI-MH, SSI-H, and TANF Groups

Current health problem	
SSI-MH	41%
SSI-H	62%
TANF	15%
Current mental health problem	
SSI-MH	63%
SSI-H	35%
TANF	19%
Current comorbid health and mental health problems	
SSI-MH with health problem	30%
SSI-H with mental health problem	24%
TANF with mental health and health problem	6%

Analysis revealed numerous significant findings. For example, SSI-MH children were older (*M* = 13.2; SD 3.22) than SSI-H children (*M* = 11.6; SD 3.84) or TANF children (*M* = 11.1; SD 3.56). SSI-MH and SSI-H boys had more current mental health (73%) or health (63%) problems respectively than boys with TANF coverage (51%). Children were more likely to be Black or non-Hispanic. Table 1 provides estimated prevalence rates by SSI/TANF groups.

Among the SSI-MH group, there were significantly higher rates of unmet need than the TANF group (11% v. 1% respectively), but not significantly higher than the SSI-H group (9%). Among children having comorbid mental health and health care needs, higher rates of unmet need were found for SSI-MH children (11%) than TANF children (0%). Although not significant, it is interesting that children with health problems had more unmet need (14%) than children with mental health problems, state the authors.

The implications of this study suggest the importance of comprehensive managed care policies that address both mental health and health needs of children; integrated and carve-out policies should be reassessed to ensure that children receiving services will receive the full benefits of mental health and health care services. Additionally, more effort should be geared toward providing education on mental health assessment, prevention and early intervention for primary care physicians.

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

April, 2005
No. 109

Macy, R. D., Behar, L., Paulson, R., Delman, J., Schmid, L., & Smith, S. (2004, July/August). Community-based, acute posttraumatic stress management: A description and evaluation of a psychosocial-intervention continuum. *Harvard Review of Psychiatry* [Perspectives], 217-228.

Keywords: Community Services Program, trauma, children and families

The Community Services Program (CSP) of the Trauma Center in Boston has developed an effective community-based psychosocial trauma intervention in metropolitan Boson. The CSP operates with the philosophy that intervention strategies should be geared toward the specific critical incident and should develop interventions according to the *community's perception* of the event. To this end, the CSP offers a continuum of psychosocial interventions geared toward helping children, youth, and their families cope with trauma.

The CSP has been in operation for the past 15 years and potentially serves 90,000 school aged children in metropolitan Boston. The CSP provides short-term, immediate interventions to help stabilize and prevent long-term psychosocial problems through a posttraumatic stress management (PTSM) program that establishes partnerships with professional providers, school-based professionals and a range of community leaders (i.e., clergy, nurses, youth workers, etc.). Working with these leaders, mental health staff assess the community's perceptions of the impact of the event along with its cultural, social and economic impact and thus develop an intervention best suited to a given community and its individuals. Working with mental health staff, these community leaders can also identify those who are most affected by the event (i.e., unable to regroup psychologically within a reasonable amount of time) and can encourage them to take advantage of the intervention. The first task of the PTSM intervention is to build a sense of safety among those affected by the traumatic event; it then seeks to empower community members and leaders by engaging them in "a central role in the resolution of, and community adaptation to, traumatic losses" (p. 217).

Although the PTSM is flexible enough to provide other interventions, there are generally four structured interventions provided to trauma victims: orientation sessions, stabilization groups and coping groups, and individual and dyadic counseling sessions. The CSP trains about 260 *community leader*s each year to assist with interventions; training in the PTSM program includes skill building seminars, practice, and supervised responses during actual interventions. *Professional partners* receive additional training to prepare them for triaging trauma scenes and taking leadership roles. In the aftermath of a traumatic event such as homicide, suicide and suicide attempts, gang violence, and car and school bus accidents trained professional partners may rely upon CSP staff for consultation and support. In other cases, the CSP may be asked to provide direct intervention.

Program evaluation

In 2003 the CSP was independently evaluated for its effectiveness. Three assessments were conducted: (a) Twenty-nine stakeholders (i.e., political, community, and religious leaders; professionals/agency staff; and recipients of the intervention) completed qualitative, structured interviews about the quality of the PTSM and its impact on the community; (b) 63 randomly selected intervention cases were identified and, using a case-extraction protocol, researchers assessed the breadth, depth and effectiveness of the PTSM intervention, along with the staff resources expended; and (c) the effectiveness of the training provided to both community leaders and professional partners was assessed with a questionnaire.

Results of this initial evaluation were positive. Most stakeholders reported on the responsiveness of the program, the high visibility of the staff, the competency of leaders and partners in the affected community, their cultural competency, and the overall quality of the program. The case record review captured the type

Continued...

and quantity of services offered. Eight different interventions were offered, with a range of intervention techniques: 25% of the cases included consultations, debriefings and orientations; supportive services were utilized in 33% of the cases; and 15% included defusing situations during or in the wake of a traumatic event. Results of the training questionnaire also indicated the effectiveness of the CSP (*M* = 4.7 on a 5 point likert scale). Eighty-eight percent of respondents received the basic training for community leaders, and 90% of all respondents had learned and retained the skills necessary to handle traumatic events. Further, 89% reported that their training had enabled them to intervene in other traumatic events not responded to by the CSP. Overall, 90% of trainees reported satisfaction with the program with regard to traumatic events in the workplace, and 70% found the program helpful to friends and family, followed by 56% with regard to their own community.

In conclusion, these initial findings for the CSP mark it as a program that merits further investigation. The authors write: "As in any new field, there is much work to be done to clarify theories and the practical applications of these theories, and to scientifically test models of best practice. The model presented here has evolved through practice, based on current knowledge. It has achieved some face validity and, through an initial evaluation, the beginnings of validation of its worth" (p. 227).

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

May 2005
No. 110

Foster, M. E., & Connor, T. (2005). Public costs of better mental health services for children and adolescents. *Psychiatric Services, 56*(1), 50-55.

Keywords: children's mental health, cost analysis, national evaluation of the CCMHS program

This analysis compared costs of mental health services in a system-of-care (SOC) community with traditional services in a matched community. Unlike other fiscal studies of systems-of-care costs, the authors factored mental health care expenditures incurred by other sectors of care (i.e., juvenile justice, child welfare, and special education) into their analysis. Although mental health services provided by SOC sites continue to be more expensive than traditional services, results of this study revealed that the difference in cost between SOC and traditional services may not be as great as previously thought.

Data for the study were supplied by the national evaluation of the Comprehensive Community Mental Health Services for Children and their Families program and other budgetary sources. Data covered fiscal years 1997-2000 and were collected during the first 12 months after a youth entered into the study. Youth were either from an SOC community in Canton, Ohio (*n* = 220), or from a traditional service provider in Youngstown, Ohio (*n* = 211). Youth at both sites were about 11.5 years old and youth in both groups tested in the clinical range for emotional and behavioral problems as measured by the Child Behavior Checklist and the Child and Adolescent Functional Assessment Scale. Per diem rates were roughly the same for both sites.

The authors used a two-part model to investigate (a) overall mental health expenditures by sector, and (b) expenditures for youth who received care in each sector. Results for the first part of the model revealed that services provided by the core mental health sector (i.e., services directly provided by the mental health sector) were higher for the SOC ($3,533) than for the comparison community ($1,954). However, when only the costs for individuals served by these sectors was factored into part two of the model, the authors found that "the between site gap decreased from 81% to 18% (p. 53)" for core mental health services. Differences in expenditures for juvenile justice and child welfare expenditures in the SOC system were largely responsible for this reduced between-site gap between SOC and traditional services. When costs for youth receiving services were factored into the analysis, average expenditures for mental health services for special education remained significantly higher for the SOC site than for the comparison community. Yet the costs for youth receiving core mental health services reduced significantly. Although not significant, costs for youth receiving services in the juvenile justice and child welfare sectors were higher in the comparison community than in the SOC ($7,597 v. $5,601 and $11, 893 v. $8,219, respectively). Costs for inpatient services were also higher in the comparison community.

In summary, cost analyses for mental health services through the juvenile justice, child welfare and special education sectors may not adequately capture the costs for youth served by these sectors. In this study the authors looked at the costs of services for youth who received services. Thus, results suggest that SOC services may not be as expensive as previously thought when mental health expenditures for youth served by juvenile justice, child welfare, and special education are factored into cost analyses. According to the authors, it is not clear whether services received through the SOC reduced the need for services in the other sectors or whether services provided in the other sectors reduced the need for core mental health services (i.e., cost shifting or cost offset). However, what is clear is that "these youths are creating substantial costs for other systems; our results suggest that those expenditures might be reduced if these youth received [core] mental health services" (p. 54). Further, "the full fiscal impact of improved mental health services can be assessed only in the context of their impact on other services" (p. 50).

Hazen, A. L., Hough, R. L., Landsverk, J. A., & Wood, P. A. (2004). Use of mental health services by youths in public sectors of care. *Mental Health Services Research, 6*(4), 213-226.

Keywords: mental health, alcohol/drug, child welfare, juvenile justice, special education

The authors examined lifetime rates of mental health service use by youth active in at least one child-serving sector in a large metropolitan area. High lifetime rates of mental health service use were found for most of the sample; 87% of all youth used outpatient services at least once, and 45% used inpatient services. Youth involved in the mental health and special education sectors used services the most, while youth involved in the juvenile justice system used services the least.

The study included 1,706 randomly selected youth who were receiving services from one or more of the following child-serving sectors: (a) mental health, (b) alcohol/drug services, (c) child welfare, (d) juvenile justice, and (e) special education. On average, youth were 14.16 years old (*SD* = 3.14), and most were male (66%). Caucasians comprised over one-third (39%) of the sample, followed by Latino (27%), African American (19%), Asian-Pacific Islander (8%), and bi-racial or other (8%). Psychiatric diagnoses were identified with the DISC-IV, and the Service Assessment for Children and Adolescents (SACA) captured services received over the youth's lifetime and for the past 12 months. Selected results by child-serving sector follow:

- Youth involved in the *mental health sector* (*n* = 919) had high rates for specialty mental health outpatient services, specialty inpatient services, residential inpatient services and school-based services. Of all youth, 87% used outpatient services at least once, and 45% received inpatient services.
- Youth in the *special education sector* (*n* = 428) had high rates of school-based services and high rates for specialty mental health services. Almost all youth in this group (90%) used specialty outpatient services and over 40% had been hospitalized for a psychiatric problem. Youth in this group were less likely to have been involved with the child welfare and juvenile justice sectors when compared to the other groups. Of the entire sample, 71% received school-based services.
- Youth in the *child welfare sector* (*n* = 453) were likely to be placed in foster homes, residential treatment centers, group homes and emergency shelters, and to receive specialty mental health outpatient services. They were less likely to be involved with the juvenile justice system or to receive school-based services when compared to the other groups. Thirty-six percent of all youth were placed in foster care.
- Youth receiving care through the *alcohol/drug services sector* (*n* = 175) were highly likely to be placed in residential treatment centers and group homes. They were also likely to be placed in a juvenile detention center or to have contact with a probation officer. Further, they were likely to use informal outpatient services such as peer counseling. Compared to the rest of the sample, this group of youths was less likely to have used specialty mental health outpatient services. The percentage of youth involved with alcohol/drug services is not reported.
- Youth in the *juvenile justice system* (*n* = 505) showed a decreased likelihood of using most services when compared to youth served by the other sectors. This was the case for school-based services, specialty and non-specialty mental health outpatient services and other services provided outside the formal mental health system. These youth were likely to use services related to juvenile justice, to have special school placements, and to use informal outpatient services. Of all youth, 38% had come in contact with a probation or correctional officer, and 32% were placed in a detention center.

