

Source: 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.

This article reports on one of few studies that examines patterns of attrition as well as child, family, and system characteristics in order to better understand why some youth and families remain in a system of care (SOC) while others do not (p. 377). The study found five significant predictors of attrition for children and adolescents: 1) depressed/isolated symptomatology at time of referral, 2) substance abuse, 3) general risk for psychiatric problems, 4) the number of presenting problems at the time of referral, and 5) urgency status at intake (see Table 1). The implications of this study are especially salient for policy and services research aimed at reducing premature termination of services among youth and their families in a system of care.

Table 1: Child Characteristics by Attrition Group

	Refusers <i>n</i> = 54	Dropouts <i>n</i> = 24	Completers (Non-attrition) <i>n</i> = 39	<i>p</i> value
Referral reasons (%):				
Significant risk for psychiatric problems	19 ^b	38 ^a	33 ^a	.05
Depressed/isolated	41 ^b	71 ^a	28 ^b	.01
Substance Abuse	17 ^b	33 ^a	8 ^b	.01
> 1 referral reason	80 ^a	88 ^a	59 ^b	.05
Intake status: Urgent	32 ^b	79 ^a	80 ^a	.01

Note: ^a and ^b represent rates that significantly differ from one another.

The authors collected data from closed case records of youth referred to a system of care (*N*=117) between 1992-1999, and created three mutually exclusive groups by which data were then analysed. The three groups included youth and their families who either: 1) agreed to be referred to an SOC, but later *refused* services offered by the SOC; 2) *dropped out* of treatment prematurely before or after having worked with a service review team, or; 3) *completed* at least some treatment

goals, and/or received some services. Only one-third of youth and their families (*n* = 39) comprised the third group.

The majority of youth in this study were male (71%), and Caucasian (80%). No significant differences were found between groups (i.e., refusers, dropouts, and completers) with regard to gender, age, or ethnicity. Most referrals were made by the state's Department of Children and Families, followed by other CASSP member programs, and schools. Although insurance status (private vs. Medicaid) was used as a proxy for socioeconomic status, findings did not reveal a relationship between income and dropout rates; nor did insurance status predict attrition.

The authors suggest that youth who dropped out of or refused treatment represented very complex cases of risk and comorbidity. For example, 88% of dropouts and 80% of refusers were referred to the SOC for more than one reason (i.e., depressed, suicidal, substance abuse, etc.), while this was the case with only 60% of completers. Depressed and isolated symptomatology as well as substance abuse were found to be much more prevalent among refusers and dropouts than completers. These findings suggest that "The greater likelihood of youth with [numerous] conditions dropping out after the creation of an individualized service plan may in fact reflect the difficulty of maintaining children and adolescents with comorbid diagnoses in treatment" (p. 379).

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“Notably, intake urgency was also found to significantly predict retention in the program at least through the establishment of a treatment plan (i.e., the number of urgent cases was greater among both the dropouts and the completers), suggesting that more acute cases are staying in treatment longer than those judged to be chronic at the time of referral. Since the present system schedules the initial service review team meeting in response to the acuteness of the identified case (i.e., within two weeks, if case is considered urgent), it is possible that the higher attrition rates for chronic cases is a function of increased time spent on the waiting list. A number of previous studies examining waiting list duration have shown that increased time before assessment and treatment initiation is associated with higher rates of attrition.”
p. 378

Intake status was also predictive of attrition. At referral, youth were classified into one of three groups: a) urgent, needing to be seen within two weeks; b) semi-urgent, needing to be seen within one month, and c) non-urgent, or chronic, needing to be seen when possible. Four-fifths of both dropouts and completers were placed on urgent status. Please see the side bar for a discussion of intake status and its implications for retention and attrition within a system of care.

It should be noted that the SOC in this study is considered “one of the most well established” (p. 370), with a full time case manager and family advocate, 24-hour mobile crisis service and active involvement from 36 community agencies from across the county. Accordingly, the authors suggest that these rates of attrition are “particularly noteworthy,” since youth were offered a “comprehensive and individualized array of services” (p. 378).

While this study addresses a very important topic, it also reveals the need for data collection geared toward understanding attrition and retention. Because data for this study were taken from archival records, children and families were not available to provide any insight into why attrition occurred from their perspective. It is important that data collection efforts provide direct feedback from children and their parents about their decisions to refuse or drop out of treatment; without this information we will lack crucial insight into the mental health needs of children and their families.

Overall, the authors suggest that “future, more careful analysis of timing of drop-out will require much larger samples and some matching in terms of both referral status and recommended ser-

vices” (p. 380). They also note that data gleaned for this study were not always collected with standardized instruments, and thus speak to “the urgent need for the development of such instruments that not only serve formal research efforts, but also feed clear and useful information back into the system in a meaningful and timely way” (p. 380).