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ABSTRACT

This collection of papers presented at a 1996 conference on children's mental health focuses on models to improve service delivery. Papers have the following titles and authors: (1) "Empirical Evaluation of an Alternative to Hospitalization for Youth Presenting Psychiatric Emergencies" (Scott W. Henggeler); (2) "An Experimental Study of the Outcomes Associated with Three Crisis Intervention Programs for Children in Psychiatric Crisis and Their Families: Preliminary Findings" (Mary E. Evans and others); (3) "The Alternatives to Residential Treatment Study: Initial Findings" (Albert J. Durchnowski and others); (4) "Coming Home: The Full Inclusion of Children with Serious Emotional Disturbances" (William E. Reay and Calvin P. Garbin); (5) "Challenges to the Use of Respite for Children Receiving Short-Term In-Home Psychiatric Emergency Services" (Roger A. Boothroyd and others); (6) "Mobile Outreach for Children and Families: An Effective Approach to Stabilization" (Janice M. Moore and Shelly Morningstar); (7)"Researching a Moving Target: A Study of Inpatient Treatment in the 90s" (Carol Cornsweet Barber and others); (8) "Transition to Adulthood: How Are Youth with Severe Emotional Disabilities Different from Non-Disabled Youth?" (Mieko Kotake Smith); (9) "Effective Transition" (Starr Silver); (10) "Transition to Adulthood: Issues of Youth with Mental Illness" (Ann Vander Stoep); (11) "Mental Health Service Utilization by Transitional Youth" (Maryann Davis); (12) "Best Practices for Navigating Rough Waters: Transition of Youth with Emotional/Behavioral Disorders into Adulthood" (Hewitt "Rusty" Clark); (13) "Adolescent Suicide: The Implications of Coping, Family Functioning and Their Interactions for Prevention and Intervention" (Ronald F. Bobner and others); (14) "Gender Appropriate Services for Adolescents with Serious Emotional Disturbances: A Gender Competency Model" (Patricia M. Wilson and others); and (15) "Multicultural Mental Health Training Program: A Comprehensive Training Program for Improving Service Delivery to Ethnic Minority Children and Families" (Richard Briscoe and others). (Individual papers contain references.) (DB)

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Empirical Evaluation of an Alternative to Hospitalization for Youth Presenting Psychiatric Emergencies

Scott Henggeler, Alberto Santos, Susan Pickrel, Barbara Trout,Thomas Hiers, Joseph Zealberg, Lisa Hand & Melisa Rowland

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An Experimental Study of the Outcomes Associated with Three Crisis Intervention Programs for Children in Psychiatric Crisis and Their Families: Preliminary Findings

Mary E. Evans, Roger A. Boothroyd, Mary I. Armstrong, Anne D Kuppinger & Paul E Bellair

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The Alternatives to Residential Treatment Study: Initial Findings

Albert J. Duchnowski, Michael Johnson, Kimberly Hall, Krista Kutash & Robert Friedman

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Symposium:
Alternatives to the Hospitalization of Youth Presenting Psychiatric Crises

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Introduction

The purpose of this symposium was to describe preliminary data evaluating empirically-based alternatives to the hospitalization of youth presenting psychiatric crises. The pages that follow summarize three presentations which addressed this topic area.

The first presentation addressed the reasons for generating these alternatives, followed by a description of a recently funded NIMH R01 study developed to determine whether an intensive family- and home-based treatment utilizing multisystemic therapy (MST) is a more effective and less costly strategy than hospitalization for addressing the mental health emergencies of adolescents with severe emotional disturbances (SED).

The second presentation reported on the early outcomes of a federally-funded project in the Bronx, NY in which children presenting for psychiatric emergency services were randomly assigned to one of three treatment conditions.

The last presentation described the methodology developed for the Alternatives to Residential Treatment Study (ARTS) and reported the preliminary findings from a sample of subjects in the first wave of a project evaluating longitudinal outcomes. Finally, the policy implications of these projects were discussed.

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Empirical Evaluation of an Alternative to Hospitalization for Youth Presenting Psychiatric Emergencies

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There is a widely held concern that children's mental health services have overrelied on expensive and restrictive inpatient treatments (e.g., Burns & Friedman, 1990; Henggeler & Santos, in press; Office of Technology Assessment, 1986, 1991; Saxe, Cross, & Silverman, 1988; Sondheimer, Schoenwald, & Rowland, in press; Stroul & Friedman, 1986). Such overreliance presents several significant difficulties that have important implications for clinical practice and health policy.

First, a grossly disproportionate percentage of mental health dollars are devoted to a relatively small percentage of youth who may or may not require such intensive services (Dougherty, 1988; Burns, 1991).

Second, this disproportionate allocation of financial resources might be justified in part, if youth treated in inpatient facilities were significantly more disturbed than their counterparts who are treated in outpatient facilities. Yet, studies indicate that approximately 50% of the youth treated in inpatient facilities do not have a severe or acute mental illness and that a proportion of youth presenting danger to themselves or others do not require inpatient treatment, especially if a home-based crisis intervention is available (Weithorn, 1988).

Third, there is no evidence indicating that inpatient psychiatric treatment of adolescents is more effective than any less restrictive treatment including no treatment (Burns, Thompson, & Goldman, in press; Office of Technology Assessment, 1991; Stroul & Friedman, 1986; Tuma, 1989).

Fourth and finally, psychiatric hospitalization can have substantial negative effects. Hospitalization (a) fails to empower families, subsequently fostering dependence (Kiesler & Sibulkin, 1987; Sondheimer, Schoenwald, & Rowland, in press) (b) greatly restricts individual liberties and often pressures youth to conform to behavioral norms that have little counterpart in the outside world (Melton & Spaulding, in press); and (c) exposes youth to poor role models and labels them in ways that can impede future functioning (Henggeler, 1989).

The central goal of this NIMH funded RO1 study is to determine whether an intensive family- and home-based treatment (Crisis Family Preservation) is a more effective and less costly strategy than psychiatric hospitalization for addressing the mental health emergencies of adolescents with SED. Specifically, this study includes a 2 (treatment condition: Crisis Family Preservation vs. hospitalization) x 5 (time of assessment: within 24 hours of referral, post hospitalization, post family preservation, and 6- and 12 month follow-ups) design, with random assignment of yoked subjects to treatment conditions. Participants will include 252 12-17 year-old adolescents with SED referred to the projects by the Youth Crisis Stabilization Program of the Charleston/Dorchester Community Mental Health Center. Youths will be presenting severe mental health problems such as homicidal intent, suicidal intent, serious affective disorder or psychosis. A comprehensive multimethod, multisource evaluation will address the following questions:

1. "To what extent does Crisis Family Preservation services prevent hospitalization and reduce the symptoms precipitating the crisis?"
2. "Over the long-term (12 months), to what extent does Crisis Family Preservation maintain reductions in identified symptoms; ameliorate the family, peer and community problems

associated with such symptoms; and prevent subsequent institutional placement?"

3. "What factors moderate or mediate treatment?"
4. "What are the comparative financial costs of the treatment conditions?"

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An Experimental Study of the Outcomes Associated with Three Crisis Intervention Programs for Children In Psychiatric Crisis and Their Families: Preliminary Findings

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Crisis Intervention

Each year, approximately 55,744 children in New York State present at hospital emergency rooms experiencing a psychiatric crisis. Very little is known about the services they receive and the effectiveness of these services. The same can be said for children with acute psychiatric problems presenting nationwide. Although a number of intervention programs have been developed for these children and their families, little systematic data exist to evaluate the outcomes associated with these programs.

In 1987, the New York State Office of Mental Health established Home-Based Crisis Intervention (HBCI) programs in five sites, including the Bronx. HBCI, an intensive in-home family preservation program, is New York's version of the Homebuilder's model developed in Tacoma, Washington (Kinney, Madsen, Flemming & Haapala, 1979). This program was designed to prevent out-of-home placement, including hospitalization of children in psychiatric crisis. The federally funded research demonstration study [National Institute of Mental Health (NIMH)/Center for Mental Health Services (CMHS)] discussed here sought to answer questions regarding the effectiveness of this program in comparison with a culturally competent, enhanced program (HBCI+) and a crisis case management program (CCSI). Specifically, the questions we sought to answer were: What program works best for whom? Can these services be used instead of hospitalization? What factors are associated with service choices for children in crisis and their families?

The following table briefly outlines the salient characteristics of the three programs being studied in this research. All are intensive, in-home interventions which are typically four to six weeks in length.

Based on the logic model for this research, we are collecting data in the areas of child characteristics, family characteristics, provider characteristics, program characteristics, child outcomes, family outcomes, system outcomes, and provider outcomes.

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Table 1

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Table 1
A Comparison of Home-Based Crisis Intervention (HBCI),
Enhanced Home-Based Crisis Intervention (HBCI+),
and Crisis Case Management (CCM)

Program Attribute	HBCI	HBCI+	CCM
Target population	Children and youth living at home who are at-risk of an inpatient admission due to psychiatric crisis	Children and youth living at home who are at-risk of an inpatient admission due to psychiatric crisis	Children and youth living at home who are at risk of an inpatient admission due to psychiatric crisis
Program goals	Resolve immediate crisis, teach skills, improve family relationships, link to needed services	Similar to HBCI with the added goal of providing long-term family support services	Assess needs, provide concrete services, link child and family to needed services
Program focus	The child within the context of the family	The child within the context of the family	The child within the context of the family
Caseload per worker	Two families in crisis	Two families in crisis	Four families in crisis, four families requiring "generic" case management services[1]
Duration of service	4-6 weeks	4-6 weeks	4-6 weeks
Respite	No respite provided	In-home and out-of-home respite available	In-home and out-of-home respite available
Staff training	HBCI training	HBCI training, plus training in cultural competence and working with violence in families	Intensive case management and crisis intervention training
Post-crisis family support services	No post-crisis family support services provided	Services available through bilingual, bicultural parent advocate who establishes a parent support group and provides individual parent advocacy	No post-crisis family support services provided
Flexible service dollars	Not available	An average of $100 per family available to meet individualized needs	An average of $150 per family available to meet individualized needs
In-home visits and supports	Provided within 24 hours of intake and on a regular and frequent basis throughout the crisis period	Provided within 24 hours of intake and on a regular and frequent basis throughout the crisis period	Provided within 24 hours initially, and as needed thereafter
Psychiatric services	Psychiatrist available to provide assessment and treatment services within the home	Psychiatrist available to provide assessment and treatment services within the home	Psychiatrist consultation available to crisis case managers and to families for medication review
Funding	State resources only	State resources for HBCI components and grant funds for enhancements	State resources for case managers and in-home respite and grant funds for out-of-home respite

[1] Families receiving "generic" case management services are not part of this research project

The services demonstration involved the establishment of HBCI+ through enhancing the basic HBCI model with respite care, flexible service money, a parent advocate, and staff training in cultural competence, as well as working with families who may be exposed to violence within the family or larger environment. The Hispanic Research Center provided the training in cultural competence, translated instruments into Spanish, pre-tested the instruments and was responsible for data collection in children's homes. Training regarding intrafamily violence was provided by Earl Braxton and colleagues and training on strategies for raising children in socially toxic environments was provided by James Garberino. Crisis Case Management (CCM) was developed from New York's Intensive Case Management program by providing staff training in dealing with children in crisis, providing respite care, and by decreasing the caseload of case managers.

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Method

The research uses a three group positive-controlled randomized study design in which eligible, consenting children/families presenting to two of the three emergency intake sites in the Bronx are randomly assigned to one of the three treatment conditions (HBCI, HBCI+, CCM). Eligible children are those 5 to 17 years of age, living in the Bronx at home with a natural, foster, or adoptive family, who are experiencing a psychiatric crisis requiring immediate intensive intervention. In the absence of these services the child would likely be hospitalized or placed in a restrictive setting. Finally, it must be safe for the child to return home with intensive services and the family must be willing to receive in-home services. Data on the child and family characteristics and functioning are collected on intake, at termination from the intensive program (4-6 weeks), and at 6 months post-termination. Data are also collected on all children presenting to the psychiatric emergency settings to allow comparison of those hospitalized, referred to in-home services, and referred to other less intensive services in the community.

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Results

The data presented are for the first 125 children/families enrolled in the intensive in-home interventions and the first 671 children presenting to the emergency settings. The children average 12.4 years (range 5-18) with equal proportions of males and females. The majority were of Hispanic origin (64%), with 30% Black/African-American and 6% other. The most common diagnoses were disruptive behavior disorders (30%), with 18% presenting with adjustment disorders, 14% with psychotic disorders, and 17% with mood disorders. Clinicians noted that 77% were experiencing functional impairment due to the disorder and 86% demonstrated behavior dangerous to self or others. Of these children, 51% were enrolled in special education programs, 40% had received prior mental health treatment and 9% had been previously hospitalized for a psychiatric disorder.