According to the authors, it is not surprising that the mental health and special education sectors would provide the highest rates of mental health services among all five child-serving sectors. However they note the low rates of service use among youth involved in the juvenile justice system and suggest that this finding merits additional investigation.

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June 2005
No. 112

Kraemer Tebes, J., Bowler, S. M. Shah, S., Connell, C. M., Ross, E., Simmons, R., et al. (2005). Service access and service system development in a children's behavioral health system of care. *Evaluation and Program Planning, 28*, 151-160.

Keywords: services received, barriers to services, implementation, referrals

Two system-level indicators of how well a system of care (SOC) meets the needs of children with emotional and behavioral disorders and their families are *services received* (proportional to services recommended by multi-agency review teams) and *barriers to services*. The authors tracked these indicators over an eight-year period in which an SOC moved through three stages of development: early, middle, and full implementation. Results revealed that the numbers of services received significantly increased as barriers to services decreased.

Participants were 2,073 youth who were enrolled in Rhode Island's SOC within an eight-year period; during this time, the SOC underwent three stages of development: early, middle, and full implementation. The first stage began with the initial funding of the SOC through the Child and Adolescent Service System Program (CASSP), and the receipt of further funding and services enhancements occurred during the middle stage. Demographic data collapsed over all study years indicate that most youth were male (71%), and most were white (70%). Three-quarters (76%) of youth who were referred for services had moderate levels of functioning and symptomatology as measured by the Children's Global Assessment Scale (CGAS). Further, most youth were referred for comprehensive services from mental health agencies (41%), while other referrals were from schools (19%), informal referrals (e.g., self, parent, friend; 18%), and other (i.e., child welfare, juvenile justice, social services, etc.; 22%). The Resource and Outcome Data Form (RADOF) recorded referral sources, services received, and barriers to services. Data were collected on individual youth for three months, and recommendations for services were made by multi-agency review teams. Barriers measured on the RADOF included service availability, appropriateness of services, cultural competency issues, funding problems, and individualized planning problems.

Results indicate that the enrollment of non-white youth increased over the life of the project. Most youth with moderate levels of impairment entered the SOC during its final phase. Youth with low levels of impairment tended to enroll during the middle phase of the SOC, and the number of children who entered the system with severe impairment doubled over time. Informal referrals and referrals from juvenile justice increased throughout the study, but referrals from schools and other service sectors decreased.

With regard to the proportion of services received relative to services recommended, service use increased significantly: during the initial phase, 48% of all services recommended were received, followed by 69% in the middle phase and 80% in the final phase. Additionally, as services received increased, the number of barriers per service recommended decreased from 1.83 to 1.76 to .61 for the initial, middle, and final stages of implementation, respectively.

This study provides an opportunity to look at access to services in one SOC over an eight year period. Results suggest that the two system-level indicators provide useful empirical data on SOC implementation. The authors write: "These indicators of access are based on the operation of the multi-agency review team, and thus, represent system-level indicators of service access. The consistency of findings over time and across the different types of services monitored is suggestive of the types of changes that can be observed when system-level indicators are used to monitor change in a developing system of care" (p. 158).

Eamon, M. K., & Mulder, C. (2005). Predicting antisocial behavior among Latino young adolescents: An ecological systems analysis. *American Journal of Orthopsychiatry, 75*(1), 117-127.

Keywords: Latino, cultural competence, poverty, acculturation

In this ecological study the authors investigated the effects of poverty on factors both inside and outside the Latino home to identify which factors encourage or mitigate the effects of poverty on antisocial behavior among Latino adolescents. Although adolescents in this study were not tested for mental health problems, the results lend themselves to further examination by children's mental health researchers. Results revealed that peer pressure and neighborhood quality mediated the effect of poverty on antisocial behavior, and high levels of acculturation among Latino mothers was significantly related to a reduction in antisocial behaviors.

Data on Latino youths were taken from the larger National Longitudinal Survey of Youth (NLSY), a nationally representative sample of approximately 9,000 adolescents. Participants for the current study (N = 420) were between the ages of 10-14 years, and over half were Mexican American (68%). Puerto Rican and Other Latinos comprised 17% and 15% of the sample, respectively. On average, children had lived in poverty for about one-third of their lives. Antisocial behavior was measured with items from the Behavior Problem Index, and variables of interest included: sociodemographics; mother's acculturation (i.e., English speaking, U.S. resident); poverty; neighborhood quality; school quality; peer pressure; parent-youth conflict and attachment; physical punishment; and the extent to which mothers monitor their children's whereabouts.

A series of multiple regression analyses revealed that boys were likely to have significantly higher antisocial behavior ratings than girls. For all youth, the likelihood of having high rates of this behavior was associated with length of time living in poverty. However positive peer pressure and neighborhood quality mediated the effect of poverty on this behavior. Mother's increased acculturation also significantly reduced ratings of antisocial behavior. Additionally, school quality and neighborhood quality were negatively associated with antisocial behavior. Results further suggest that mother's childbearing age and education did not influence the development of this behavior. Finally, parent-youth conflict was unrelated to antisocial behavior; according to the authors, this finding was unexpected, "given the importance of family and harmonious relationships among many Latinos" (p. 124).

Implications of this study include the importance of addressing mother's acculturation, peer pressure, and school and neighborhood quality when planning individualized and culturally competent family-focused services.

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July, 2005
No. 114

Rowland, M. D., Halliday-Boykins, C. A., Henggeler, S. W., Cunningham, P. B., Lee, T. G., Kruesi, M. J., et al. (2005). A randomized trial of Multisystemic Therapy with Hawaii's Felix Class youths. *Journal of Emotional and Behavioral Disorders, 13*(1), 13-23.

Keywords: Multisystemic Therapy, Asian multiethnic, Hawaii, continuum of care

This randomized trial compared the effects of Multisystemic Therapy on a group of youth receiving services through Hawaii's Continuum of Care (COC)[1] with youth receiving usual services also through Hawaii's COC. Although the project ended prematurely due to implementation issues, results showed improvement among MST youth on measures of mental health symptomology, criminal behavior, and family social support when compared to youth receiving usual COC services.

The results reported below are for all youth (*N* = 31) who received six-month follow up assessments before the termination of the study. These youth lived on the island of Oahu with family or a caregiver, were at risk of out-of-home placement, and met the qualifications of the Felix Youth Degree (i.e., for "youths attending a public school and qualified to receive mental health services via a structured Individualized Education Plan process applying IDEA or Section 504 criteria," p. 14). Youth and their families were randomly assigned to one of two groups: (a) MST treatment within the context of Hawaii's COC, (*n* = 15); and (b) usual services provided by the COC (*n* = 16). There were no significant differences between groups, except that MST youth had higher rates for self-reported delinquency. All youth were an average age of 14.5 years (range: 9-17). Most of the youth were boys (58%), and 84% of both groups were multiracial Asian (i.e., primarily Asian, Pacific Islander and Caucasian). Ten percent were Caucasian, and 7% were Asian American and Pacific Islander. On average, all youth had been hospitalized twice for psychiatric or substance abuse problems and had been arrested 7.5 times before entering the study. Almost all youth (94%) met criteria for one or more clinical diagnoses at intake, with conduct disorder (39%) and bipolar disorder (32%) the two most common diagnoses. A battery of measures was administered at intake and at six-months follow up, including measures for: mental health, substance use, criminal activity, school placement/attendance, family relations and family social support.

Results showed significantly greater improvement by MST youth on the youth version of the Child Behavior Checklist for internalizing and externalizing symptoms when compared to usual services youth. MST youth also reported significantly fewer instances of criminal behavior when compared to their counterparts. MST was also more effective at maintaining youth in the community, with an average of 3.75 days in out-of-home placement compared to 11.83 days for usual services youth. Marginally significant, MST youth also spent 42% more days in school per month when compared to usual services youth. Additionally, although the researchers expected to find an improvement in family functioning for MST youth, they did find near-significant improvements for social support among caregivers when compared to caregivers of usual services youth.

Enrollment into the study began in July 2000, but by August 2001 the program had been discontinued, for five reasons: (a) there were difficulties with recruiting an adequate number of participants who were at risk of out of home placement; (b) there was a limited number of therapists familiar with this evidence-based practice; (c) consultations between MST consultants and providers were inhibited by the time zone difference between Hawaii and the mainland; (d) there were difficulties getting providers (e.g., hospitals, residential services, and child welfare) to buy-in to the MST model, and; (e) there were political factors that affected the "perceived fiscal stability" (p. 20) of the project.

Continued...

Although the project was terminated early, the authors write that the core MST home-based and crisis intervention components were "operational throughout the project" (p. 14). Overall, "these findings show, in spite of generally low treatment fidelity, that the intensive MST program developed by [Hawaii] to serve the mental health needs of its most challenging youths achieved a portion of the desired goals (decreased symptoms, improved functioning, decreased use of restrictive placements)" (p. 21). Finally, while the authors did not provide an analysis of the effects of MST on culture, this is the first study of MST on a primarily Asian multicultural population.

[1] For more about Hawaii's COC, see *Data Trends* #57.

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

July, 2005
No. 115

Hoagwood, K. E. (2005). Family-based services in children's mental health: A research review and synthesis. *Journal of Child Psychology and Psychiatry, 46*(7), 670-713.

Keywords: family involvement, intervention, child and family services

This study reviewed literature on family involvement in the treatment of children with emotional or behavioral disorders. Specifically, articles were about families who received interventions; families who collaborated in their child's intervention, and; core components of family involvement. Very few scientifically rigorous studies of such family-based services were found.

The literature search was conducted with four databases to identify articles of interest published since 1980 (key words: family support, skills training, parent management, education, counseling, therapy, consultation, engagement, alliance, empowerment, choice, collaboration, etc.). From a set of 4,000 articles, the authors selected studies that were empirically rigorous; that is, they used experimental designs, used a controlled design, and clearly described the intervention models such that comparisons with control groups would be possible. Forty articles met these criteria, although many of them were about health related problems in children or adult mental health issues.

The final selection of articles on children's mental health were then categorized as falling into one of three groups: (a) families as recipients of interventions (i.e., family education or psychoeducation, support, adjunctive services, engagement services and empowerment interventions); (b) families as co-therapists (i.e., families as collaborators); and (c) core components of family involvement (i.e., therapeutic alliance, engagement, empowerment, expectations, and choice). The author did not review studies of family therapy (e.g., Multisytemic therapy) or parent management training because an extensive body of literature already exists for these interventions.

(a) Families as Recipients Services for Families (*N* = 13)

Most articles were about studies of interventions that included elements of education, support, engagement in services, and empowerment, or were designed to teach parent skills. Of those articles, most reported on programs that combined psychoeducation, support and skill training. There were very few family education models identified; however three notable studies were discussed by the author.

There were very few empirically rigorous studies of *family support programs*, which teach new behaviors in a multifamily group setting and encourage support among families. However, there were a large amount of theoretical pieces and pre-post evaluations for such interventions. Some multifamily group programs had positive outcomes (e.g., increased engagement, fewer ADHD symptoms, enhanced parent well-being, and increased treatment retention), but "no rigorous studies have been conducted yet to determine how or whether multifamily groups are associated with improved outcomes" (p. 700). Further, the author found very few *adjunctive therapy interventions* (i.e., interventions that combine elements of one program with another). One such model augmented a problem-solving intervention with Problem Solving Skill Training and Parent Management training, and barriers to treatment decreased. Another study compared individual behavior

Continued...

therapy with multifamily group skills training; results included greater knowledge and behavior change among recipients. Two studies found that a phone-delivered *engagement intervention* increased families' use of services. Only one controlled study was found for *empowerment interventions*. Recipients were trained in assertiveness, communication, goal setting and problem solving and how to find community resources. Fourteen months after the intervention, parents were more knowledgeable and had more self-efficacy than the control group.

(b) Families as Co-Therapists: Services with Families (*N* = 6)

With the exception of studies of autism, there were no studies identified that focused on families as co-therapists in treatment and children's mental health outcomes. Three studies on families as co-therapists for children with autism found that parents had favorable experiences with co-therapy, parents were more involved with their children, and children's behavior improved.

(c) Studies of Core Processes of Treatment (*N* = 21)

From this emerging field of study the author identified articles that fell into five categories: (a) most articles were about the quality of therapeutic relationships between parents and therapists and their outcomes; some compared therapeutic alliance with therapy; (b) others investigated the kinds of expectancies families have about services with regard to family engagement; (c) studies of empowerment, self-efficacy, and "the processes by which families gain mastery about use of services" were also found; (d) some studies focused on parent expectations for services, including their underlying values when seeking treatment; and (e) some studies were concerned with the effects of family choice; this is an undeveloped area but is "likely to be studied with increasing rigor in the future" (p. 702).

Factors such as the quality of the therapeutic alliance, the nature and extent to which family perspectives are explicitly embodied in treatment planning, parental perceptions of continuity and support, and issues of trust these factors reflect deep values of significance to many families of children with health or mental health problems. Unfortunately, rarely are such variables measured in treatment outcome studies. A range of family-relevant measures should be routinely incorporated into clinical efficacy or effectiveness studies. (p. 708).

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According to Hoagwood, "the implications of this review are sobering…there are far too few well-conducted, scientifically rigorous studies of family-based services in children's mental health services to conclude that these interventions decisively improve youth clinical outcomes" (p. 708). However, there are promising studies of adult mental health outcomes that include family involvement and "these models can and should be imported into the field of children's mental health services research" (p. 708). Further, the author suggests that "the range of outcomes that are typically assessed in treatment outcome

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July, 2005
No. 116

Kessler, R. C., Berglund, P., Demler, O., Jin, R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 593-602

Wang, P. S., Berglund, P., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 603-613

Keywords: National Comorbidity Survey Replication, DSM-IV, children

This *Data Trends* presents two articles about the National Comorbidity Survey Replication (NCS-R). The NCS-R is the first national study of adults who were asked to reflect on childhood experiences with mental health issues. Half of all mental health problems begin by age 14, and the median age for some childhood illnesses begins at age 11.

Face-to-face interviews with respondents (*N* = 9282) were conducted between February 2001 and April, 2003. During Part I of the survey DSM-IV diagnoses were generated by the World Health Organization Composite International Diagnostic Interview. Part II asked about risk factors, consequences, additional disorders and other variables of interest. Respondents between the ages of 18-44 were asked about their age at the first onset of symptoms and their age when they first sought treatment for a disorder.

Half of all respondents who had mental health problems at some time in their life reported symptoms that began by the age of 14. The median age for the onset of social phobia was 13 years. The median age for the onset of impulse control disorders and anxiety problems was 11 years. Age of onset was associated with a very narrow age range for childhood disorders: impulse control problems tended to develop between the ages of 7-15; substance abuse disorders between the ages of 18-27 years, and mood disorders between the ages of 18-43. Overall, the median length of time between the onset of problems and treatment was about 10 years, indicating a significant lag between onset and treatment.

These important articles provide an updated view of childhood mental health problems and their age of onset. Half of all lifetime cases of mental health problems began by the age of 14. In order to reduce the prevalence of mental health disorders, interventions must begin during adolescence.

Corrigan, P. W., Demming Lurie, B., Goldman, H. H., Slopen, N., Medasani, K., & Phelan, S. (2005). How adolescents perceive the stigma of mental illness and alcohol abuse. *Psychiatric Services 56*(5), 544-550.

Keywords: mental illness, stigma, adolescents

According to the authors, empirical research on mental illness stigma among adults has revealed three findings: (a) persons with mental illness are judged more severely than persons with physical health conditions; (b) people who abuse alcohol are judged more severely than persons with mental illness, and (c) familiarity with someone having a mental illness reduces stigma. The authors conducted a study to determine whether similar findings hold true for adolescents as well. The first two findings (above) were the same for teens as they were for adults; however the third finding suggests the opposite; that is, familiarity with someone having a mental illness does *not* reduce stigma among teens.

Participants (*N* = 303) were teens from Southern California with a mean age of 16.4 years (*SD* = 2.5). Over half (56%) were female. Most teens were White (61%), followed by Hispanic (13%), those with two or more racial/ethnic groups (13%), Asian American (6%), Black (6%), and American Indian (1%).

The teenagers completed a revised version of the Attribution Questionnaire (rAQ) The rAQ provides four vignettes that parallel the following scenario: "Brandon is a new student in your class. Before his first day, your teacher explained that Brandon is mentally ill and is transferring from a special school" (p. 545). The other three vignettes depict the new student as having a "drinking problem," a "brain tumor that makes him act like he has a mental illness sometimes," and "has leukemia, a cancer of the blood" (p. 545). After reading each vignette, teens were asked to rate each individual in the vignette according to seven items: responsibility, pity, anger, dangerousness, fear, help, and avoidance. A revised version of the Level of Contact Report, which ascertains familiarity with mental illness, was also completed by the teens. This report includes 12 situations that vary in the degree of contact that a participant might have had with a person with mental illness; questions range from least intimate contact, such as never having observed a person with mental illness, to most intimate, living with a person with mental illness.

As shown in Table 1, only 11% of students had not knowingly come into contact with a person with mental illness. Twenty-nine percent had a relative with a mental illness, and 7% lived with someone having a mental illness. Compared to mental illness, brain tumor, and leukemia, alcohol abuse was stigmatized the most, with students tending to blame alcohol abuse on the individual, and to express anger and fear at their condition. Mental illness was associated with pity, dangerousness, fear, help, and avoidance, while having a brain tumor reduced the stigma associated with mental illness. Compared to mental illness, having a brain tumor revealed

Table 1. Affirmative responses to questions about familiarity with mental illness. *N* = 303

Variable	*n*	%
I have never observed a person with mental illness	33	11
I have watched a television show that included a person with mental illness	264	87
I have observed a person with severe mental illness	227	75
I have been in a class with a person with severe mental illness	151	50
A friend of the family has a severe mental illness	85	28
I have a relative who has a severe mental illness	88	29
I live with a person who has a severe mental illness	21	7
I have a severe mental illness	12	4

Continued...

lower scores for pity, dangerousness, and fear. Leukemia was judged more compassionately than alcohol abuse, mental illness, or brain tumor. Alcohol abuse and mental illness were viewed with more blame and anger and with less pity than were brain tumor or leukemia.

Interestingly, students who were familiar with someone having a mental illness exhibited more stigma toward mental illness than their less-acquainted counterparts. This finding may be due to "statistical artifacts" (p. 549) or to cognitive development in teens. That is, compared to adults who have had more opportunities to learn about mental illness, teens "have less information and more tentatively formed attitudes about people with mental illness" (p. 549). A third possible explanation for this finding suggests that stigma is determined by familiarity with persons having a mental illness and how they display their symptomatology; for example, hospitalization for psychosis may fuel the stigma for dangerousness while more benign symptoms may elicit pity. While further work is necessary to understand this finding, it may be the case that anti-stigma mental health campaigns should be redesigned to meet the cognitive needs and social experiences of adolescents.

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September, 2005
No. 118

Snowden, L. R. (2005). Racial, cultural and ethnic disparities in health and mental health: Toward theory and research at community levels. *American Journal of Community Psychology, 35*, 1-8.

Keywords: collective efficacy, social capital, social equilibrium, social dynamics

This article suggests that until we begin to think of change on a community level instead of an individual level, little progress will be made in providing mental health services to culturally diverse and ethnic minority communities. This theoretical paper discusses the importance of (a) population thinking, (b) collective efficacy, (c) social capital and social norms, and (d) social equilibrium and social dynamics for mental health services research and other health fields and the link between these concepts. According to the author, "community-level knowledge has profound intervention-related implications at policy levels" (p. 1). Snowden's discussion of these topics is summarized below:

(a) Population Thinking

Snowden describes his research of racial, cultural, and ethnic disparities within communities and neighborhoods in the state of California and illustrates the diversity represented within the state. In this context, he discusses the meaning of population thinking, in which one is "sensitive to underlying structures and processes of social change" (p. 3), being careful to consider the impact that the environment of the community has upon the well-being of all of its children and families. For example, an improvement in the overall environment of a school (possibly due to a policy change or implementation of a new program) might have a positive impact on a teacher which in turn is reflected in an improvement in his/her interactions with students.