Most of the children (76%) were being raised in single parent households of three or more children (55%). Few mothers had completed high school (25%) and few were working (25%). Most received assistance from Medicaid (65%) and/or Aid to Families with Dependent Children (36%). More than half the families had an income less than $10,000 per year.

Figure 1 shows the overall dangerousness of the child's condition as rated by clinicians using a risk assessment instrument developed by Gutterman and Levine (1992). Significant differences in the assessed dangerousness existed among children referred to each of the three interventions.

Children admitted to the hospital were most at risk clinically, had the lowest capacity for cooperating with a treatment plan and had the lowest parental support, while those in the in-home condition were intermediate, and those referred to other community programs were rated least at risk on all three subscales.

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Figure 1

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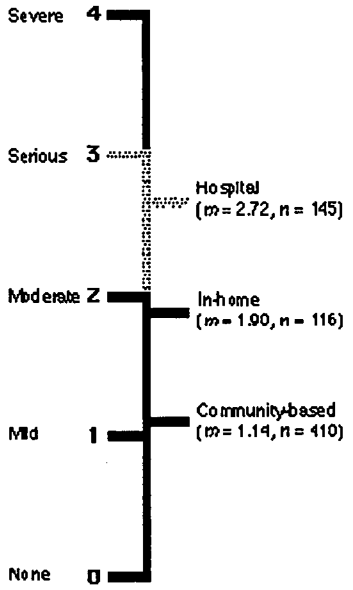

Figure 1
Overall Dangerousness of
Child's Condition
(N=641)*

* All group differences statistically significant.
Gutterman et al, 1993.
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Looking at data for the first 86 children to complete the in-home intervention indicates that they experienced a significant gain in self-esteem from intake (Mean = 47.4) to discharge (52.5) as measured by the Piers-Harris Children's Self-Concept Scale (Piers, 1984). Beginning with high t-scores on Total Problems, Internalizing and Externalizing subscales as measured by the Child Behavior Checklist (Achenbach, 1991), these children did not experience a decrease in their scores on discharge from the intensive programs.

Regarding family data, scores on cohesion and adaptability, as measured by the Family Adaptability and Cohesion Scales (Olsen, Portner & Lavee, 1985) increased significantly from admission to discharge (see Figure 2).

The family's social supports, measured by the Inventory of Socially Supported Behaviors (Barerra, Sandler & Ramsey, 1981) indicated no change from admission to discharge. What is most striking is that the social support scores were so low for families enrolled in all three programs, indicating that families were not only financially, but socially impoverished.

Finally, regarding parent satisfaction with the treatment program, parents in all three conditions reported a high level of satisfaction with services. It is interesting to note, however, that there was an ordered effect regarding satisfaction with skills gained. Parents in CCM were least satisfied, those in HBCI were intermediate and those in HBCI+, as we hypothesized, were most satisfied.

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Discussion

This project is still in an early stage. We will be enrolling children/families until we have 260 families completing the intervention. To date, however, we have learned several things. The first is that children in psychiatric crises can be cared for safely in their homes, given a sufficiently intensive intervention. Secondly, left to exercise their clinical judgment, clinicians differentiate among children referred to inpatient, in-home and community treatment settings. That is, they make decisions regarding the child's placement based on their assessment of the severity of the child's condition and the child and caregiver's ability to participate in a treatment plan. The data indicates that the in-home programs may not be functioning to divert hospitalization, one of the original goals for these programs. A sizeable proportion of the children assessed (20%) are referred for hospitalization despite the availability of intensive in-home services.

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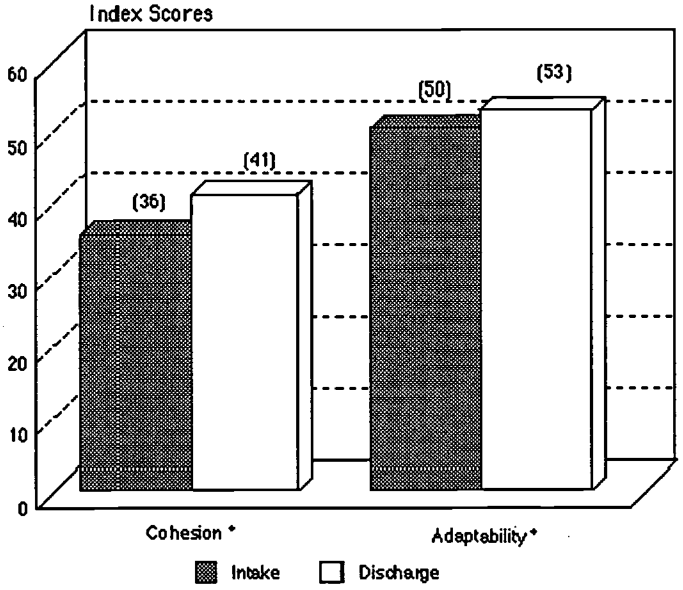
Figure 2
Family Adaptability and Cohesion
(*N*=86)



* Gains from intake to discharge are statistically significant

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The Alternatives to Residential Treatment Study: Initial Findings

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Introduction

As the public sector becomes more and more driven by the requirement to demonstrate accountability for its policies and programs, the children's mental health system will be required to support policy decisions with favorable outcomes. As Burns and Friedman (1990) have indicated, empirical data in the children's mental health field is sparse. Furthermore, it is a new field with emerging methodologies and measurement instruments. In this context of pressing need and evolving research strategy, the Alternatives to Residential Treatment Study or ARTS was implemented.

While a randomized clinical trial would be the best approach to evaluate the efficacy of alternatives to residential treatment, we determined that available resources and currently available instruments could not adequately support such a study. Consequently, we attempted to design a systematic, descriptive study that would give important information to the field and contribute to the knowledge base. The system of care framework developed by Stroul and Friedman (1986) had a major influence on the CASSP initiative and offered a focus for ARTS.

By the early 90s the conventional wisdom about treating children with serious emotional disabilities began to shift in the location of treatment. Previously, it was assumed that intensive treatment could only be delivered in a hospital or institutional residential setting. This assumption was being challenged by an emerging collection of programs that attempted to keep the child in a community setting, preferably at home or in a home-like setting. The Kaleidoscope Program in the inner city Chicago area emerged as a leader through many training activities for the CASSP community and then through the adoption of its program principles by Alaska and Vermont for state-wide program implementation. Another important influence at the time was the Ventura County Children's Demonstration Project in California. This program served as an example of cross agency, collaboration to implement an integrated service delivery system with flexible funds and community based programs. The Therapeutic Foster Care Program offered by the Pressley Ridge Youth Development Extension (PRYDE) was another influential program in terms of its training and research activities. These programs offered a natural laboratory to examine the emerging models of family centered, child focused treatment models that were alternatives to traditional institutional placement.

The design we planned aimed to answer some important questions in the field. These questions were: What are the characteristics of the children served in these programs? What are their social service histories? What services are delivered in these programs? What happens to children in these programs over time in terms of their symptoms, cognitive and emotional functioning, and living conditions?

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Results and Discussion

The ARTS protocol and procedure have been fully described in an earlier publication (Duchnowski, Johnson, Hall, Kutash, & Friedman, 1993). The protocol was administered at program entry, six months, and twelve months after admission. There were 144 children in the study.

These programs serve youths who have multiple problems that are of a long duration and severe in intensity. With an average age of slightly over 14, there were 61% who had contact with the justice system for an average of eight times. They had an average of four placements in mental health residential treatment centers and only 36% entered the current program from their home.

Involvement with the child welfare system was common. Sixty-nine percent of the families had worked with a child protection worker because of a charge of abuse or neglect. In addition, 55% of the children in the study had been placed out of their home because of a charge of abuse.

The group as a whole had very poor academic performance, with 80% below grade level in reading and 90% in math. Not surprisingly, 80% had a past history of placement in special education programs.

This is a group of youngsters that was well known to the major child serving agencies, i.e., mental health, child welfare, juvenile justice, and special education upon placement in the programs that we studied. The average age of problem onset was reported to be 6.8 years while the average age at the time of first service was 8.7 years. On the average, almost five more years would elapse before the children were placed in the current program, a time during which there were multiple contacts with multiple agencies.

There was an unexpectedly low number (36%) of children who were living with their family at the time of program entry. Since all of these programs valued family preservation, we anticipated that we would observe extensive work with families. However, the high percent of children in state custody and in out-of-home placements indicates that many of the children were already estranged from their families before entering the programs being studied. This may have contributed to the finding that only 34% of the children were in the custody of a family member after 12 months in the program. Many of the children had not been involved with their family for a long period of time.

Child Functioning Indicators. The results from measures of emotional and behavioral functioning (CBCL & YSR), and functional impairment (CAFAS), are very encouraging. Scores at the 12 month interval were significantly lower than at program entry, indicating a reduction in emotional problems and functional impairment. Results from the RBPC also indicated improvement in this domain but only the conduct disorder scale yielded a significant difference. The extreme level of emotional problems in these children is indicated by the finding that even though their scores on the CBCL are significantly lower after 12 months of treatment, the mean is still in the clinical range. The mean for the YSR, however, below the clinal range at post-test.

Scores on measures of academic performance taken at the 12 month point are also encouraging. While the average achievement level may still be below expected grade level, the means for both reading and math were significantly higher after 12 months. Results from testing in these programs indicate that children with serious emotional disabilities can improve academic performance and reverse the downward spiral of poorer and poorer test scores. All of the other scales such as self esteem and the SSRS yielded results that indicated improvement after 12 months but the differences were not statistically significant. Likewise, the measures of family functioning and impact on family yielded non-significant differences though they showed improved status. The results from the latter two measures may have been influenced by the small number of families available to complete these scales.

Services and Placement Outcomes. There were 47 different services that children in the study received. These ranged from out patient mental health to supervised living services. We reduced the 47 different services to 11 different categories and found that 80% of the children received between four and seven different categories of service. All children received case management.

After 12 months of treatment, we evaluated the restrictiveness of living arrangement and school placement. In terms of where they lived, 40% were in less restrictive settings, 32% at the same level, and 28% were living in a more restrictive setting. In school, 31% were in a less restrictive setting, 56% were at the same level, and 13% were taught in a more restrictive setting than at program entry.

These initial results are viewed as promising and indicative of improvement in the functioning of children who have serious emotional disabilities when treated in a community based program. The results should encourage continued examination of community based services employing rigorous research designs.

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8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida, 1996

Coming Home: The Full Inclusion of Children with Serious Emotional Disturbances

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Introduction/Purpose

In 1993, the Nebraska Department of Social Services contracted with the Center for the Advancement of Human Development (the Center) to design and implement community-based mental health/child welfare services in two service districts in Nebraska. The purpose of this contract was two fold: (1) return adolescents who were placed in out-of-state institutions; and (2) prevent adolescents from being placed in out-of-state institutions by serving referred youth. The Center was also required to identify psychosocial variables associated with various aberrant youth behavior and identify the level of community tolerance of those behaviors.

In response, the Center developed two group living programs, specialized therapeutic foster care, home-based therapy, and family support services. The Center developed the capacity to receive 20 adolescents into care within the first 40 days of operation and developed 10 therapeutic foster care families within 10 months. In April, 1995, the Center began the process of acquiring 23 family support workers to provide a total of 3,680 hours of family support services per month, and is implementing an in-school wraparound program. Additionally, the Center was awarded an expansion contract to include two additional districts in Nebraska.

To develop the service system, the Center and the Nebraska Department of Social Services agreed to a purchase of service arrangement beginning on day one of the contract. System financing was accomplished through a 60 day pre-payment consideration with very aggressive utilization rates and outcomes established as contract stipulations for the two year contract period.

Fiscal outcome data strongly demonstrated significant cost savings to the State of Nebraska. Clinical outcome data strongly supported the inclusion and integration of youth into community programs including public education, and the further use of less restrictive levels of care for this population. However, data also indicate that certain youth and adolescent behaviors present serious barriers to community inclusion efforts. Identifying the variables associated with various child behaviors has permitted an early identification of those children who show a very strong probability of experiencing extreme difficulties in school. Extreme behavioral difficulties in school were predictive of community exclusion in favor of a placement in a locked correctional facility. Prior to this project, program evaluators were limited to capturing this information after the child had been excluded. This project has provided a mechanism to predict which children will experience extreme levels of behavioral difficulties in order to develop intervention strategies before the child enters school.