> "Community level knowledge has profound intervention-related implications at policy levels" (p. 1).

(b) Collective Efficacy

According to Snowden, collective efficacy, or the willingness to act on behalf of one's community, differentiates well-functioning communities from poorly functioning communities. During this discussion, he cites an example of the misconception that crime rates are higher in minority communities because of the racial and ethnic composition, when in fact high crime is likely more a result of a lack of collective efficacy. Collective efficacy is often reflected in well-functioning community service organizations, churches, and informal supports through strong neighbor networks.

(c) Social Capital and Social Norms

For purposes of this discussion, Snowden expands upon the idea that social capital refers to social norms operating at a group level, and he emphasizes that norms that include social capital are facilitative "they reconcile competing personal interests in the name of a common goal" (p. 4). He further states that norms can change and cites as an example that after a shift away from blaming victims in domestic violence situations, the judicial system responded with harsher penalties for perpetrators of these crimes. These norms improve economic productivity and social well being. Snowden further states that "social capital is a key step along the road to a comprehensive account of prosocial norms" (p. 5).

Snowden stresses that it is critical for social capital to be analyzed on a group as well as an individual level and further emphasizes that this enables psychologists to analyze prosocial norms things such as engagement, trust, and reciprocity from a broader perspective.

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(d) Social Equilibrium and Social Dynamics

Because conditions within the community change, Snowden argues that social capital is not static and that prosocial norms are susceptible to the competition of "actors" within a group. He further states that the balance of forces between prosocial norms and opposing norms define a state of equilibrium within the community.

Conclusion

In this article, Snowden expresses concern regarding the lack of knowledge in the field about the impact of the concepts of population thinking, collective efficacy, social capital and social norms, and social equilibrium and social dynamics upon communities in considering the health and overall well-being of children and families. The author further expresses his interest in advancing theory and research at social and community levels and states that community-level knowledge has intervention-related implications at policy levels.

Snowden concludes this article by stressing that it is critical that professionals within the field better understand how prosocial norms and practices are formed, how they compete against opposing norms, and how they respond to changes within the community. He further states that public policy literature and academic policy analysis are critical to understanding social problems, and this knowledge will substantially contribute to policy development related to important social issues.

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September, 2005
No. 119

McDonald, E. J., McCabe, K., Yeh, M., Lau, A., Garland, A., & Hough, R. L. (2005). Cultural affiliation and self-esteem as predictors of internalizing symptoms among Mexican American adolescents. *Journal of Clinical Child and Adolescent Psychology, 34*(1), 163-171.

Keywords: Mexican culture, POC Study, internalizing symptoms, adolescent girls

One of the areas being studied by the Patterns of Care project in San Diego is the impact of self-esteem and affiliation with one's cultural community on internalizing problems across cultures. Previous studies have shown that adolescent Latino girls with low self-esteem are at increased risk of developing internalizing problems when compared to Latino girls with high self-esteem. Other studies suggest that a close identification with Latino and Mexican culture may inhibit the development of internalizing problems among Hispanic youth. The current study investigates the extent to which self-esteem and identification with Mexican culture moderate the effects of internalizing problems. The authors found that low self-esteem is a risk factor for internalizing problems among Mexican girls with low affiliation to their ethnic culture.

Participants were a subsample of the Patterns of Care (POC) project participants from San Diego County[1]. The current study included Mexican American adolescents (*N* = 94) who were receiving services from one or more of the following sectors: alcohol and drug treatment (2%) mental health (62%), schools (23%), child welfare (30%) and juvenile justice (15%). The average age of participants was 13.40 years (*SD* = 1.54), and there were more boys (55%) than girls in the sample. Almost all adolescents (89%) and under half (41%) of all parents were born in the United States. Data on the participants were collected with the Youth Self Report, the Child Health Questionnaire (which utilized a self-esteem subscale), and the Pan Acculturation Scale. Youth and their caretakers were interviewed about psychological symptoms, self-esteem and level of affiliation with Mexican culture at entry into the study and two years later.

While girls had more internalizing symptoms than boys, self-esteem was associated with internalizing symptoms for both boys and girls. Further analysis revealed that higher self-esteem at baseline predicted lower internalizing scores for both boys and girls, although this finding was not significant for boys. However, girls who had low self-esteem were significantly more likely to develop internalizing problems if they were not highly affiliated with Mexican culture. No significant relationship was found between cultural identity and gender for boys, suggesting that "for boys, self-esteem is related to internalizing symptoms regardless of affiliation with Mexican culture" (p. 169).

According to the authors, Mexican culture tends to emphasize interpersonal relationships, sharing, and cooperation. Yet within Mexican culture, boys are often encouraged to think independently and to develop assertiveness skills, while girls tend to derive their identity from relationships. Given this distinction in gender roles, it is not surprising that girls' affiliation with Mexican culture would act as a moderating influence on the development of internalizing disorders. This study supports the suggestion that "maintaining affiliation with traditional Mexican cultural values and familial support systems may protect Mexican American [girls] living in the United States from the development of mental health problems" (p. 164). Overall, the study promotes the value of having a close association with one's cultural background, at least for Mexican girls.

Note: [1]For more information about the POC study, see *Data Trends* #35, #55, #86 and #101.

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October, 2005
No. 120

Huang, L., Stroul, B., Friedman, R., Mrazek, P., Friesen, B., Pires, S. et al. (2005). Transforming mental health care for children and families. *American Psychologist, 60*(6), 615-627.

Keywords: New Freedom Commission, mental health, transformation

This article is based on the deliberations of the Subcommittee on Children and Families of the President's New Freedom Commission. While not the actual report of the Subcommittee, the article outlines recommendations for policy reform. The Subcommittee surveyed 250 stakeholder groups (i.e., youth and their families, provider associations, practitioners, researchers, and state and local program directors) to arrive at recommendations for policy to transform the mental health care system in America. Their investigation included site visits to successful and innovative treatment and prevention programs (i.e., early childhood, school-based, wraparound, juvenile justice, and mental health programs) and an analysis of over 1,200 comments solicited by the Commission about innovative strategies for policy reform. Selected recommendations of the Subcommittee follow:

- *Develop Comprehensive Home- and Community-based Services and Supports*. Although a number of least restrictive services (e.g., intensive home-based care, day treatment, mentoring, respite care, wraparound, and therapeutic foster care) are available in some communities, the majority of children in need of these services do not receive them. To rectify this problem, "federal and state governments should provide incentives, and work in partnership with families and the private sector, to encourage the investment of resources in building a full range of home- and community-based services and supports" (p. 619). Further, stakeholders need to "go where the children are" (p. 619) to provide these services. In particular, children entering the juvenile justice or child welfare sectors should be screened for mental health problems and appropriate services should be made available so these children and adolescents may receive care in the least restrictive setting possible.
- *Develop Family Partnerships and Family Support*. According to the authors, "true partnerships between families and professionals have yet to be achieved" (p. 619). To strengthen family participation in the arena of mental health services and supports, policymakers need to encourage families to participate at both the community and systems levels on behalf of their children. Family support services also should be made available, and family-run organizations should be encouraged, supported and promoted. Additionally, "the need [for families] to relinquish custody in order to receive necessary care" (p. 620) must be eliminated.
- *Provide Culturally Competent Care and Reduce Unmet Need and Disparities in Access to Services*. While children and their families from racial and ethnic minorities experience barriers to services (e.g., fragmented services, costs, and stigma) experienced by other populations, they must also contend with barriers that are specific to their culture (e.g., language barriers and different ideas about mental illness). Writing that "there is no simple solution to this problem," the authors suggest that strategic plans be put in place to address these disparities and that they be based on the "voices, views, and recommendations of representatives and families from diverse racial and ethnic groups" (p. 620). Agencies at all levels should work with racial and ethnic groups to ensure that children receive the services they need. Additional recommendations include: better data collection for ethnic/racial groups; evaluations of barriers to services specific to a given culture; "minimum standards for culturally and linguistically competent behavioral health care" (p. 621); indicators for culturally competent care; financial considerations; and a diverse workforce.

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- *Implement Evidence-based Practices*. In order to ensure that children and their families receive empirically supported prevention and treatment interventions, effective services must be developed, disseminated, and implemented with fidelity. Innovative programs for development and dissemination must be established, promising practices must be identified, and evidence-based interventions must be conceptualized to include the evidence-based processes that "cut across a number of clinical interventions" (p. 621).
- *Coordinate Services, Responsibility, and Funding to Reduce Fragmentation*. Writing that "responsibility [for the current mental health system] is spread over a complex patchwork of programs operated by federal, state, and local governments and the private sector" (p. 621), the authors suggest that each involved agency institute a cross-agency plan for mental health interventions for children and their families, ensuring collaborative efforts to provide services, supports, and financing reforms. Suggested improvements to financing structures include: cost shifting, maximization of federal and state funds, blended funding, and dedicated revenue streams.
- *Increase Prevention, Early Identification, and Early Intervention*. One paper written for the Subcommittee noted that there are no infrastructures in place that cut across agencies and disciplines to provide prevention, identification, and early intervention for young children and their families. Further, there are few training programs to help parents, teachers, and practitioners identify young children who are at risk of developing behavioral and emotional problems. Accordingly, the authors recommend the establishment of an infrastructure at the federal, state and local levels that can "plan, develop and support" (p. 623) prevention and early identification programs.
- *Strengthen Early Childhood Intervention*. Relative to older children, very little research has been conducted on early childhood mental health problems and their interventions. To rectify this problem, the authors propose: parent and practitioner education about the early child development; the creation of national awareness of mental health problems among young children; early screening and intervention in child settings (e.g., day care, kindergarten); professional training in early intervention; and the elimination of barriers to services, "particularly in diagnostic and financing systems" (p. 623).
- *Expand Mental Health Services in Schools*. "Children receive more services through schools than through any other public system" and as a result, schools "offer a strategic opportunity to provide effective services to many children in need" (p. 623). Schools must be utilized to their fullest capacity to provide such services, including preventive and early intervention programs. School health clinics should be central to the provision of services, and funding for such clinics must be written into federal and state budgets. Further, initiatives should be made to help schools implement the Individuals with Disabilities Education Act.
- *Strengthen Accountability and Quality Improvement*. One concern of the Subcommittee is that "children's mental health services and systems have suffered from a lack of reliable, practical, policy-relevant data and accountability mechanisms to guide decision making and quality improvement at both the system and service delivery levels" (p. 624). To remedy this problem, they recommend: accurate information gathering systems, reliable measures, quality control feedback systems, collaboration with multiple stakeholders, attention to issues of privacy and confidentiality, and a theory of change.