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Method/Procedures

Service Outcomes as Contract Stipulations

The Nebraska Department of Social Services and the Center agreed that much of the service system in Nebraska has been developed in the absence of empirically derived information. Programs have been funded, children have been placed, and policies developed based largely on lobbying efforts, story telling, and clinical intuition. In an effort to change the 'standard operating procedure,' the Nebraska Department of Social Services and the Center agreed to include service outcome measures as contract stipulations in an effort to establish strategies to promote empirically derived information sources which could inform multiple users of service, policy makers, clinical professionals, and others interested in the issues of treating children with emotional disturbances. In that spirit, the Center and the Nebraska Department of Social Services agreed to the following:

1. The Center would build a service system which would be comprised of group living, therapeutic foster care, intensive family preservation services, and school supportive services in two rural districts to respond to the individual mental health needs of children who were placed out-of-state in long-term psychiatric care facilities, and to return those children to the home districts. All employees of the system would be hired from the local communities.
2. As an incentive to return these children as soon as clinically possible, the Center received 60 days pre-payment on a two year contract as a function of program initiation. The Center would be required to maintain a utilization rate better than 96% after the first 40 days of program service.
3. All youth and adolescents would be served by the local public education system, with the expressed desire that all children be fully integrated into regular education classes, with special education supportive services provided within the regular education setting if required.
4. Empirically derived program as well as child/family indicators would be developed and fully implemented with the aim that those indicators and outcome variables would be used to identify precise difficulties in serving these and similar adolescents and families in rural settings.
5. The Center would maintain a "no reject" policy regarding children admitted to the system of care.
6. The Center would develop further program components at discharge based upon the identified needs of each child (wrap around model of service provision; independent living).

Subjects
The Center obtained a complete set of data on each adolescent served. The first program component 'on-line' was the group-living facilities, which served all of the children returned from out-of-state institutions. All adolescents categorized as the prevent from going out-of-state' group received services from the group-living facilities as well. Child demographics are shown in Table 1.

It should be noted that the Group Living programs also provided 213 days of emergency and temporary (less than 15 days average length of stay) care for an additional 19 adolescents.

The adolescents served were primarily older, with long histories of placements in very restrictive placements. Many of these youth did not possess age appropriate social skills, or problem-solving strategies. In the face of confrontation or frustration, they would frequently resort to temper tantrums or destructive out-bursts, followed by requesting 1:1 therapy sessions. Most of the children had not attended a public school for more than two years.

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Measurement/Instrumentation

In an attempt to identify problem-prone child behaviors associated with the two most influential contextual settings in which youth must participate, the Center employs the following instruments:

1. Daily Adjustment Indicators (DAI; Burchard, 1990). The DAI is a 25 item (binary) behavior checklist designed to be completed by adult caretakers on a daily basis across all living environments.

2. Eyberg Child Behavior Inventory (ECBI; Eyberg, 1992). The ECBI is a 36 item behavior checklist that allows the adult to rate each child behavior from never to always and permits a second rating per behavior on a second adult dimension: Is this [behavior] a problem for you? Adult direct care providers complete this checklist monthly. This inventory yields a total problem score and a total intensity of behavior score for each child
3. Sutter-Eyberg Student Behavior Inventory (SESBI; Sutter & Eyberg, 1992). The SESBI is a 36 item behavior checklist that allows the teacher to rate each child behavior from never to always. This inventory also rates a second caretaker dimension: Is this [behavior] a problem for you? Teachers complete this checklist every other month. As with the ECBI, measures include a total problem score and a total intensity of behavior score for each child
4. Community-Oriented Programs Environment Scale (COPES; Moos, 1987). This instrument, designed for community-based treatment programs (e.g., board and care homes, sheltered workshops, and halfway houses), includes 100 items, 10 subscales, normed on 74 programs. Youth rate their living environment using COPES every other month.
5. Achenbach Youth Self-Report (CBCL; Achenbach, 1983). Youth complete this 112 item behavior problems checklist at intake and discharge.

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Results and Implications

By returning these targeted adolescents, the State of Nebraska received an annualized savings of $1,067,621.00. In other words, in the absence of this service, Nebraska would have spent an additional $1,067,621.00 during the fiscal year. These actual savings were used by the Nebraska Department of Social Services to 'sell' the service system to policy makers, and argue the legitimacy of alternative levels of care for very seriously involved adolescents.

Preliminary data analysis included performing various correctional analyses, analysis of mean scores, and regression analysis. Very early in this work it was determined that separating the data by 'time in service' provided very useful information.

The children and youth demonstrated sufficient variability from month to month on the Daily Adjustment Indicators and the COPES. A description of the DAI can be seen in Table 2.
It is important to recognize that the first month data does not represent a full month 'in care.' It represents the month the youth entered the program. In other words, the data is representative of some portion of the total days of the month the child was in care. The second month actually represents the first full month of data (see Table3).
The COPES permits an analysis of the child's perception of his/her living environment. Generally, the lower the score the less the child is engaged in his/her living situation.

The regression analysis was designed to answer the following two part question: Which criterion variable, (the youth's Sutter-Eyberg Student Behavior Checklist score or Eyberg Behavior Inventory Intensity/Problem score), and what set of predictor variables (DAI) and (COPES), would result in the best predictive model?

Being able to answer the above complex question could equip program staff to quickly evaluate a youth's potential for problems in different environments based upon an earlier assessment. These instruments are completed by the youth, the program staff, and school personnel, thus representing multiple informants in different settings. Provided that a meaningful model could be built, such a statistical model could promote more comprehensive clinical and program decisions.

For example, it was determined that in general, elevated Physical Aggression scores and elevated Verbal Abuse scores in the residential setting were predictive of serious problems in school (Sutter-Eyberg

Behavior Checklist -Intensity of Behavior Score). In other words, if children, demonstrated elevated scores on these DAI dimensions, they tended to have extreme difficulties in the education settings as well. It should be recognized that this pattern held true regardless of age or community in which the youth was served.

The second analysis involved the COPES scores with the DAI dimensions against the Sutter-Eyberg scores. A slightly different but more complete picture emerged after this analysis. There was an interaction effect between the COPES scores and the two DAI dimensions. However, Physical Aggression scores at month two and three and the COPES score tended to be the best predictors of behavioral difficulties in the educational setting. Children scoring the lowest on the COPES tended to score the highest on the Physical Aggression dimension, and had the most difficulties (behaviorally) in school.

Our full analysis indicated that the children scoring the lowest on the COPES tended to be the children that obtained the highest scores on Physical Aggression at months two and three; had extremely elevated scores on Verbal Aggression, had the highest Sutter-Eyberg Intensity Scores, and did not remain in school, or the community. In fact, the children who statistically fit this profile were eventually targeted first by the school; referred to the county attorney's office by school personnel, received a new petition (delinquent) by the county attorney, and placed in Nebraska's correctional facilities after a hearing by a county judge.

It should be noted that each of these targeted children had past delinquent charges, and were not citizens of the communities were they received residential or educational services.

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Discussion

The current data indicate that these children did act very differently from the other children in care, regardless of the county of origin. However, the associated 'characteristics' are important considerations at this point in the analysis. What defines these children as a 'set' vs. other children whose scores are similar becomes critical when developing both clinical interventions and administrative positions. Were these children treated differently somehow? If so by whom? Did these children fail to 'fit' into the community's picture of youth who should be served by community services?

Clearly, the educational settings played an important role in the identification and referral process to the county attorney's office. If providers are to successfully serve troubling children, it is important to be able to recognize those children who demonstrate an elevated risk of being removed from communities, and to introduce interventions aimed at changing that trajectory. Educational settings represent important spheres of community influence&shyp;as schools began to encounter difficulties beyond their ability to manage, they may engage the local county attorney's to invoke various legal mechanisms to relieve the pressure. These mechanisms can result in charges being filed on targeted youth and placement in correctional facilities, by-passing less restrictive interventions.

The local school authority's use of the county attorney's office appears to a method of defining the parameters of acceptable adolescent behavior and asserting the community threshold of tolerance. Although it is too early to clearly articulate the behaviors associated with that threshold, it is obviously interactive, and subject to change through social intervention at the school level. With the accumulation of additional data a more precise picture will emerge.

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Table 1

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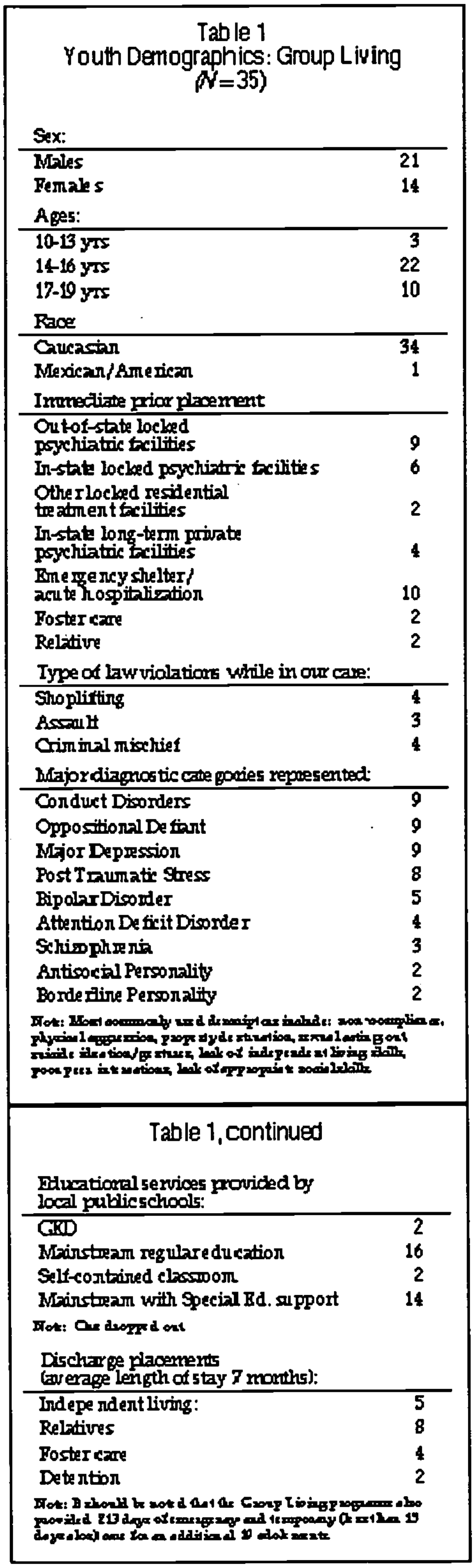

Table 1
Youth Demographics: Group Living
(*N*=35)

Sex:	
Males	21
Females	14
Ages:	
10-13 yrs	3
14-16 yrs	22
17-19 yrs	10
Race	
Caucasian	34
Mexican/American	1
Immediate prior placement	
Out-of-state locked psychiatric facilities	9
In-state locked psychiatric facilities	6
Other locked residential treatment facilities	2
In-state long-term private psychiatric facilities	4
Emergency shelter/ acute hospitalization	10
Foster care	2
Relative	2
Type of law violations while in our care:	
Shoplifting	4
Assault	3
Criminal mischief	4
Major diagnostic categories represented:	
Conduct Disorders	9
Oppositional Defiant	9
Major Depression	9
Post Traumatic Stress	8
Bipolar Disorder	5
Attention Deficit Disorder	4
Schizophrenia	3
Antisocial Personality	2
Borderline Personality	2

Note: Most commonly used descriptors include: non-compliance, physical aggression, property destruction, sexual acting out, suicide ideation/gestures, lack of independent living skills, poor peer interactions, lack of appropriate social skills.

Table 1, continued

Educational services provided by local public schools:	
GED	2
Mainstream regular education	16
Self-contained classroom	2
Mainstream with Special Ed. support	14

Note: One dropped out

Discharge placements (average length of stay 7 months):	
Independent living:	5
Relatives	8
Foster care	4
Detention	2

Note: It should be noted that the Group Living program also provided 213 days of emergency and temporary (less than 15 days also) care for an additional 19 adolescents.

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Table 2

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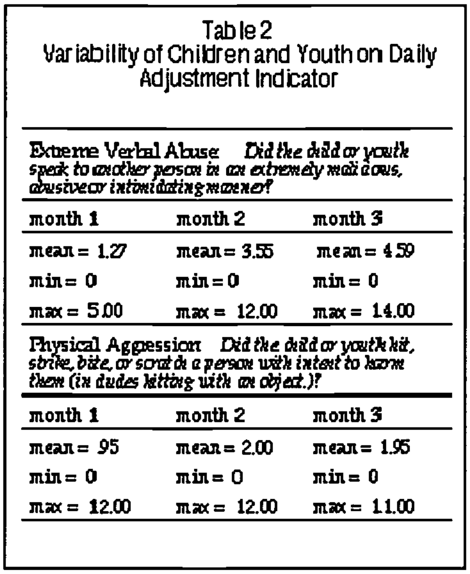

Table 2
Variability of Children and Youth on Daily Adjustment Indicator

Extreme Verbal Abuse *Did the child or youth speak to another person in an extremely malicious, abusive or intimidating manner?*

month 1	month 2	month 3
mean = 1.27	mean = 3.55	mean = 4.59
min = 0	min = 0	min = 0
max = 5.00	max = 12.00	max = 14.00

Physical Aggression *Did the child or youth hit, strike, bite, or scratch a person with intent to harm them (includes hitting with an object.)?*

month 1	month 2	month 3
mean = .95	mean = 2.00	mean = 1.95
min = 0	min = 0	min = 0
max = 12.00	max = 12.00	max = 11.00

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Table 3

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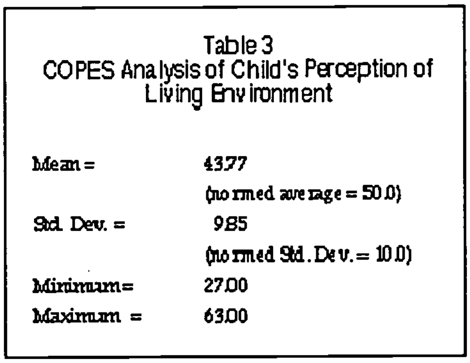

Table 3
COPES Analysis of Child's Perception of Living Environment

Mean =	43.77 (normed average = 50.0)
Std. Dev. =	9.85 (normed Std. Dev. = 10.0)
Minimum=	27.00
Maximum =	63.00

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Challenges to the Use of Respite for Children Receiving Short-term In-home Psychiatric Emergency Services

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Overview

Each year, numerous children, adolescents, and their caregivers seek help in psychiatric emergency settings. Although the mental health field lacks standardized approaches to treat these children and to support their families (Rosenn, 1984), short-term, intensive, in-home interventions modeled on the Homebuilders program (Fraser, Pecora & Happala, 1991) are being widely disseminated.

In 1987, the New York State Office of Mental Health (NYSOMH) established Home-Based Crisis Intervention (HBCI) as an intensive in-home service option for families. HBCI is modeled on the Homebuilders program, which provides short-term services to families with a child experiencing a psychiatric crisis. In 1993, the NYSOMH received a three-year research and demonstration award from the Substance Abuse and Mental Health Services Administration (SM-50357) to study the delivery of in-home crisis services. In this project, two new intensive in-home psychiatric emergency programs for children and their families&shyp;an enhanced version of Home-Based Crisis Intervention (HBCI+) and Crisis Case Management (CCM)&shyp;were implemented and are being compared to the existing HBCI program. In-home and out-of-home respite services are additional supports available to families assigned to the HBCI+ and CCM conditions. This summary describes the respite services available to parents in the HBCI+ and CCM conditions, examines the use of respite in these programs during the first year of the project, identifies the barriers to the use of respite raised during a focus group conducted to increase respite use and the steps implemented to minimize identified barriers, and compares the profiles of children and families who use and do not use respite. Only families who completed the full intervention are included in this analysis.

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What are the respite services available to families as part of this study?

In-Home Respite: For families enrolled in the HBCI+ and CCM programs, in-home respite has been made available on both an emergency and planned basis. In-home respite is provided by workers specifically trained to care for children with significant mental health needs. Services to a family are typically provided by the same respite care provider who is selected to match the needs of the child and the family. Given the cultural diversity in the Bronx, English and Spanish speaking respite care providers are available. In-home respite services are also not required to specifically take place within a family's home. Respite care providers can engage in recreational activities with a child such as going to the zoo, seeing a movie, or taking a trip to the mall. A separate pool of money is available to cover the costs associated with such activities. Additionally, in-home respite services are not restricted to the identified child (i.e., the child receiving either HBCI+ or CCM), but also are available for his/her siblings.

Out-of-Home Respite: Out-of-home respite care is also available to families enrolled in the HBCI+ and

CCM programs. In out-of-home respite, a child is taken into the home of a trained respite care family. Out-of-home respite providers were hired and trained by a private agency licensed by NYS to provide such service. Given the short-term nature of the intervention in this project, out-of-home respite stays are limited to three days per occasion, but there is no limit on the number of instances in which it may be used. As is the case with in-home respite, out-of-home respite is available on both an emergency and planned basis. Respite is also provided by the same respite care family, to the extent possible, for families using out-of-home respite on multiple occasions. As possible, respite homes are selected to match the needs of the child and the family and both English and Spanish speaking respite providers are available. Out-of-home respite can also involve extended days that do not require an overnight stay.

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How has the use of respite during the first year of the study corresponded with prestudy projections?

In-Home Respite: It was projected that 3,480 hours of in-home respite would be used during the first year of this project (58 families x 6 weeks x 10 hours per week = 3,480 hours). As shown in Figure 1, examination of the 59 families enrolled in the two study conditions (CCM and HBCI+) with access to in-home respite indicates that 16 families (27%) used this service. These 16 families used 847 hours or 24% of the available in-home respite hours (see Figure 2). The number of hours of in-home respite services that families received ranged from 2 to 106 hours, averaging 41 hours.

Out-of-Home Respite: It was projected that 400 days of out-of-home respite would be used during the first year of this project. The same 59 families enrolled in CCM and HBCI+ during the first year also had access to out-of-home respite. Three families (5%) used this service (see Figure 1). These 3 families used 11 days or 3% of the available out-of-home respite days. As shown in Figure 2, the number of days of out-of-home respite services that families received ranged from 2 to 5 days, averaging 2 days.

During the first year of the study the use of both in-home and out-of-home respite fell below anticipated levels. Over two thirds of the families with access to in-home and out-of-home respite did not use either service. The majority of the families using respite used in-home service. Only three families used out-of-home respite.

Why has the use of respite during the first year of the project been below anticipated levels?

As part of the project data collection schedule, parents are interviewed at discharge. During the interview, parents whose child was enrolled in one of the two programs with access to respite are asked about their knowledge of these services. An examination of their responses indicates that nearly 62% of the parents remembered being informed about the availability of in-home respite while 59% recalled being told about the availability of out-of-home respite. In excess of one-third of the parents were unaware of the availability of both in-home and out-of-home respite.

Additionally because many of the families who had been informed of the availability of respite services had not used them, a focus group was conducted to discuss issues related to the use of respite. Focus group participants included in-home and out-of-home respite providers, HBCI+ and CCM providers, staff from the two hospital intake sites, parents, research staff, and program personnel. In all 21 individuals with varying perspectives and opinions concerning the use of respite services were convened for a three hour session to identify obstacles preventing the use of respite and to develop strategies for minimizing these obstacles.

During the focus group, participants identified 37 obstacles limiting the use of respite services. These obstacles were then sorted into like categories by five external raters and the joint proportion matrix was factor analyzed resulting in ten obstacle groupings which are summarized in Table 1. As shown in this table, parents and services providers' need for more information was identified as an obstacle limiting the use of respite. Parents expressed having many unanswered questions about respite and services providers indicated they were not clear about what respite entailed.

It was also acknowledged that respite had a negative connotation and was viewed by parents and services providers as the first step in removing a child from the home. Parents believed that using respite signified they were not doing a good job taking care of their child, and services providers expressed reservations about the therapeutic value of respite.

Issues involving choice and flexibility were also identified as obstacles. Parents did not feel they were given a role in planning respite services and did not have an opportunity to assess the respite services. It was believed that children could not be matched to respite providers and that respite could not be accessed on an as needed basis.

Other obstacles raised during the focus group related to the safety of children during respite care. Both parents and service providers wanted information about the recruitment, training, and supervision of respite providers.

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What actions have been taken to minimize the obstacles limiting the use of respite identified during the focus group?

1. Informational brochures have been developed.
2. To provide complete and accurate information on the respite services, separate brochures have been developed detailing in-home and out-of-home respite services and are available in both English and Spanish. Brochures are given to families by the services provider and include telephone numbers of individuals who can answer any questions they may have.
3. Respite providers have been placed on retainers.
4. To enhance the flexibility in accessing respite, respite workers have been placed on retainer. This ensures that respite providers are available if and when a family/child decides to use respite.
5. An out-of-home respite family held an "open house" for service providers.
6. So that the service providers could meet a respite familyand become better informed about these services, an open house was held.
7. In-home and out-of-home respite coordinators are informed when a new child is enrolled in the study.
8. To ensure that respite is considered for each child, respite coordinators contact service providers when a child is enrolled in the study to discuss if and how respite services might be helpful to the family.
9. Increased dialogue and awareness regarding respite.
10. Research and program staff routinely discuss respite with service providers. Service providers are now asked to indicate why families did not use respite.

What are the similarities and differences in the profiles of families and children who have used and not used respite services?

Table 2 summarizes the characteristics of families and children who have used and not used respite services. Significant differences were found between respite users and nonusers concerning the number of children in the household and the identified child's age. Families using respite had more children living at home (mean = 3.3) compared to nonusers (mean = 2.2) and the identified child was younger (mean = 10.3 years old) compared to nonusers (mean = 13.3 years old). Additionally, families using respite had significantly lower level of social support (mean = 74.1) compared to families who did not use respite (mean = 89.9; Barrera & Ainley, 1983).

Although not statistically significant, families using respite services were less likely to have an adult in the household who was employed and the identified child was more likely to be living with neither biological parent.

No differences were found in the number of adults living in the household, the maternal caretaker's age or educational level, or the child's race, ethnicity, gender, degree of dangerousness, or primary diagnosis.
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The research demonstration project is funded by a grant from the Substance Abuse and Mental Health Services Administration (SM-50357)
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Figure 1

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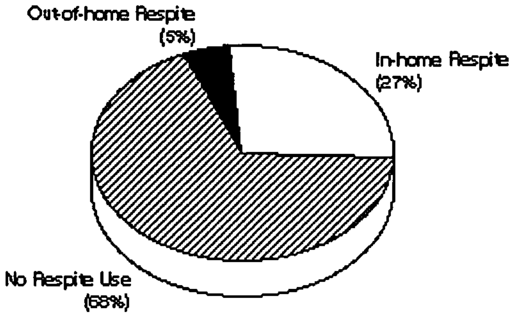
Figure 1

Use of In-home and Out-of-home Respite

(*N*=59)



Bronx: 11/93 to 10/94

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Figure 2

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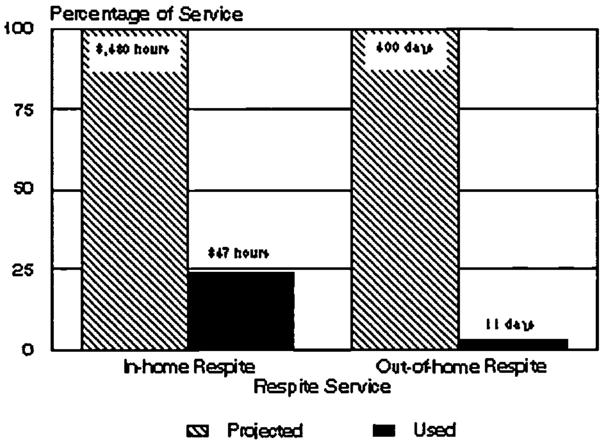
Figure 2
Comparison of Projected and Actual Use of
In-home and Out-of-home Respite