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- *Build the Workforce*. Curricula often take years to catch up to current trends in practice. However, it is imperative that preservice training shift its focus from office and clinic-based practices to a family-oriented, individualized, community-based approach to children's mental health. Further, practitioners should be prepared to work in the community itself (i.e., in the school, juvenile justice, and child welfare settings) and to collaborate with other agencies involved in services for the child and family. Training also must "enhance cultural competence for all [practitioners], and the field must create specific incentives and strategies to recruit and train culturally and linguistically diverse practitioners" (p. 625).

These recommendations of the Subcommittee highlight critical challenges to the children's mental health service system and outline needed areas of change if we are to achieve the vision of the President's New Freedom Commission on Mental Health.

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October, 2005
No. 121

Tolan, P. H. & Dodge, K. A. (2005). Children's mental health as a primary care concern: A system for comprehensive support and service. *American Psychologist 60*(6), 601-614.

Keywords: access to services, psychology, prevention, intervention, training

The authors call for a complete transformation of the mental health system for children with emotional and behavioral problems and their families. They suggest that "a comprehensive primary system of mental health care [should] be a central part of psychology's agenda" (p. 602) to provide mental health services to children and their families. The authors discuss four key components to guide such a transformation. According to the authors, the systems-of-care philosophy "can be applied at any needed level to any of the four areas outlined here" (p. 608): (a) easy access to culturally competent, evidence-based services and supports for all children and families and especially for children with a DSM-IV generated diagnosis; (b) an emphasis on prevention of mental health problems before they develop into DSM-IV diagnoses; (c) the provision of short-term interventions for children having sub-clinical (i.e., without a DSM-IV diagnosis) mental health problems and their families; and (d) the promotion of awareness in child-serving settings (e.g., primary health care, schools, day care, after school programs, etc.) of mental health problems, interventions and supports. These components overlap conceptually and strategically and are briefly summarized below.

Overall, the authors stress the importance of restructuring and reconceptualizing children's mental health services delivery so that children's mental health becomes a primary concern among practitioners (psychologists, psychiatrists, mental health counselors, primary care doctors, etc.), families, and society in general. This requires "considerable deliberation and significant shifts in current practices and policies" (p. 607). It also requires public and practitioner awareness that mental health problems can contribute to other health concerns and, if left untreated, child mental health problems can lead to further mental health problems and economic costs in adulthood. Thus, one way of making mental health care a primary concern is to educate practitioners and the public about the social and economic costs of untreated mental health care.

Another way of promoting mental health services for all children is to encourage the development and use of empirically-based preventive strategies for children who are at risk of mental health problems. Also, children with sub-clinical symptoms should have short-term access to preventive interventions. Frequently insurance pays for children with a DSM-IV generated diagnosis but not for children without a diagnosis. In order to transform the mental health system, insurance laws and policies should reflect the importance of preventive interventions in the treatment of children at risk for emotional and behavioral problems.

Additionally, the existence of effective interventions must be made known to the public and to practitioners, and more work must be done to determine whether efficacious programs are also effective in "real world" settings for both children with a DSM-IV generated diagnosis and for those who are at risk of a mental health problem. Access to empirically-based services should be encouraged by having mental health services available in schools, primary health care clinics, day care centers, churches, community centers and other community-based organizations; the provision of mental health services in various child-serving settings also will educate the public about the prevalence of mental health problems in children and the availability of services.

Finally, the authors mention that psychology training programs are central to accomplishing an integrated mental health services delivery system. These practitioners must be "trained to interpret and rely on empirical evidence" (p. 612) and programs should be put into place that encourage mid-career training. Notably, "the

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next decade of doctoral training must assert the need for a new breed of public health psychologist, one who understands epidemiology, developmental psychopathology, prevention and mental health promotion approaches, and evaluation procedures along with the more typical skills" (p. 612).

In conclusion, this article is significant in that it appears in a leading psychology journal, encourages the promotion and use of evidence-based practices, and endorses the systems-of-care philosophy. The role of the psychologist should be to collaborate with other stakeholders (i.e., the American Psychological Association and the Substance Abuse and Mental Health Services Administration) to educate the public about evidence-based preventive and treatment interventions, to promote children's mental health as a primary concern, and to help bridge the gap between what is known about child development, social functioning, and mental health. Psychologists must work with other stakeholders and practitioners to deliver accessible, family-focused, culturally competent, evidence-based practices for children with severe emotional and behavioral problems and for those who are at risk of such disturbances.

Schaeffer, C. M., & Borduin. (2005). Long-term follow-up to a randomized clinical trial of multisystemic therapy with serious and violent juvenile offenders. *Journal of Consulting and Clinical Psychology, 73*(3), 445-453.

Keywords: Multisystemic Therapy, juvenile justice, adolescents, adults, mental health

This article reports on the longest follow-up study to date on the effects of Multisystemic Therapy (MST) on reducing criminal involvement into adulthood. The authors reviewed arrest records for youth randomly assigned to either MST or individual therapy (IT) an average of 13.7 years after services were administered. MST recipients were significantly less likely to be rearrested after treatment when compared to recipients of IT. Compared to IT recipients, those who received MST were less likely to be arrested for serious, nonviolent, and drug related crimes.

At the time of the initial study, youth (*N* = 176) were between the ages of 12-17 years, and had an average of 3.9 felony arrests. Almost half (47.8%) of the sample had been arrested for a violent crime. Although the average age at first arrest was 11.7 (*SD* = 1.9), youths did not receive services until they were, on average, 14.4 (*SD* = 1.4) years old. Most of the sample was male (70%), and 76% were White. African Americans (22%), Asian Americans (1%) and Hispanics (.09%) comprised the rest of the sample. At the time of sentencing, youth were randomly assigned to receive either MST (*n* = 92) or IT (*n* = 84) interventions. MST interventions are individualized, flexible, offered in the home and community, and address cognitive problems with action-oriented solutions. Like MST, IT interventions focus on personal, family and academic issues, and services are provided in the community in this judicial district. However, IT interventions focus on the individual only, rather than on environmental factors (home, school, community, etc.) highlighted by MST. Youth received an average of 20.7 (*SD* = 7.4) hours of MST services, or 22.5 (*SD* = 10.6) hours of IT services. Seventy-three youth completed the MST program, and 59 youth completed the IT program. Data on those who dropped out of either program were included in the following analysis to "provide a conservative test of MST effects" (p. 446).

The current study was conducted an average of 13.7 (*SD* = 1.2) years after MST and IT services were provided; the mean age of the sample was 28.8 (*SD* = 1.8) years. State arrest records were available for 93.8% of the original sample. State juvenile and adult databases were accessed to determine whether these individuals had been convicted of crimes after leaving MST or IT interventions. Results indicate that 50% of MST recipients continued to commit crimes, versus 81% of IT recipients. IT youth were also over four times more likely to be rearrested compared to MST youth. IT recipients were 2.57 times more likely to be arrested for a violent crime (e.g., assault, rape) and 2.63 times more likely to be arrested for a nonviolent crime (e.g., breaking and entering, theft) and 3.33 times more likely to be arrested for a drug related crime when compared to MST recipients. MST youth were sentenced to 61% fewer days of confinement in adult detention centers and received 37% fewer probation days when compared to IT youth.

Previous research on MST has shown this intervention to be effective in the short term at reducing recidivism in adolescents with delinquency problems (See *Data Trends* #29 and #90). This study suggests that the effects of MST may continue after adolescence. According to the authors, "Information regarding the possible lasting benefits of empirically supported treatments such as MST could greatly assist policymakers and program administrators in selecting and implementing mental health programs for serious juvenile offenders" (p. 445).

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December, 2005
No. 123

Weisz, J. R., Sandler, I. N., Durlak, J. A., & Anton, B. S. (2005). Promoting and protecting youth mental health through evidence-based prevention and treatment. *American Psychologist, 60*(6), 628-648.

Keywords: prevention, treatment, evidence-based interventions

This article presents a conceptual framework for linking prevention strategies with mental health treatment for children and their families. The child, family, community and culture comprise the "core" of the model, around which various prevention and treatment strategies and settings are organized. The concept of cultural competency acts as a mediating influence between the child and family and the proposed intervention strategies and settings. Ranging from the level of whole populations that do not necessarily need mental health services to individuals with severe emotional disorders, treatment interventions include:

- *Health promotion/positive development*: addresses entire populations and is intended to promote general positive health and reduce the risk of later problems through various avenues, such as positive youth development programs and academic enhancement programs.
- *Universal prevention*: addresses risk factors among groups (such as schools or a group of classrooms) without attempting to identify which particular children are at risk.
- *Selective prevention*: addresses groups at risk of mental health problems, such as children exposed to traumatic events; does not involve an attempt to identify which children, specifically, are at risk for mental health problems.
- *Indicated prevention*: targets those who have mental health problems but do not necessarily meet criteria for a diagnosis; may intersect with time-limited therapy.
- *Time-limited therapy*: provides treatment for a single episode of care (i.e., for a limited number of sessions) for those diagnosed with a mental health problem; treatments are often manualized.
- *Enhanced therapy*: provides treatment for an extended period of care (i.e., beyond a single episode) for those diagnosed with a mental health problem/disorder; includes booster sessions.
- *Continuing care*: provides an array of services over extended periods "to support effective living in individuals diagnosed with persistent, long-term conditions" (p. 632).

The first four interventions seek to prevent mental health problems, while the last three interventions provide services to those who are identified as having mental health problems; thus, "treatment strategies that address serious emotional problems and disorders are complemented by preventive strategies that address risk before it has evolved into debilitating forms" (p. 633).

Strengths of the model include interventions that address mental health problems at different levels of prevention and treatment. Further, the model accounts for a wide variety of people in diverse settings (e.g., home, schools, neighborhood agencies, primary care clinics, outpatient mental health, day treatment programs, residential facilities, and inpatient units), potentially reaching children and families from all walks of life.

Next, the authors report on a number of programs considered to be evidence-based, while also discussing gaps in prevention and treatment that may hinder the full utilization of the model. With regard to gaps in research and practice, the authors note that there are few evidence-based programs in some settings (e.g., primary care clinics, residential facilities), and for a range of disorders (e.g., suicide, eating disorders) and comorbid disorders. There is also a need to identify "necessary and sufficient" (p. 639) intervention elements and to understand why some programs work in certain settings and others do not. More research also needs to be conducted to identify how change occurs, and to strengthen the connection between empirical science and "real world" settings. Additionally, more research on what counts as an evidence-based practice should be conducted.