Bronx: 11/83 to 10/84

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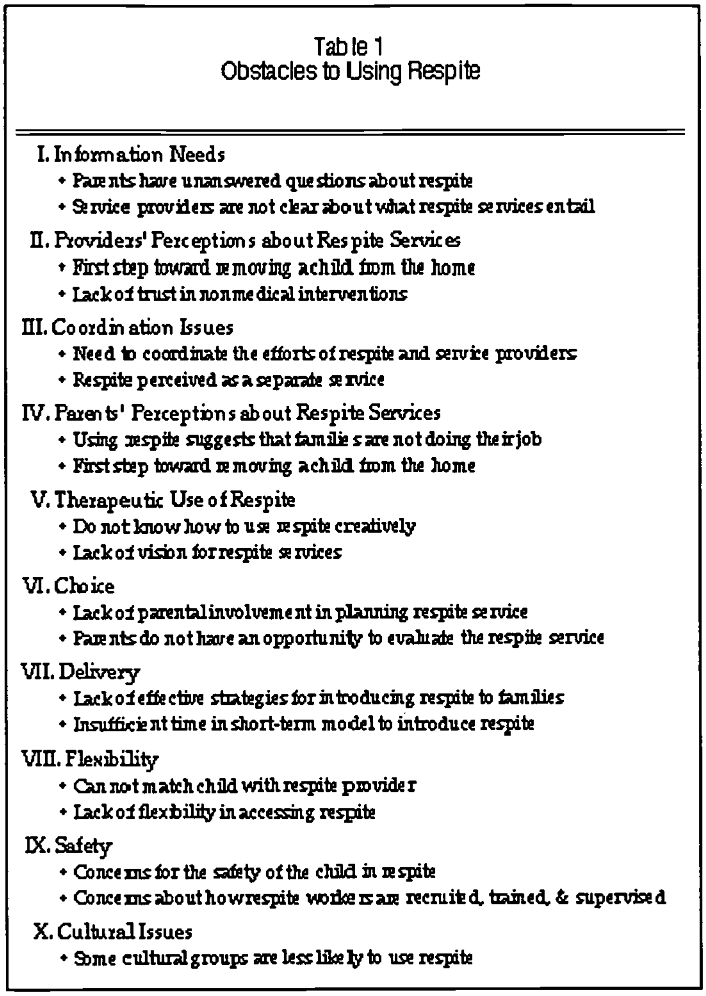

Table 1
Obstacles to Using Respite

I. Information Needs
- Parents have unanswered questions about respite
- Service providers are not clear about what respite services entail

II. Providers' Perceptions about Respite Services
- First step toward removing a child from the home
- Lack of trust in nonmedical interventions

III. Coordination Issues
- Need to coordinate the efforts of respite and service providers
- Respite perceived as a separate service

IV. Parents' Perceptions about Respite Services
- Using respite suggests that families are not doing their job
- First step toward removing a child from the home

V. Therapeutic Use of Respite
- Do not know how to use respite creatively
- Lack of vision for respite services

VI. Choice
- Lack of parental involvement in planning respite service
- Parents do not have an opportunity to evaluate the respite service

VII. Delivery
- Lack of effective strategies for introducing respite to families
- Insufficient time in short-term model to introduce respite

VIII. Flexibility
- Can not match child with respite provider
- Lack of flexibility in accessing respite

IX. Safety
- Concerns for the safety of the child in respite
- Concerns about how respite workers are recruited, trained, & supervised

X. Cultural Issues
- Some cultural groups are less likely to use respite

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8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Mobile Outreach for Children and Families: An Effective Approach to Stabilization

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Introduction/Purpose

Recent years have witnessed a renewed interest in emergency mobile outreach services designed to respond immediately and intensively to persons experiencing psychiatric crises. Various studies have described mobile outreach programs serving adults (Steer, Diamond, Litwok & Henry, 1979; West, Litwok, Oberlander & Martin, 1980), young and elderly adults (Winogrond & Mirassou, 1983), and families, including those with adolescents and/or young children (Bengelsdorf & Alden, 1987; Buchta, Range & Wetzel, 1974; Everstine, Bodin & Everstine, 1977; Kinney, Madsen, Fleming & Haapala, 1977). For the most part, these studies suggest that mobile emergency services are effective in resolving crises and deterring clients from hospitalization. This finding has, however, been called into question by Fisher, Geller and Wirth-Cauchon (1990). In their examination of 1986 data from Massachusetts, those authors found that their results "... fail to support the numerous claims regarding the ability of mobile crisis intervention to reduce the use of hospitalization" (p. 251). In interpreting their findings, the authors do not deny the value of mobile intervention, but rather, call for more rigorous evaluation in order to maximize its effectiveness (p. 252).

Standing in contrast to the conclusions of Fisher, et. al. (1990), are the results of a preliminary study that focused upon the Children's Mobile Outreach program (CMO) offered under the auspices of the organization now known as TRIS Comprehensive Mental Health Services. During the program's infancy, the vast majority of CMO's admissions were children and adolescents whom mental health screeners had originally referred to TRIS for placement in its acute care program, designated as a Children's Crisis Intervention Services (CCIS) unit. It became apparent, however, that after receiving CMO services, many of these clients were stabilized and no longer needed inpatient care. In fact, an initial outcome study (Moore, 1990) found that, during the program's first 18 months of operation, 68.3% of its clients were diverted from admission to more intensive acute care/hospital settings.

The early success of this program, combined with relatively scarce and inconclusive literature regarding mobile mental health intervention, contributed to the decision to undertake the present study. Added to that was the desire to examine the program as it had evolved in response to changes within the environment.

In the years following the original study, the CMO program continued to be regarded as an effective alternative to hospitalization for children and adolescents in psychiatric crises. As the knowledge of the program spread, the majority of referrals were made specifically for CMO crisis intervention services, as opposed to CCIS placement. The program continued to serve children and adolescents who were among the most seriously disturbed, however, due to circumstances arising within the broader mental health care system, it became necessary for CMO to incorporate a new service dimension. Subsequent to the opening of two new community hospital-based CCIS units (with a total of 28 beds), CMO was faced with declining admission rates. The program adapted by extending its services to children and adolescents who were being discharged from the 3 CCIS units now in the region. Retaining its primary goal of deterring children and adolescents from hospitalization, CMO continued to provide initial crisis response to children and families, and now offered adjunct, follow-up "post-discharge" services for clients leaving CCIS settings who required assistance in making the transition back to the community.

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Method/Procedures

The present outcome study was undertaken in an effort to determine the effectiveness of the CMO program as modified. Clinical information was obtained from client records and/or directly from clients and CMO staff. All 192 clients served and discharged by the CMO program between January 1, 1992 and December 31, 1992 were included in the study. With few exceptions, referrals to the program originated with local designated mental health screeners, or with the 3 CCIS units (for patients being discharged). Of the clients included, 131 (68%) were community referrals, and 61 (32%) were "post-discharge" referrals in the process of leaving CCIS/hospital settings.

The mobile outreach team, composed of counselors, program managers and a supervising psychiatrist, provided clients with emergency response capability 24-hours per day, 7 days per week. Emergency on-site visits by a two- member team were made in response to crisis referrals and client-initiated crisis calls, and were supplemented by on-going follow-up contacts, again at the client's location (usually home). Services for post-discharge clients were initiated at the CCIS unit prior to discharge, when possible, and were continued at the client's residence within the community.

Of the total number of clients, the majority (82%) received crisis stabilization services, including crisis intervention, psychosocial assessment, counseling, problem-solving, parent training, etc.. However, a significant portion (18%) of both community and post-discharge clients were seen for the purpose of "assessment only," in which case services were short-term and involved collaborative assessment, treatment and follow-up recommendations.

Program effectiveness was evaluated by examining client stability, as assessed by the outreach program treatment team, along with residential status of all 192 clients at the time of their discharge from CMO. Further evaluation of program effectiveness occurred by means of a 6-month follow-up telephone survey. Attempts were made to contact 83 previous clients and their families (selected according to CMO discharge date) to determine the client's status 6 months after CMO discharge. Whenever possible, these telephone contacts were initiated by CMO counselors who were known to the client and family. Of the 83 attempted contacts, 59 (71.1%) were actually completed.

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Results and Implications

At the time of their discharge, 67.7% of all clients served by CMO during this 12-month period were viewed as stable. Little difference was detected between community and post-discharge clients, of whom 66.4% and 70.5%, respectively, were considered stable. However, when the 34 clients who had received "assessment only" services were removed from the total, the overall stabilization rate rose to 73.4 percent.

Discharge destinations reflected similar success. Of the 192 clients included, 72.9% were discharged to their homes or foster homes, 4.7% were placed in less restrictive residential settings, and 3.1% were discharged to alternative juvenile justice programs. Taken together, this meant that 80.7% avoided possible admission to an inpatient unit.

The 6-month follow-up survey confirmed that a large percentage of clients remained stable and were able to continue residing in the community. At follow-up, 76.3% of clients and 67.8% of families perceived the client as stable at follow-up. Within the 6-month period following the completion of CMO services, only 2 (3.4%) of the 59 clients contacted were hospitalized and only 4 (6.8%) were admitted to a CCIS unit. The majority (89.8%) remained with their natural and foster families.

The results presented here are consistent with those of the initial CMO study. Together they lend support to the view that short-term, intensive in-home services can have immediate impact upon children and adolescents who are experiencing psychiatric crises, and can thereby reduce the need for admission into acute care facilities. Furthermore, these findings suggest that intensive in-home services can play a significant role in promoting a successful transition to the community, following hospital discharge, possibly reducing tendencies toward recidivism.

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8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

Researching a Moving Target: A Study of Inpatient Treatment in the 90's

Authors

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Introduction

This paper presents data on children and adolescents moving through inpatient and residential treatment programs.

The study began in 1990, and was designed to study treatment at the Menninger Children's Hospital. At that time, six out of seven hospital units were doing long-term treatment, which averaged one year. We originally designed the study to compare youngsters who received treatment as recommended with those whose treatment was foreshortened by financial constraints. Most treatment in this setting was supported by private insurance.

By 1995, changes in insurance coverage patterns (i.e., few treatments were not foreshortened by financial constraints) and the development of a broader continuum of services prompted a reexamination of the goals of the project. We concluded that there was significant value in attempting to conduct a careful study of the treatment system, using standardized measures to understand and describe the children and families that were served. We felt it important to go beyond the superficial satisfaction and outcome measures required by managed care and accreditation agencies. While recognizing the potential for bias inherent in internal evaluation, we affirm the strengths engendered by having researchers who are familiar with the workings and foibles of a complex clinical system.

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Method

Subjects in the study were children and adolescents, ages nine to seventeen, who were admitted to inpatient or residential treatment at the Menninger Children's Hospital. Treatment consisted of comprehensive diagnostic assessment, psychosocial milieu therapy (including groups and individual talks), a specialized school setting, family therapy, and, in most cases, medication and/or psychotherapy. Youngsters and their parents completed semi-structured interviews and questionnaire measures at admission, at discharge from long- term (greater than two months) treatment, and at 18 and 36 months after admission to treatment. Treatment staff also completed behavior checklists after two weeks of treatment and at discharge for long-term patients. Questionnaire measures included the Achenbach Child Behavior Checklist and Youth Self-report as well as a number of other scales; this discussion reports data from the Achenbach scales at admission, discharge from long-term treatment, and 18 month follow-up (Achenbach, 1983; 1991).

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Results

Demographic and Descriptive Characteristics

For the first 303 patients included in the study, the mean age was 14.4 years old (sd = 1.9); patients were about evenly divided by gender, with 48% males. Most (91%) were Caucasian, with a mix of other ethnic groups, none representing more than 3% of the total. Socioeconomic status, rated by the Hollingshead 2-factor index, was distributed as follows: I: 21%; II: 28%; III: 22%; IV: 24%; V: 3%.

Half of these patients had no prior inpatient admissions; 16% had one prior, 19% two, 8% three, and 7% four or more prior inpatient admissions. The most common principal diagnoses were affective disorders (40%), and personality disorders (31%). Disruptive behavior disorders represented a significant proportion (18%), and only 5% of patients had a principal diagnosis of a psychotic disorder.

The mean length of stay for the sample was 127 days (sd = 168); the median stay was 37 days. Forty-five percent of the sample stayed less than one month; 20% stayed 1-2 months, 23% stayed two months to one year, and 12% stayed longer than a year. It should be noted, due to changes in insurance coverage and increase in community-based options, the mean length of stay dropped from 207 days for the first 100 patients in the study (median = 57) to 87 days for the most recent 100 patients (median = 27).

At admission, patients reported moderately high levels of problems on the Youth Self-Report (mean Total Problems = 63.8; N = 190); parents reported more problems, with a mean T-score of 73.0 (N = 184) for Total Problems on the Child Behavior Checklist, well into the clinical range. Unit staff, after observing the patients for two weeks, also reported quite high levels of problems, particularly given the limited time frame and contained setting (mean Total Problems = 62.8, N = 257).

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Change at Discharge from Long-term Treatment

Multi-variate analyses of variance were conducted to examine the change from admission to discharge on the Internalizing and Externalizing scales, and on Total Problem Scales, of the Achenbach checklists, for self, parent, and staff report. All analyses found significant decreases in problems reported. For the Youth Self-report (N = 46), both Internalizing and Externalizing problems decreased, but overall change was mostly attributable to decreases in reports of externalizing symptoms. Parents (N = 38) reported significant decreases attributable to changes in externalizing symptoms. Clinical staff (N = 65) also observed decreases in symptoms; however, the magnitude of changes they reported was somewhat less, perhaps because they were observing behavior in a constrained setting and a more limited time frame, and they reported mostly decreases in internalizing symptoms attributable to externalizing problems.

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Conclusions

In spite of multiple pragmatic and methodological obstacles, including significant organization and staffing changes, these initial results are encouraging. It appears that youngsters in inpatient and residential treatments begin treatment with elevated scores on measures of both internalizing and externalizing problems, and these symptoms do decrease in the course of treatment. Although they appear sensitive to different aspects of improvement, patient, parents, and staff all report significant declines in symptoms at discharge from long-term treatment, and both patients and parents also document this improvement at an 18- month follow-up point. It is notable that short and long-term patients did not show different rates of improvement on these measures; further analyses may separate those patients who have completed treatment from those who had not, and will examine other measures to better understand the impact of different types of treatment.

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8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

Symposium:
Transitional Youth: The Challenges and Service Needs of Youth with Serious Emotional Disturbances as Young Adults.

Maryann Davis, Ph.D.

Authors
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Introduction

Assurance of smooth transitions to the adult service system has been identified as one of the guiding principals of a model system of care for emotionally disturbed children and youth (Stroul & Friedman, 1986). Improvement in helping youth transition to the adult system was one area that Child and Adolescent Service System Program (CASSP) grants funded, and emphasized. However, no states have reported significant progress in this area to the federal agency that oversees CASSP, and many states identify this as an area of weakness (Judith Katz-Leavy, personal communication, Dec 1992).

Complications to such transitions include lack of coordination between child and adult service systems that serve youth with serious emotional disturbance (SED), philosophical differences between the two systems that discourage use of needed adult services, and the common symptoms of conduct disorder and drug and alcohol involvement in the youth population that do not fit the criterion for chronically mentally ill that establish priority populations for the adult system (Stroul & Friedman, 1986). These barriers are assumed to cause many youth in need of services to fall through the cracks between the child and adult system.

The need for transitional services comes at a particularly challenging period in the lives of youth since this is the period during which they are expected to finish school, move on to post-secondary school education/training, obtain employment, develop independence from family, and deepen friendships to build their social network. This is a challenging period for all youth, and youth with SED are much more vulnerable to the pitfalls of this age because of the nature of their disability. Thus, the lack of treatment is believed to have wide-ranging effects on the well-being of this population, and their likelihood of eventually needing more expensive services from the mental health, criminal justice, substance abuse and child welfare systems.

Few researchers, however, have tackled the question by examining outcomes or service needs of children with SED during the years of early adulthood. This discussion presents the results of three outcome studies, a service utilization study and a study of model treatment programs for transitionally aged youth. Findings from these studies form a coherent picture of some of the characteristics and needs of this population, and provide potential programmatic answers.

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Outcomes

Transition to Adulthood; How are Youth with Severe Emotional Disabilities Different from Non-Disabled Youth?

Mieko Kotake Smith, Ph.D.

Method Results

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Method

The study sample included 41 students attending special education classes for youth with severe behavior and emotional disabilities in public intermediate and high schools (Severely Behaviorally Disabled students [SBH]), and 41 non-disabled students in the same community (Comparison Group). Personal interviews were used to collect data from students and their parent/guardian. Interviews were repeated in the 2nd and 3rd years. The student questionnaire was based on the University of South Florida's instrument (see Silver below), while this investigator developed the parent questionnaire.

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Results

Characteristics of the Students: The mean age of the students with disabilities (SBH), and the Control group were 15.44 and 15.57 years respectively. SBH students were predominantly male (76%), while Control students were predominantly female (68%). SBH students were 27% African-American compared to only one African-American student in the Control group. All other students were Caucasian. Chi-square analysis was used to indicate differences between the groups.
Living Situation: The majority of both groups (92% Control, 73% SBH) lived in a house. The majority of Control students (95%) lived in one place during the past 12 months, compared to only 52% of SBH students, suggesting a higher rate of residential instability for the SBH Group. Additionally, 50% of SBH students lived with one parent, while 61% of Control students lived with two parents.

Family: Parent education levels in both groups were similar: 85% of the parents of the Control Group and 70% of those in the SBH Group had completed high school or attained higher education. Group differences were found on several family measures: (1) Approximately half of Control students reported that their family took part in recreational activities at least twice a month, while only 15% of SBH students reported doing so; (2) Significantly more Control students reported being able to discuss sex and other problems with family than SBH students; (3) Almost all Control students reported that their family had a religion, while only two-thirds of SBH students did so.

Social Life: Students in both groups experi-mented with alcohol, but a significantly greater number of SBH students had used drugs ($p < .05$). Also, more Control students belonged to social or community groups, participated in physical activities more frequently ($p < .05$), and more embraced religion than SBH students ($p < .001$). Half of Control students named individuals with whom they had frequent contact (family, peer acquaintances) as their hero, whereas the majority of SBH students name individuals with whom they had no personal contact as their hero (i.e.. sports figures, entertainers). Family members were named as role models more frequently among Control students than SBH students ($p < .05$). Overall, SBH students showed less involvement in constructive social activities.

School: Students in both groups reported that at school they learned many skills, however, they reported acquisition of few job or parenting skills. SBH students received less guidance about getting involved in the community and participated in more vocational planning at school ($p < .001$). Both groups reported positive interactions with school personnel.

Social and Daily Living Skills: Both groups were similar in their social and daily living skills, however, the skills level of SBH students at the third interview was similar to the level of Control students during the first interview, indicating that SBH students lagged behind in this development by about two years.

Services Received: SBH students received significantly more services than Control students, including individual counseling, problem solving training, help in getting along with others, coordination of services, help in getting a job, group therapy, alcohol counseling, and drug counseling.

Life Changes: Fourteen subjects were lost among SBH students (34% loss) during the three year project. Only four Control students dropped out of the study (10% loss). Four SBH student graduated from high school, while 13 Control students graduated. One of the SBH graduates entered college (25%) compared to 85% of Control student graduates. One of each group entered the military, two of SBH students entered the work force (50%).
How to Promote (and Not Interfere with)

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Effective Transition

Starr Silver, Ph.D.

Method Results

Youth placed in psychiatric residential facilities are often overlooked in studying transition to young adulthood. This study examined transitional youth in both school and residential settings.

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Method

The Youth in Transition (YIT) study was conducted in 1990. Young adult subjects (n=215) were randomly selected from a pool of 359 participants, aged 18-22, who were enrolled in the National Adolescent and Child Treatment Study (NACTS). NACTS is a longitudinal study of children with emotional disturbance identified and served by the public education and mental health systems (Silver, Duchnowski, Kutash, Friedman, Eisen, Prange, Brandenburg, & Greenbaum, 1992). In addition to conducting interviews with young adults, a separate interview was conducted with one of their parents (usually the mother; n = 156). The young adult interview instrument contained questions about secondary and post-secondary education and training, employment history, income, marital status, social involvement, and receipt of public-sector services. Parents were interviewed about factors that helped or impeded their child's progress in making the transition to young adulthood.

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Results

The sample was evenly representative of youth originally served in special education classes (n=106) and residential mental health settings (n=109). The sample is representative of the larger NACTS sample.

Service Needs
Less than 10% (n=21) were currently in high school; a small number (n=15) were in post-secondary settings. High school is a major venue for receiving services, under various federal mandates. Whereas most of these youth received services while there were still in high school or a residential facility, this picture dramatically changed after they left these settings. For example, only 11% of the sample was currently receiving mental health counseling. Rates of service were similarly low for substance abuse treatment (3.8%) and case management (6.9%). In addition, small numbers of young adults reported they currently received assistance with planning a career (10.8%), getting a job (12.9%), or keeping a job (0.7%).

Young adults were asked whether they would like to receive each of the above services. The most desired service was help with planning a career, endorsed by nearly 42% of the sample. Young adults also wanted help with getting a job (34.5%), keeping a job (23.2%), and transportation (21.1%), which may be related to job acquisition and retention. A desire for mental health counseling (23.9%) and help with raising children (24.6%) also was expressed. Parents were asked the following open-ended question: "What did your child need the most to make the transition to adulthood, but didn't get?" Some parents gave more than one answer; therefore, a total of 211 responses were coded. One category of needs was vocational assistance. Twenty-seven of the responses (12.8%) from parents fell into this category. Issues mentioned in this category included skills assessment, job hunting skills, and skills training. The data from the young adults themselves and their parents are consistent in showing the need for further vocational assessment, planning, and on-going support.

A second need endorsed by parents was the need for additional counseling services (38 responses, or 18.0%). This finding dovetails with what was reported earlier on young adults' desire to receive mental health counseling. Other forms of assistance that parents stated their child needed, but didn't get, included help with staying in school (26 responses, or 12.3%), having their child learn independent living skills (19 responses, or 9.0%), and the need for parents themselves to get more support from the system (15 responses, or 7.1%).

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Transition to Adulthood: Issues of Youth with Mental Illness

Ann Vander Stoep, M.S.

Methods Results

These studies examined the outcomes of youth discharged from a psychiatric residential program, homeless transition-aged youth with severe emotional impairment, and an entire county's youth who had received mental health services who aged-out of child services.

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Methods

Study 1. A 5-year longitudinal study, ending
in 1992, included 86 adolescents with serious psychiatric impairment who were consecutive discharges from Washington state's first psychiatric residential treatment program at Seattle Children's Home. Most of the participants in this study did have the type, severity, and chronicity of mental illnesses, such as schizophrenia and major affective disorders, which would gain them access to the adult mental health system.

Study 2. A 3-year prospective study of 50 homeless adolescents living on the streets of Seattle began in 1990. The transition-aged youth in this study had severe emotional experiences of abuse and out-of-home placements. The majority of participants in this study did not have the type nor chronicity of mental illnesses which would gain them access to the adult mental health system.

Study 3. An evaluation of all public children's mental health services in King County, WA was conducted in 1992.
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Results

It was clear that in King County, adolescents receiving mental health services were not simply a younger cross-section of the adults who receive mental health services. A large proportion of adults receiving mental health services generally did not receive or even need mental health services as children. To a large extent the adult and children's systems treated very different clientele.

In our longitudinal study of 86 of the state's most impaired youth, by several measures of adjustment (e.g, number of episodes of psychiatric hospitalizations, number of arrests, number of days detained, use of crisis line), 19-year olds were having a hard time relative to the years before and after that year. Their participation in gainful activities, school and employment decreased during their nineteenth year. These youth were also more likely than youth reported in the 1980 US Census (BOC, 1982) to be living on their own (16% vs. 8%), and less likely to be living with parents or relatives (37% vs. 83% 18-19yr olds, and 58% of 20-24 yr olds). There has been a trend in our mainstream culture to stretch the apron strings during this transition time; this easement has not been extended to some of our most vulnerable citizens.

Many of the youth in the Seattle Children's Home did meet eligibility criteria for adult services. Often services received were inappropriate. A number who received residential services were placed in group homes and hospitals crowded with older adults who were highly medicated and chronically impaired. For several youth, the symptom which differentiated them from their residential peers was frequent attempts to run away. Other youth qualified for adult outpatient case-management services which did not provide adequate support to help them complete developmental tasks.

In King County, two-thirds of the 17-18 year olds receiving mental health services did not meet the criteria for adult services. The plight of this population is exemplified by a 17-year old Caucasian male with a diagnosis of conduct disorder and post-traumatic stress disorder subsequent to repeated episodes of physical and sexual abuse, and borderline personality traits. Raised in a family with a history of substance abuse, he had been in the mental health, juvenile justice, and foster care systems since the age of nine. At age 17 he participated in a children's intensive case management program with flexible funding which provided a therapeutic aide who shared his apartment, walked him to school, and tutored him. He received children's day treatment services with biweekly individual counseling sessions, weekly occupational therapy, and psychiatric evaluation, as needed. Many human and monetary resources have been invested in keeping this youth alive, safe, and functional. When he turns 18, however, these resources will no longer be available. Because he does not carry the diagnosis necessary for gaining access to the adult mental health system, he will not be able to receive services, he will no longer have a live-in aid, a counselor, a case manager, medications nor a treatment program. It is possible that he will spend most of his remaining years moving in and out of the correctional system.

So, what leads to good outcomes among this population? Using the longitudinal study data, we examined predictors of adjustment in young adulthood in terms of residential and financial independence, employment, school completion, and minimal days in hospital and arrests within each of three major diagnostic subgroups. We found that attaining a high level of vocational training during adolescence, family supportiveness of residential treatment, participation in outpatient services during the first six months after discharge from residential treatment, and living in a community (as opposed to a residential treatment or hospital setting) at six months post-discharge were related to successful adjustment at three months post-discharge.