Continued...

In conclusion, the authors provide a model of prevention and treatment intervention that fits well with systems of care values. In particular, the model is child and family centered, accounts for interventions at the community level, encourages cultural competency, and emphasizes evidence-based practices and their dissemination into real world practice. They write: "Efforts to build interventions that work well in everyday practice will clearly require active, ongoing collaboration among researchers, practitioners, and consumers a process likely to benefit all three groups" (p. 644).

Stahmer, A. C. Leslie, L. K., Hurlburt, M., Barth, R. P., Webb, M. B., Landsverk, J., & Zhang, J. (2005). Developmental and behavioral needs and service use for young children in child welfare. *Pediatrics, 116*(4), 891-900

Keywords: child welfare, NASCAW, behavioral and developmental disorders

This study examines a national sample of children under six years old who have come into contact with the child welfare (CW) system. The authors identify the proportion of children who are at risk of behavioral and developmental disorders; the type of behavioral and developmental problems these children have; what percentage of these children receive services, and how service use is related to clinical and non-clinical factors. Results indicate that about half of the sample was in need of services (i.e., education, mental health, primary care) for behavioral or developmental problems; behavioral problems were more common than developmental problems. However, only 22.7% of all children received any services for behavioral or developmental problems. Specifically, 12.9% of infants and toddlers (0-2 years) and 31.6% of preschoolers (3-5 years) received services.

Data for the present study were from the National Survey of Child and Adolescent Well-being (NASCAW), and included children (*N* = 2,813) who fell into one of three categories: (a) live in out-of-home placement (*n* = 641), (b) live at home with an active CW case (*n* = 1,177), or (c) live at home with an inactive case (i.e., were investigated for maltreatment but no further action was taken; *n* = 995). Preschool children comprised about half (52%) of the sample, and about half of the sample was male (52%). Most children were White (47%), followed by African Americans (28%) and Hispanics (19%). Supervisory neglect (43%) and physical neglect (33%) were the two most common reasons for coming under investigation by CW. Assessments were conducted with caregivers, child welfare workers, and the child approximately 5.3 months after the start of a CW investigation, and again about 8 months later. A battery of instruments collected the following information: sociodemographics; level of CW involvement; maltreatment history; risk for behavioral or developmental problems; developmental/cognitive status; language and communication level; behavioral needs; social skills; adaptive behavior; and service use. Two versions of the Child Behavior Checklist (one for children ages 2-4, and another for ages 4-18) were used to assess emotional and behavioral problems. With regard to the several measures used to identify emotional and behavioral problems, developmental and behavioral problems were aggregated "because early intervention programs typically serve children with any area of risk; these areas of delay/dysfunction often overlap in young children" (p. 893). Selected, significant results follow:

- Children who were removed from their homes were more likely to be infants and toddlers than preschoolers.
- Infants and toddlers were one-third less likely to receive any services when compared to preschool children. (Risk factors may be more difficult to identify at this age, or children may be expected to "outgrow" their problems.)
- Compared to children placed outside of the home, children who remained at home were more likely to be White.
- Compared to children removed from their homes, children living at home with an active case were less likely to be Hispanic.
- After controlling for need, African-American children were half as likely to receive services as White children.
- Compared to children remaining at home, those placed outside of the home were more likely to have been referred to CW for supervisory neglect or abandonment.

Continued...

- Children who came into contact with CW as a result of abandonment were three times more likely to receive services than their counterparts.
- Across age groups, 11.5% of all children received *mental health* services; 7.8% received primary health care services, and 11.8% received services through the education sector.
- Children at risk for behavioral and developmental disorders were more likely to receive services as the number of risk domains increased.
- Children remaining in the home (regardless of case status) were "much less likely" (p. 896) to receive services than children who were placed outside of the home; children living at home with no active case were the least likely to receive services.

Although the CW system has been called a de facto mental health system (see *Data Trends* #101), results indicate substantial unmet need among this young sample, and particularly for infants, toddlers, and children living at home. According to the authors, "CW programs do seem to facilitate moving preschool children with high need into services once they enter foster care. However, many younger children placed in out-of-home care, and all young children remaining at home, are much less likely to receive services even in the presence of need" (p. 898).

Finally, children at risk of behavioral and developmental disorders are frequently seen in primary care offices before and after CW investigations. Yet children in this sample were least likely to receive primary care services when compared to educational and mental health services. Publication of this article in a leading pediatric journal may help alert physicians to the behavioral and developmental needs of infants, toddlers, and preschoolers.

DATA TRENDS

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

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
Issues 107-124 summarized January – December 2005

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

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.

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.

Issue 13: Farmer, E., Stangle, D., Burns, B., Costello, E. J., & Angold, A. (1999). Use, persistence, and intensity: Patterns of care for children's mental health across one year. *Community Mental Health Journal*, *35*(1), 31-46.

Issue 14: Rosenheck, R. A. (1999). Principles and priority setting in mental health services and their implications for the least well off. *Psychiatric Services*, *50*(5), 653-658.

Issue 15: Wu, P., Hoven, C., Bird, H., Moore, R., Cohen, P., Alegria, M., Dulcan, M., Goodman, S., McCue Horwitz, S., Lichtman, J., Narrow, W., Rae, D., Reigier, D., & Roper, M. (1999). Depressive and disruptive disorders and mental health service utilization in children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(9), 1081-1092.

Issue 16: Walsh, M. E., Brabeck, M. M., & Howard, K. A. (1999). Interprofessional collaboration in children's services: Toward a theoretical framework. *Children's Services: Social Policy, Research, and Practice*, *2*(4), 183-208.

Summarized during calendar year 2000

Issue 17: 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.

Issue 18: Henggeler, S. W., Rowland, M.D., Randall, J., Ward, D. M., Pickrel, S. G., Cunningham, P. B., Miller, S. L., Edwards, J., Zealberg, J. J., Hand, L. D., & Santos, A. B. (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.

Issue 19: 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.

Issue 20: The Robert Wood Johnson Foundation. (2000). *The importance of trust in medical care, papers and publications: David Mechanic, Ph.D. [Author series 1(12)]*. Investigator Awards in Health Policy Research: Author. Retrieved from: http://www.ihhcpar.rutgers.edu/rwjf/author_series_detail.asp

Issue 21: Knitzer, J. (1999 February). *Promoting resilience: Helping young children and parents affected by substance abuse, domestic violence, and depression in the context of welfare reform*. NY: National Center for Children in Poverty, the Joseph L. Mailman School of Public Health. Retrieved from: http://cpmcnet.columbia.edu/dept/nccp/main10.html

Issue 22: Weisz, John R. (2000 Spring). 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.

Issue 23: 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.

Issue 24: 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.

Issue 25: 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.

Issue 26: Pires, S. A., Stroul, B., & Armstrong, M. L. (2000 Spring). *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: 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.

Issue 27: Koplan, J. P., & Fleming, D. W. Current and future public health challenges. (2000). *Journal of the American Medical Association 284,* 1696-1698.

Issue 28: Stiffman, A., R., Hadley-Ives, E., Elze, D., Johnson, S., & Doré, P. (1999). Impact of environment on adolescent mental health and behavior: Structural equation modeling. *American Journal of Orthopsychiatry, 69*(1), 73-86.

Issue 29: 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.

Issue 30: Lopez, S. R. & Guarnaccia, P. J. J. (2000). Cultural psychopathology: Uncovering the social world of mental illness. *Annual Review of Psychology*, 51, 571-598.

Summarized during calendar year 2001

Issue 31: Holden, E. W., Friedman, R. M., & Santiago, R. M. (Eds.). (2001). The National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program [Special Issue]. *Journal of Emotional and Behavioral Disorders, 9*(1).

Issue 32: Hodges, K., & Wotring, J. (2000). Client typology based on functioning across domains using the CAFAS: Implications for service planning. *The Journal of Behavioral Health Services and Research, 27*(3), 257-270.

Issue 33: Garland, A. F., Aarons, G. A., Saltzman, M. D., & Kruse, M. I. (2000). Correlates of adolescents' satisfaction with mental health services. *Mental Health Services Research, 2*(3), 127-139.

Issue 34: Briggs-Gowan, M. J., Horwitz, S. M., Schwab-Stone, M. E., Leventhal, J. M., & Leaf, P. J. (2000). Mental health in pediatric settings: Distribution of disorders and factors related to service use. *Journal of the American Academy of Child & Adolescent Psychiatry, 39*(7), 841-849.

Issue 35: Garland, A. A., Hough, R. L., McCabe, K. M., Yeh, M., Wood, P. A., & Aarons, G. A. (2001). Prevalence of psychiatric disorders in youths across five sectors of care. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*, 4, 409-418.

Aarons, Gregory A., Brown, Sandra A., Hough, Richard L., Garland, A. F., & Wood, P. A. (2001). Prevalence of adolescent substance use disorders across five sectors of care. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*, 4, 419-426.

Issue 36: Cuffe, S. P., Waller, J. L., Addy, C. L., McKeown, R. E., Jackson, K. L., Moloo, J., & Garrison, C. Z. (2001). A longitudinal study of adolescent mental health service use. *Journal of Behavioral Health Services & Research, 28*(1), 1-11.

Issue 37: Mendel, Richard A. (2001). *Less cost, more safety: Guiding lights for reform in juvenile justice.* Washington, DC: American Youth Policy Forum. Retrieved from: http://www.aypf.org/lesscost/

Issue 38: Walrath, C. M., Sharp, M. J., Zuber, M., & Leaf, P. (2001). Serving children with SED in urban systems of care: Referral agency differences in child characteristics in Baltimore and the Bronx. *Journal of Emotional and Behavioral Disorders, 9*(2), 94-105.

Issue 39: dosReis, S., Zito, J. M., Safer, D.J., & Soeken, K. L. (2001). Mental health services for youths in foster care and disabled youths. *American Journal of Public Health, 91*(7), 1094-1099.

Issue 40: Stiffman, A. R., Hadley-Ives, E., Dore, P. Polgar, M., Horvath, V., Striley, C., & Elze, D. (2000). Youths' access to mental health services: The role of providers' training, resource connectivity, and assessment of need. *Mental Health Services Research, 2*(3), 141-154.

Issue 41: NIMH National Advisory Mental Health Council's Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment. (2001). *Blueprint for Change: Research on Child and Adolescent Mental Health*. Washington, DC: National Institute of Mental Health. Retrieved from: http://www.nimh.nih.gov/child/blueprin.pdf

Issue 42: Ringel, J. S., & Sturm, R. (2001). National estimates of mental health utilization and expenditures for children in 1998. *Journal of Behavioral Health Services and Research, 28*(3), 319-332.