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Service Utilization
Mental Health Service Utilization by Transitional Youth.

Maryann Davis, Ph.D.

Methods Results

This is a study of the mental health service utilization by young adults who were treated in deep-end care as minors in Massachusetts.

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Methods

Subjects consist of 97 young adults who received treatment in adolescent day treatment, residential or hospital programs for public sector youth between January 1988 and December 1993. Client records were reviewed for all youth in these programs who were between the ages of 19 to 25 on 7/1/92. ID numbers were used to track all Department of Mental Health (DMH) services received between 7/1/92 and 7/1/94 using the computerized client tracking system. The client tracking system records all services received by adults with case managers, and any adult receiving DMH services other than outpatient treatment is assigned a case manager. Group comparisons were made between subjects and a matched control group of other adults in the computer system (age, race, gender & geographic area matched). Thus, adolescents who later received adult services were compared to adolescents who did not, and to the average adult consumer of the same age.

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Results

Forty-seven percent of youth who received adolescent services received some case manage-ment as adults. There were no differences in the distribution of those who received services (Adult+) and those who did not (Adult-) across adolescent programs. (See Table 1)

There were no significant group differences in primary diagnoses; with a greater percentage of the Adult+ group having a psychotic disorder than the Adult- group, and more of the Adult- group with Conduct, Adjustment and Substance Abuse disorders. The Adult+ group also averaged longer lengths of stay as adolescents, were older when admitted to the adolescent programs, and had more out-of-home

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Table 1
Group Differences

Adult+ vs. Adult-	Adult+ *	Adult- *	Probability
Length of stay during adolescence	99.0±130.3 days	47.2±65.8 days	p <.02
Age at adolescent admission	17.8±1.2 yrs.	17.1±1.3 yrs	p <.005
Out-of-home placements	6.1±5.9	3.4±3.2)	p <.01
Diagnoses;			p <.05
Mood / Anxiety Disorder	56.5%	43.5%	
Psychotic Disorder	21.7%	4.3%	
Conduct Disorder	8.7%	21.7%	
Adjustment Disorder	6.5%	15.2%	
Substance Abuse Disorder	6.5%	13.0%	
Adult+ vs. Control Adult	**Adult+ ***	**Control ***	**Probability**
High School graduate	17%	45%	p <.05
Community Services	50%	20%	p <.003
Encounters with case management	16.8±21.9	6.46±	p <.02
Residential care	41%	22%	p <.05
Psychiatric emergency rooms	26%	9%	p <.05
Inpatient service	39%	20%	p <.05

* All group statistics are means and standard deviations unless otherwise noted.

placements. Additionally, the most common adult diagnosis of the Adult+ group was Psychotic Disorder (40%) followed by Mood Disorder (24%) and Personality Disorder (20%).

This is a markedly different pattern from the pattern of this group in adolescence. Of the seven individuals who were diagnosed as psychotic as adolescents, five (71%) were still diagnosed as psychotic as adults. Of the seven individuals diagnosed as mood disordered as adolescents only one (14%) was diagnosed as mood disordered as an adult. Three were diagnosed as having a psychotic disorder (43%), one with an adjustment disorder and two with other disorders. Fewer of the Adult- group had completed high school than the average adult consumer, but proportionately more had received community-based services, residential care, inpatient services and had been in psychiatric emergency rooms as adults. The Adult+ group had also had more encounters with case managers as adults than the average adult consumer. There were no group differences in marital or custody status.

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8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Best Practices for Navigating Rough Waters: Transition of Youth with Emotional/Behavioral Disorders Into Adulthood

Hewitt "Rusty" Clark, Ph.D.

Methods Results

The purpose of this study was to identify the values and best practices of programs which are preparing and supporting transitional youth for employment, educational opportunities, and independent living.

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Methods

Two hundred fifty-four programs were nominated and surveyed for site visits. A preliminary survey was mailed to each of these sites requesting basic descriptive data on both the program and its consumers. A second survey was sent to the 91 programs whose descriptions indicated that they were serving individuals with serious emotional/behavioral disorders, and that at least a portion of these individuals was in the young-adult age group. The second survey requesteddetailed information about conditions during the program's last complete reporting year. Nine sites were selected for a site visit. A team of professionals, including a parent advocate, visited each site.

The information gleaned from administrators, staff, agency records, parents, and consumers permitted formulation of recommendations regarding program values and best practices that appear to be critical to the transitioning of these youths.

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Results

Program varied greatly in the array of supports and services available for consumers within each of the transition domains of employment, education, independent living, and community life. Similarly, they varied in the practices used and the program values that they exemplified. Nevertheless, there were commonalities across all nine programs, embracing the values of: (a) consumer-centered orientation including consumer and family involvement, family-role resolution, acknowledgement of cultural differences, and building on consumer strengths; (b) community-inclusion environments with an emphasis on consumers functioning in community settings alongside persons without disabilities; and (c) continuity from consumer's perspective with a focus on consistency in staff to whom consumers relate and consistency across services. One limitation that most programs voiced, and which is related to the continuity from consumer's perspective value, is the categorical age-determined funding: in which federal/state policy sets arbitrary ages for admission and discharge.

Within the domains that the programs addressed, each program attempted to meet the features of the comprehensiveness of supports and services value. Nevertheless, administrators, staff, and parents at each site identified additional supports and services that were needed for some of the consumers. Although all of the programs were, to some extent, providing flexibility in supports and services, a few of the programs retained categorical components, which were not as individualized or flexible as would be needed to meet consumer's needs for establishing independence.

Regarding the safety-net of support value, one of the programs embodied the concept of unconditional care, and the practice of allowing consumers to identify their sources of support from the individuals around them. Although all of the programs shared practices related to the value of skill development teaching, one program stood out as having the most systematic and effective teaching methods for assisting consumers in acquiring community-relevant skills, particularly in the social-problem solving and life skills areas. This program, as well as a second, had particularly strong commitments to the value of outcome orientation through their systematic consumer/program evaluation and through the tracking of progress for each consumer across multiple goals.

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Conclusions

It is clear from these studies that youth with SED exiting child-serving systems face enormous challenges. All three outcome studies found that youth with SED, regardless of whether they were in special classes, or in residential psychiatric care, were less likely to finish school, gain employment and have adequate social support. Their ties with their families were more distant, rendering them more dependent on their own abilities, underscoring the need for effective transition policies that help them gain employment, continue training, build social supports and avoid trouble. Smith's study indicated that students showed positive gains from services they had received, but their development was delayed. This points even more strongly to the need for continued service provision to youths who age out of children's services.

It is clear that many youth do not make it successfully to the other side of the services bridge; many youth do not receive any needed intensive mental health services, and others receive developmentally, culturally, and restrictively inappropriate care. It is clear that these youth are aware of their needs, with so many indicating desire for services. However, it is not clear how they should access them, or if they will be judged eligible for those services. Since policies do not support smooth transitions between service systems at this time, it is important to provide youth and their families with information and support so that they can advocate for their rights.

It is also important for parents and all professionals working with these and other systems to begin to coordinate their efforts and work together for effective transition. It is clear that the knowledge is out there to guide better efforts in addressing these young adults' needs. Some wonderful programs, with values that should be carried to the transitional system, are already in place, and able to provide expertise to others. It is important to note, however, that only two of the nine model programs had conducted any kind of outcome assessment. Further research is clearly needed, not only in terms of evaluating specific programs, but also in evaluating the effect of policies as they are developed, and identifying coordinating mechanisms that will be necessary for the variety of transitional service needs that know no agency boundaries.

Evaluation of any transitional intervention will require long-term tracking, since data indicate that several years may be required to see long term effects. Outcomes must evaluated in terms of the domains of educational attainment, employment, community adjustment and quality of life. It
is also important that the service systems be evaluated for their impact on the success of interventions.

Some federal progress can be seen in providing services for transitional youth. Public Law 101-476, the Individuals with Disabilities Education Act (IDEA), requires transitional planning for all students with disabilities (including SED). Furthermore, this federal legislation requires that transition services must be included in a student's Individualized Education Plan by age 16. The act recognizes the interagency needs of youth with disabilities, and requires each state to formulate policies and procedures for developing and implementing interagency agreements which describe the role of each agency. The legislation also establishes procedures for resolving interagency disputes. While this legislation may serve as a good model, it still does not address the needs of the many transitional youth who drop out of school, and do not fall under the mandate of the legislation.
States should not wait for legislation to mandate how transitional services for youth with SED must be handled. Most importantly, agencies should take responsibility for this population&shyp;a primary reason that young adults do not recieve needed services is that they fail to meet the eligibility criteria of existing services. This leads to the failure of services to address the developmental needs of young adults who have serious impairments, but are not diagnosed as having a chronic mental illness; who have more capacity for independent living, but need more guidance and support than individuals without emotional disabilities.
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Florida Mental Health Institute, University of South Florida,1996

Adolescent Suicide: The Implications of Coping, Family Functioning and Their Interactions for Prevention and Intervention

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Introduction

It has become apparent over the past ten years that the role of the family has been identified as an increasingly significant variable with regard to adolescent suicide. Some authors go as far as to say that "family related factors appear to be the most significant contributor to youth suicide" (Husain, 1990). As critical as these variables appear to be, very little information is available about the family characteristics of youths that kill themselves. Furthermore, family characteristics of youths who attempt suicide are often described as a side feature of investigations of other factors, and these generally focus on the family characteristics only after an attempt has occurred. Little is known about those family factors that are precursors to the suicide attempt or about the mechanisms underlying "the relation of family characteristics and social supports to youth suicidal behavior" (Pfeffer, 1989).

Most studies that have attempted to elucidate underlying mechanisms have focused on constructs such as family communication, emeshment, cohesion, flexibility, affective involvement, affective responsiveness, behavior control, roles, and problem solving. Concurrent with the family research on adolescent suicide, a separate body of literature has developed which focuses on adolescent coping skills and their relation to adolescent suicide. These studies suggest that adolescent coping skills are beneficial in therapy situations involving suicide ideation and attempts (Orbach & Bar-Joseph, 1993). It is reasonable to assume that these skills are shaped, in part, by the adolescent's experiences within the family context. Other investigators have suggested that family therapy is an appropriate treatment modality for adolescents at risk for suicide (Berman & Jobes, 1992; Richman, 1986). A logical next step is to investigate the family's impact on adolescent coping skills and to identify potential family interventions focused on expanding the adolescent's coping repertoire.

Family Literature. Adolescents often feel alienation to which the family contributes (Smith, 1981). Some theories suggest that poor communication patterns within the family will promote stress that contributes to suicidal behavior of children (Gould, 1965). Other theories suggest that lack of good mothering results in the child feeling abandoned and unloved (Sabbath, 1969). However, of the studies completed, several characteristics of families appear with consistency: family conflict (Cassorla, 1980; Cohen-Sandler, Berman & King, 1982; Corder, Page & Corder, 1974a; Corder, Shorr, & Corder, 1974b; Davidson, Choquet, & Facy, 1976; Jacobs & Teicher, 1967; Kosky, Silburn & Zubrick, 1990; McKenry, Tishler & Kelley, 1982; Spirito Brown, Overholser & Fritz, 1989a; Tishler, McKenry, & Morgan, 1981; Williams & Lyons, 1976; Withers & Kaplan, 1987); history of family suicide (Barter, Swaback & Todd, 1968; Brent, Kolko, Allen & Brown, 1990; Cassorla, 1980; Corder, Shorr & Corder, 1974b; Davidson, Choquet, & Facy, 1976; parental alcohol/drug abuse (Angel, Taleghani, Choquet & Courtecuisse, 1978; Davidson, Choquet, & Facy, 1976; Slaby & McGuire, 1989); and family violence, especially sepal abuse (Husain, 1990; Knittle & Tuana, 1980; Pfeffer, 1985; Slaby & McGuire, 1989). In addition, many adolescents feel they are not able to communicate with their parents (Corder, Page & Corder, 1974a; Corder, Shorr & Corder, 1974b; Marfatia, 1975) and there is often a feeling of parental rejection or disinterest (Cassorla, 1980; Davidson, Choquet, & Facy, 1976; Husain, 1990; Marfatia, 1975; McKenry, Tishler & Kelley, 1982). Along with this lack of perceived family cohesion, the loss of a parent or significant other (Barter, Swaback, & Todd, 1968; Cohen-Sandler, Berman & King, 1982; Godwin, 1986) can often intensify the feelings of alienation and separation.