Issue 43: Costello, E. J., Gordon, P., Keeler, M. S., & Angold, A. (2001). Poverty, race/ethnicity, and psychiatric disorder: A study of rural children. *American Journal of Public Health, 91*(9), 1494-1498.

Issue 44: Hoagwood, H., Burns, B. J., Kiser, L., Ringeisen, H., & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services, 52*(9), 1179-89.

Schoenwald, S. K., & Hoagwood, K. (2001). Effectiveness, transportability, and dissemination of interventions: What matters when? *Psychiatric Services, 52*(9), 1190-96.

Issue 45: Walrath, C. M., Mandell, D. S., Liao, Q., Holden, E. W., DeCarolis, G., Santiago, R. L., & Leaf, P. J. (2001). Suicide attempts in the "Comprehensive Community Mental Health Services for Children and Their Families" program. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*(10), 1197-1205.

Issue 46: Romano, E., Tremblay, R. E., Vitaro, F., Zoccolillo, M., & Pagani, L. (2001). Prevalence of psychiatric diagnoses and the role of perceived impairment: Findings from an adolescent community sample. *Journal of Child Psychology and Psychiatry, 42*(4), 451-461.

Issue 47: Taub, J., Tighe, T. A., & Burchard, J. (2001). The effects of parent empowerment on adjustment for children receiving comprehensive mental health services. *Children's Services: Social Policy, Research, and Practice, 4*(3), 103-122.

Issue 48: Walrath, C., dosReis, S., Miech, R., Liao, Q., Holden, E. W., De Carolis, G., Santiago, R., & Leaf, P. (2001). Referral source differences in functional impairment levels for children served in the Comprehensive Community Mental Health Services for Children and their Families Program. *Journal of Child and Family Studies, 10*(3), 385-397.

Summarized during calendar year 2002

Issue 49: Greene, R. W., & Abion, J. S. (2001). What does the MTA study tell us about effective psychosocial treatment for ADHD? *Journal of Clinical Child Psychology, 30*, 114-121. With commentaries by: Abikoff, H., pp. 122-125; Hoza, pp. 126-130; Wells, K. C., pp. 131-135; Whalen, C. K., pp. 1326-140; & Harwood, T. M., & Beutler, L. E., pp. 141-143.

Heriot, S. A., Evans, I. M., & Foster, T. M. (2001). An interactional approach to intervention research with children diagnosed with ADHD. *Journal of Child and Family Studies, 10*, 287-300.

Issue 50: Goldman, H. H., Ganju, V., Drake, R. E., Gorman, P., Hogan, M., Hyde, P. S., & Morgan, O. (2001). Policy implications for implementing evidence-based practices. *Psychiatric Services, 52*(12), 1591-1597.

Corrigan, P. W., Steiner, L., McCracken, S. G., Blaser, B., & Barr, M. (2001). Strategies for disseminating evidence-based practices to staff who treat people with serious mental illness. *Psychiatric Services, 52*(12), 1598-1606.

Rosenheck, R. A. (2001). Organizational process: A missing link between research and practice. *Psychiatric Services, 52*(12), 1607-1612.

Carpinello, S. E., Rosenberg, L., Stone, J., Schwager, M., & Felton, C. J. (2002). New York State's campaign to implement evidence-based practices for people with serious mental disorders. *Psychiatric Services, 53*(2), 153-155.

Issue 51: Friedman, R. M. (2002, January). *Child and adolescent mental health: Recommendations for improvement by state mental health commissions*. Unpublished Manuscript.

Issue: 52: Duggal, S., Carlson, E. A., Sroufe, L. A., & Egeland, B. (2001). Depressive symptomatology in childhood and adolescence. *Development and Psychopathology, 13*, 143-164.

Issue 53: Bruner, C., Greenberg, M., Guy, C., Little, Weiss, H., & Schorr, L. (Eds.) (2001). *Funding what works: Exploring the role of research on effective programs and practices in government decision- making.* [Monograph]. National Center for Service Integration Clearinghouse and the Center for Schools and Communities. Des Moines, IA.

Issue 54: Dierker, L., Nargiso, J., Wiseman, R., & Hoff, D. (2001). Factors predicting attrition within a community initiated system of care. *Journal of Child and Family Studies, 10*(3), 367-383.

Issue 55: Yeh, M., McCabe, K., Hurlburt, M., Hough, R., Hazen, A., Culver, S., Garland, A., & Landsverk, J. (2002). Referral sources, diagnoses, and service types of youth in public outpatient mental health care: A focus on ethnic minorities. *Journal of Behavioral Health Sciences & Research, 29*(1), 45-60.

Issue 56: Lyons, J. S., Terry, P., Martinovich, Z., Peterson, J., & Bouska, B. (2001). Outcome trajectories for adolescents in residential treatment: A statewide evaluation. *Journal of Child and Family Studies, 10*(3), 333-345.

Leichtman, M., Leichtman, M. L., Cornsweet Barber, C., & Neese, D. T. (2001). Effectiveness of intensive short-term residential treatment with severely disturbed adolescents. *American Journal of Orthopsychiatry, 71*(2), pp. 227-235.

Issue 57: Chorpita, B. F., Yim, L. M., Donkervoet, J. C., Arensdorf, A., Amundsen, M. J., McGee, C., Serrano, A., Yates, A., Burns, J. A., & Morelli, P. (2002). Toward large-scale implementation of empirically supported treatments for children: A review and observations by the Hawaii Empirical Basis to Services Task Force, *Clinical Psychology, 9*(2), 165-190. With commentaries by: Henggeler, S., et al., pp. 191-194; Bickman, L., pp. 195-199; Hogan, M. F., pp. 200-203; Gonzales, J. J., et al., pp. 204-209; Hoagwood, K., pp. 210-213; Kendall, P. C., pp. 214-216; Roberts, M. C., pp. 217-219; Jackson, Y., pp. 220-222; Jensen, P. S., pp. 223-224, & Hawley et al., pp. 225-230.

Issue 58: Jensen, P. S. (Ed). (2001). ADHD comorbidity and treatment outcomes in the MTA [Special Issue]. *Journal of the American Academy of Child and Adolescent Psychiatry, 40.*

Jensen, P. S., Introduction, p. 134-136.

Jensen, P. S., Hinshaw, S. P., & Kraemer, H. C., et al., ADHD comorbidity findings from the MTA study: Comparing comorbid subgroups, 147-158.

Conners, C. K., Epstein, J. N., & March, J. S., et al., Multimodal treatment of ADHD in the MTA: An alternative outcome analysis, 159-167.

Swanson, J. M., Kraemer, J. C., & Hinshaw, S. P., et al. Clinical relevance of the primary findings of the MTA: Success rates based on severity of ADHD and ODD symptoms at the end of treatment, 168-179.

Issue 59: Loeber, R., Farrington, D. P., Stouthamer-Loeber, M., Moffitt, T. E., Caspi, A., & Lynam, D. (2002). Male mental health problems, psychopathy, and personality traits: Key findings from the first 14 years of the Pittsburgh Youth Study, *Clinical Child and Family Psychology Review*, *4*(4), 273-297.

Frick, P. J., (2001). Effective interventions for children and adolescents with conduct disorder. *Canadian Journal of Psychiatry, 46, 597-608.*

Issue 60: Edlund, M. J., Wang, P. S., Berglund, P. A., Katz, S. J., Lin, E., & Kessler, R. C. (2002). Dropping out of mental health treatment: Patterns and predictors among epidemiological survey respondents in the United States and Ontario. *American Journal of Psychiatry*, *159*(5), 845-851.

Issue 61: Wilmshurst, L. A. (2002). Treatment programs for youth with emotional and behavioral disorders: An outcome study of two alternate approaches. *Mental Health Services Research*, *4*(2), 85-96.

Issue 62: Malmgren, K. W., & Meisel, S. M. (2002). Characteristics and service trajectories of youth with serious emotional disturbance in multiple service systems. *Journal of Child and Family Studies*, *11*(2), 217-229.

Issue 63: Leslie, D. L., Rosenheck, R. A., & Horwitz, S. M. (2001). Patterns of mental health utilization and costs among children in a privately insured population. *Health Services Research*, *36*, 113-127.

Issue 64: Dubois, D. L., Holloway, B. E., Valentine, J. C., & Harris, C. (2002). Effectiveness of mentoring programs for youth: A meta-analytic review. [Special Issue]. *American Journal of Community Psychology*, *30*(2), 157-197.

Issue 65: Kutash, K., Duchnowski, A. J., Sumi, W. C., Rudo, Z., & Harris, K. (2002). A school, family, and community collaborative program for children who have emotional disturbances. *Journal of Emotional and Behavioral Disorders*, *10*(2), 99-107.

Issue 66: Kataoka, S. H., Zang, L., & Wells, K.B. (2002). Unmet need for mental health care among U. S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry*, *159*, 1549-1555.

Issue 67: Henggeler, S. W., Clingempeel, W. G., Brondino, M. J., & Pickrel, S. G. (2002). Four-year follow-up of Multisystemic Therapy with substance-abusing and substance-dependent juvenile offenders. J*ournal of the American Academy of Child and Adolescent Psychiatry, 41*(7), 868-874.

Issue 68: Mak, W., & Rosenblatt, A. (2002). Demographic influences on psychiatric diagnoses among youth served in California systems of care. *Journal of Child and Family Studies, 11*(2), 165-178.

Issue 69: Owens, P. L., Hoagwood, K., Horwitz, S. M., Leaf, P. J., Poduska, J. M., Kellam, S. G., & Ialongo, N. S. (2002). Barriers to children's mental health services. *Journal of the American Academy of Child and Adolescent Psychiatry*, *41*(6), 731-738.

Issue 70: Slade, E. P. (2002). Effects of school-based mental health programs on mental health service use by adolescents at school and in the community. *Mental Health Services Research*, *4*(3), 151-166.

Summarized during calendar year 2003

Issue 71: Heflinger, C. A., Simpkins, C. G., & Foster, E. M. (2002). Modeling child and adolescent psychiatric hospital utilization: A framework for examining predictors of service use. *Children's Services: Social, Policy, Research, and Practice, 5*(3), 151-171.

Issue 72: Olfson, M., Marcus, S. C., Weissman, M. M., & Jensen, P. S. (2002). National trends in the use of psychotropic medications by children. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(5), 514-521.

Issue 73: Vander Stoep, A., Weiss, N. S., McKnight, B., Beresford, S. A. A., & Cohen, P. (2002). Which measure of adolescent psychiatric disorder—diagnosis, number of symptoms, or adaptive functioning—best predicts adverse young adult outcomes? *Journal of Epidemiology and Community Health 56:* 56-65.

Issue 74: Kendall, P.C., & Kessler, R. C. (2002). The Impact of Childhood Psychopathology Interventions on Subsequent Substance Abuse: Policy Implications, Comments, and Recommendations, *Journal of Consulting and Clinical Psychology, 70*(6), *1303-1306.*

Issue 75: Achenbach, T. M., Dumenci, L., & Rescorla, L. A. (2002). Ten-year comparisons of problems and competencies for national samples of youth: Self, parent, and teacher reports. *Journal of Emotional and Behavioral Disorders, 10*(4), 194-203.

Achenbach, T. M., Dumenci, L., & Rescorla, L. A. (2003). Are American children's problems still getting worse? A 23-year comparison. *Journal of Abnormal Child Psychology, 31*(1), 1-11.

Issue 76: Rosenblatt, A., & Rosenblatt, J. A. (2002). Assessing the effectiveness of care for youth with severe emotional disturbances: Is there agreement between popular outcome measures? *The Journal of Behavioral Health Services & Research, 29*(3), 259-273.

Issue 77: Taussig, H. N. (2002). Risk behaviors in maltreated youth placed in foster care: A longitudinal study of protective and vulnerability factors. *Child Abuse & Neglect: 26*, 1179-1199.

Issue 78: Teagle, S. (2002). Parental problem recognition and child mental health service use. *Mental Health Services Research*, 4(4), 257-266.

Farmer, E. M. Z., Burns, B. J., Phillips, S. W., Angold, A., & Costello, E. J. (2003). Pathways into and through mental health services for children and adolescents. *Psychiatric Services, 54*(1), 60-67.

Issue 79: Dorsey, S. & Forehand, R. (2003). The relation of social capital to child psychosocial adjustment difficulties: The role of positive parenting and neighborhood dangerousness. *Journal of Psychopathology and Behavioral Assessment, 25*(1), 11-23.

Issue 80: Henggeler, S. W., Rowland, M. D., Halliday-Boykins, C., Sheidow, A. J.,Ward, D. M., Randall, J., Pickrel, S. G., Cunningham, P. B., & Edwards, J. (2003). One-year follow-up of Multisystemic Therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(5), 543-551.

Issue 81: Lewczyk, C. M., Garland, A. F., Hurlburt, M. S., Gearity, J., & Hough, R. L. (2003). Comparing DISC-IV and clinician diagnosis among youths receiving public mental health services. *Journal of the American Academy of Adolescent Psychiatry, 42*(3), 349-356.

Issue 82: Armstrong, K. H., Dedrick, R. F., & Greenbaum, P. E. (2003). Factors associated with community adjustment of young adults with serious emotional disturbance: A longitudinal analysis. *Journal of Emotional and Behavioral Disorders, 11*(2), 66-76.

Issue 83: Kataoka, S. A., Stein, B. D., Jaycox, L. H., Wong, M., Escudero, P., Tu, W., Zaragoza, C., & Fink, A. (2003). A school-based mental health program for traumatized Latino immigrant children. *Journal of the Academy of Child and Adolescent Psychiatry, 42*(3), 311-318.

Issue 84: Glisson, C. (2002). The organizational context of children's mental health services. *Clinical Child and Family Psychology Review, 5*(4), 233-253.

Issue 85: Hodges, S., Hernandez, M., & Nesman, T. (2003). A developmental framework for collaboration in child-serving agencies. *Journal of Child and Family Studies, 12*(3), 291-305.

Issue 86: Yeh, M., McCabe, K., Hough, R., Dupuis, D., & Hazen, A. (2003). Racial/ethnic differences in parental endorsement of barriers to mental health services for youth. *Mental Health Services Research, 5*(2), 65-77.

Issue 87: The Treatment for Adolescents with Depression Study Team. (2003). Treatment for Adolescents with Depression Study (TADS): Rationale, design, and methods. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(5), 531-542.

Issue 88: Compton, S. N., Burns, B. J., Egger, H. L., & Robertson, E. (2002). Review of the evidence base for treatment of childhood psychopathology: Internalizing disorders. *Journal of Counseling and Community Psychology, 70*(6), 1240-1266.

Farmer, E. Z. M., Compton, S. N., Burns, B. J., & Robertson, E. (2002). Review of the evidence base for treatment of childhood psychopathology: Externalizing disorders. *Journal of Counseling and Community Psychology, 70*(6), 1267-1302.

Issue 89: Evans, M. E., Boothroyd, R. A., Armstrong, M. I., Greenbaum, P. E., Brown, E. C., & Kuppinger, A. D. (2003). An experimental study of the effectiveness of in-home crisis services for children and their families: Program outcomes. *Journal of Emotional and Behavioral Disorders, 11*(2), 92-102.

Issue 90: Clingempeel, W. G., & Henggeler, S. W. (2003). Aggressive juvenile offenders transitioning into emerging adulthood: Discriminating persistors and desistors. *American Journal of Orthopsychiatry*, 73(3), 310-323.

Issue 91: Whitemore, E., Ford, M., & Sack, W. H. (2003). Effectiveness of day treatment with proctor care for young children: A four-year follow-up. *Journal of Community Psychology, 31*(5), 459-468.

Issue 92: Sturm, R., Ringel, J. S., & Andreyeva, T. (2003). Geographic disparities in children's mental health care. *Pediatrics, 112*(4), 308-315.

Issue 93: Costello, E. J., Mustillo, S., Erkanli, A., Keeler, G., & Angold, A. (2003). Prevalence and development of psychiatric disorders in childhood and adolescence. *Archives of General Psychiatry: 60*, 837-844.

Summarized during calendar year 2004

Issue 94: 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.

Issue 95: 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.

Issue 96: 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.

Issue 97: 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.

Issue 98: 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.

Issue 99: 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.

Issue 100: 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.

Issue 101: 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.

Issue 102: 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.

Issue 103: 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.

Issue 104: 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.

Issue 105: 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.

Issue 106: 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.

Summarized during calendar year 2005

Issue 107: Hurlburt, M. S., Leslie, L. K., Landsverk, J., Barth, R. P., Burns, B. J., Gibbons, R. D., Slymen, D. J., et al. (2004). Contextual predictors of mental health service use among children open to child welfare. *Archives of General Psychiatry: 61*, 1217-1224.

Issue 108: Boothroyd, R. A., & Armstrong, M. I. (2005). Comorbidity and unmet service needs among Medicaid-enrolled children with identified disabilities. *Journal of Emotional and Behavioral Disorders, 13*(1), 43-51.

Issue 109: Macy, R. D., Behar, L., Paulson, R., Delman, J., Schmid, L., & Smith, S. (2004, July/August). Community-based, acute posttraumatic stress management: A description and evaluation of a psychosocial-intervention continuum. *Harvard Review of Psychiatry* [Perspectives], 217-228.

Issue 110: Foster, M. E., & Connor, T. (2005). Public costs of better mental health services for children and adolescents. *Psychiatric Services, 56*(1), 50-55.

Issue 111: Hazen, A. L., Hough, R. L., Landsverk, J. A., & Wood, P. A. (2004). Use of mental health services by youths in public sectors of care. *Mental Health Services Research, 6*(4), 213-226.

Issue 112: Kraemer Tebes, J., Bowler, S. M. Shah, S., Connell, C. M., Ross, E., Simmons, R., et al. (2005). Service access and service system development in a children's behavioral health system of care. *Evaluation and Program Planning, 28*, 151-160.

Issue 113: Eamon, M. K., & Mulder, C. (2005). Predicting antisocial behavior among Latino young adolescents: An ecological systems analysis. *American Journal of Orthopsychiatry, 75*(1), 117-127.

Issue 114: Rowland, M. D., Halliday-Boykins, C. A., Henggeler, S. W., Cunningham, P. B., Lee, T. G., Kruesi, M. J., et al. (2005). A randomized trial of Multisystemic Therapy with Hawaii's Felix Class youths. *Journal of Emotional and Behavioral Disorders, 13*(1), 13-23.

Issue 115: Hoagwood, K. E. (2005). Family-based services in children's mental health: A research review and synthesis. *Journal of Child Psychology and Psychiatry, 46*(7), 670-713.

Issue 116: Kessler, R. C., Berglund, P., Demler, O., Jin, R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 593-602

Wang, P. S., Berglund, P., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 603-613

Issue 117: Corrigan, P. W., Demming Lurie, B., Goldman, H. H., Slopen, N., Medasani, K., & Phelan, S. (2005). How adolescents perceive the stigma of mental illness and alcohol abuse. *Psychiatric Services 56*(5), 544-550.

Issue 118: Snowden, L. R. (2005). Racial, cultural and ethnic disparities in health and mental health: Toward theory and research at community levels. *American Journal of Community Psychology, 35*, 1-8.

Issue 119: McDonald, E. J., McCabe, K., Yeh, M., Lau, A., Garland, A., & Hough, R. L. (2005). Cultural affiliation and self-esteem as predictors of internalizing symptoms among Mexican American adolescents. *Journal of Clinical Child and Adolescent Psychology, 34*(1), 163-171.

Issue 120: Huang, L., Stroul, B., Friedman, R., Mrazek, P., Friesen, B., Pires, S. et al. (2005). Transforming mental health care for children and families. *American Psychologist, 60*(6), 615-627.

Issue 121: Tolan, P. H. & Dodge, K. A. (2005). Children's mental health as a primary care concern: A system for comprehensive support and service. *American Psychologist 60*(6), 601-614.

Issue 122: Schaeffer, C. M., & Borduin. (2005). Long-term follow-up to a randomized clinical trial of multisystemic therapy with serious and violent juvenile offenders. *Journal of Consulting and Clinical Psychology, 73*(3), 445-453.

Issue 123: Weisz, J. R., Sandler, I. N., Durlak, J. A., & Anton, B. S. (2005). Promoting and protecting youth mental health through evidence-based prevention and treatment. *American Psychologist, 60*(6), 628-648.

Issue 124: Stahmer, A. C. Leslie, L. K., Hurlburt, M., Barth, R. P., Webb, M. B., Landsverk, J., & Zhang, J. (2005). Developmental and behavioral needs and service use for young children in child welfare. *Pediatrics, 116*(4), 891-900

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ISSN 1537-0399

Data Trends
Summaries of Current Research Findings
in the Children's Mental Health Field
issue numbers 71-93
december, 2003

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