Coping Literature. Sadowski and Kelly (1993) believe that youth who attempt suicide have "more maladaptive cognitive-emotional behavior response sets to problematic situations than do psychiatric controls and normal controls." Lower problem solving skills are associated with suicide attempts (Asarnow, Carlson, & Guthrie, 1987; Curry, Miller, Waugh & Anderson, 1992) and Amish (1991) suggests that fewer reattempts result from learning and applying coping skills. One study indicated that social withdrawal was used more frequently by adolescents who are suicidal (Spirito, Overholser & Stark, 1989b). In addition, a number of authors have documented a connection between a diminished problem-solving capacity and suicide (Asarnow, Carlson, & Guthrie, 1987; Schotte & Clum, 1987; Schotte & Clum, 1982). Sommers (1995) indicated that youths who have attempted suicide and those who frequently ideated were less involved with the family and tended to use fewer coping strategies than those who thought about suicide less frequently. Additionally, youth with a history of suicide attempts were less likely to use relaxation and more likely to vent feelings.

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Method

Subjects and Procedures

The 410 participants volunteered for this project were obtained from 20-middle, junior, and senior high public and private schools and five adolescent psychiatric units in Ohio between 1992 and 1995. The ages of the participants ranged from 11 to 18 years. Thirty percent were male and 70 percent were female. Minorities represented 7% of the population. Both the participants and their parent(s) participated in the informed consent process. Participants completed the Family Assessment Device (FAD), the Suicide Ideation Questionnaire (SIQ), and the Adolescent Coping Orientation for Problem Experiences (A-COPE). The SIQ was used to divide participants into low and high ideator categories. The initial sample contained 320 youth who scored as low ideators, 71 who were categorized as high ideators, and 19 who were placed in the attempter category. The FAD data were Q-factor analyzed separately for each group using QUANAL (VanTurben, 1975). Differences in participant coping skills along topologies were then identified.

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Instruments

All of the instruments were developed, normed, and have reading levels appropriate for the sample populations The validity and reliability estimates of the instruments were deemed to be acceptable. The SIQ consists of either 15 (ages 13 -14) or 30 (ages 15-18) items which range in specificity of suicidal ideation. The respondent rates each item in terms of frequency within the last month. Previously determined cutoff scores were used to categorize participants according to level of ideation and, therefore, risk (1988). The FAD was developed to describe family functioning in terms of transactional and systemic properties (Epstein, Baldwin, & Bishop, 1983) and consists of 60 items comprising seven scales which measure Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behavior Control, and General Functioning. The A-COPE was developed as a tool for measuring coping skills within the context of the Resiliency Model of Family Stress, Adjustment and Adaptation (Patterson & McCubbin, 1991). It consists of 54 Likert-type items comprising twelve scales which measure ventilating feelings, seeking diversions, developing self reliance and optimism, developing social support, solving family problems, avoiding problems, seeking spiritual support, investing in close friends, seeking professional support, engaging in demanding activity, being humorous, and relaxing.

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Results and Implications

The low ideator sample was randomly divided into five subsamples. Each subsample's FAD data were Q-factor analyzed separately. The profiles from each subsample were then compared. (See Figure 1)A single stable profile was identified (N = 83). The high ideator sample was randomly divided into two subsamples and treated in a similar fashion, and one stable profile was identified (N = 23). Because of the small sample size, the attempter data were not cross validated. Again, only one profile was identified (N = 9). These profiles are presented below.

The individuals belonging to the attempter profile differed most from those belonging to the high ideator profile in their perceptions of roles, communication, and affective involvement. Similarly, the perceptions of individuals belonging to the low ideator profile differed most in terms of roles, communications, and affective involvement.

Coping skills as measured by the A-COPE also varied by profile. The youths in the attempter group were different from those in the high ideator group in that they tended to utilize problem solving ($t = 2.04$, $p = .05$, $N = 32$), spiritual support ($t=2.0$, $p = .007$. $N = 32$), and professional support ($t = 2.48$, $p = .019$, $N = 32$) to a greater extent. Youths who fit the attempter profile differed from those with a low ideator profile in that they tended to used spiritual support ($t = 2.26$, $p = .026$, $N = 92$) and professional support ($t = 6.17$, $p = .000$, $N = 92$) to a greater extent, and were less likely to endorse optimism ($t = 1.84$, $p = .07$, $N = 92$) and avoiding problems ($t = 3.24$, $p = .002$, $N = 92$). Those youths who scored as high ideators differed from low ideators in that they tended to seek professional help ($t = 2.63$, $p = .050$, $N = 106$) to a greater extent were less likely to engage in demanding activities ($t=2.22$, $p = .029$, $N = 106$), avoid problems ($t = 3.92$, $p = .001$, $N = 106$), solve problems ($t = 2.45$, $p = .016$, $N = 106$), use self-reliance ($t = 3.07$, $p = .003$, $N = 106$), and seek diversions ($t = 2.94$, $p = .004$, $N = 106$).

Given the limitations of these data, the following suggestions are offered subject to replication. It appears that adolescents from certain types of families may be at greater risk for high suicidal ideation and attempts, and that both the family characteristics and the adolescent's pattern of coping skills can be used by counselors as an indicator of risk. In addition, since the coping skills vary by profile, attention to shaping appropriate skills may serve both a preventive and therapeutic function. Historically, the teaching of coping skills was accomplished by working with the identified client. However, since these skills are, in large measure, learned within the context of the family, and since their use within the family context may serve a protective function, both the adolescent and the family may be appropriate targets for therapeutic interventions targeted on increasing the adolescent's coping skills.

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Figure 1

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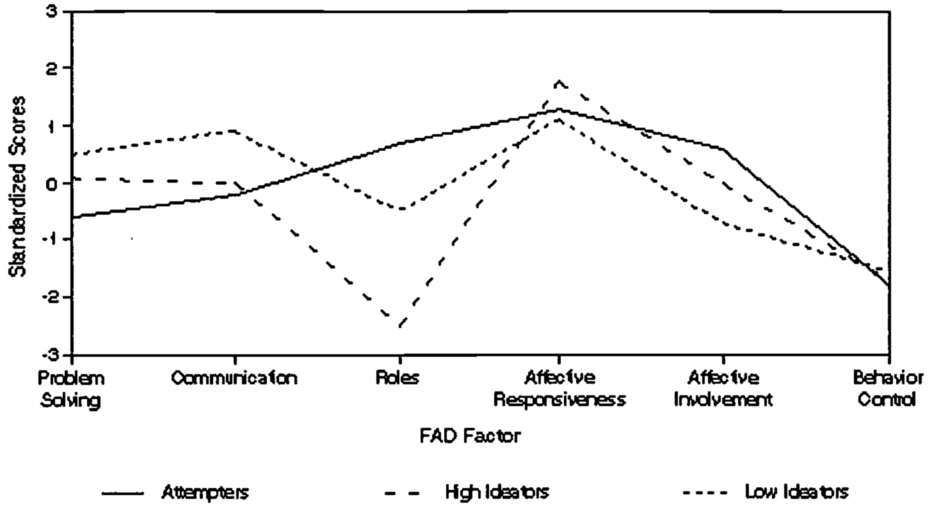
Figure 1
Low Ideator, High Ideator and Attempter Family Profiles
(N= 410)



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8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

Gender Appropriate Services for Adolescents with Serious Emotional Disturbances: A Gender Competency Model

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Introduction

Gender sensitivity and gender competence are emerging concepts in the field of children's mental health. Several areas of research affirm the importance of gender perspectives. First, studies of both adult women and men have found evidence of gender bias in clinicians' attitudes, diagnosis, assessment and treatment (Becker & Lamb, 1994; Broverman, Broverman, Clarkson, Rosenkrantz & Vogel, 1970; Ford & Widiger, 1989; Hoppe, 1984).

Second, feminist researchers have pointed to the impact of gender role socialization on the development of adolescent females' self-esteem, body image, sexuality, and identity (Chodorow, 1978; Dinnerstein, 1976; Gove, 1979; Gonsiorek, 1988; Pipher, 1985; 1994; and Zimmerman & West, 1975). Likewise, male socialization patterns have been found to have a dramatic effect on communication, difficulties with intimacy, conflict resolution, emotional constriction and the consequences of internalized homophobia.

Third, psychologists have begun to acknowledge the importance of addressing gender role socialization patterns in adolescence to prevent the onset and occurrence of adult mental health problems among women, such as depression, dissociation, eating disorders and post traumatic stress disorders (Koss, 1990; Mowbray, Herman & Hazel, 1992; Boskind-White, 1983; Brodsky & Hare-Mustin, 1980; Foa, Olason & Steketee, 1987). No longer can we ignore the importance of gender perspectives in our clinical attitudes, assessment, diagnosis, service development and treatment of youth with mental, emotional, or behavioral problems.

One initiative under Nebraska's Child and Adolescent Service System Program (CASSP) addresses the need for gender sensitive and appropriate mental health and substance abuse services for youth. This summary describes the preliminary results and implications of a statewide needs assessment. We present a Gender Competency Model to provide a developmental framework for enhancing a system of care that is responsive to the gender-specific needs of adolescents.

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Method

Delbesq (1983) developed the nominal group technique to allow for idea generation while avoiding the problems of group dynamics. The following steps outline the process for conducting nominal groups:

1. Convene in a large group. Explain the purpose of the meeting, the nominal group process, and the role of the facilitator.
2. Assemble participants into subgroups of no more than seven members and assign a facilitator to

each group. Those selected as participants should be knowledgeable about the issue and represent different perspectives. (We pre-assigned participants to ensure that each subgroup contained representatives of different perspectives.) The facilitator introduces oneself and emphasizes the need for full participation.

3. Present a single question to the group and ask participants to write their own responses. During this phase of the process, it is important that the facilitator ensures the participants proceed independently, without discussion, and in absolute silence. This approach allows each member to ponder upon his or her own ideas, to be motivated by the observance of others writing their responses, and to be involved in an atmosphere where premature decisions do not have to be made.
4. Elicit individual responses in round-robin fashion until all contributions have been made. As responses are stated, the facilitator numbers and records them on an easel thereby ensuring each member's participation. During this time, the facilitator allows no discussion by group members regarding form, format, or meaning of a response.
5. Guide participants to explain the meaning of their responses in round-robin fashion. The purpose of this clarification phase of the process is for the group to have a shared understanding of each response. The role of the facilitator during this step is to direct
6. Direct the participants to select and rank order a specific number of items from the entire list of recorded responses. (In our study, the facilitator asked group members to select and rank seven responses they identified as the most important needs of female adolescents and seven identified as the most important male adolescent needs.)
7. Repeat steps 3 to 6 for each question. (We repeated the process for a second question. The time for the entire process totaled approximately four hours).

The Nebraska Department of Public Institutions, the State Mental Health Authority, employed a nominal group technique (Delbecq, 1983) to assess the gender-specific needs of adolescents receiving mental health and substance abuse services. The Department mailed a letter to 700 randomly selected professionals located throughout the state, inviting them to participate in a needs assessment. The letter was mailed to local, regional, and state policy makers, administrators, directors, therapists, and school counselors. It stated the purpose of the study and detailed the time commitment required of those volunteering to participate.

Three facilitators conducted a total of five, 4-hour nominal groups at two sites&shyp;one urban (Lincoln) and one rural (Kearney). A total of 28 professionals from 24 organizations participated in the study (females = 18, males = 10). Although a majority of the participants were from mental health and substance abuse agencies (71%), 29% represented other child serving entities including education, health, juvenile justice, and advocacy programs. The specific questions posed to the participants were as follows:

- What are the gender-specific needs or issues of adolescents receiving mental health and substance abuse services?
- What changes would you make so that mental health and substance abuse services are responsive to the gender-specific needs of adolescents?

Following the nominal group process, the facilitator asked the first question regarding adolescent needs, elicited responses in round-robin fashion, guided participants toward clarification and asked participants to individually select the 7 most important needs of adolescent females. Participants repeated the selection and priority ranking of needs for adolescent males. The facilitator repeated the entire process (including prioritizing by gender) for the second question regarding recommended changes to adolescent services. Thus, solution generation followed identification of the needs, issues, and concerns of the youth.

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Results

The authors examined the content and the rankings of participant responses both within and across the five nominal groups. Similar responses were first combined into a single gender-specific item. Rankings across similar responses were then summed for each item. Finally, items from all five nominal groups were arranged into similar categorical areas and the numerical summed ranks for each item within a category were added together. The resulting value was then assigned to a topical category. The category receiving the highest summed rank represents the top priority area. This process was repeated for both questions.

It should be noted that the organization of similar responses into a gender-specific item and these items into categories was expedited by the nominal group process. During the clarification phase of the process, all participants along with the facilitators, reached a shared understanding of the generated ideas. The authors relied upon this understanding as the basis for categorizing the needs and recommended changes into topical areas.

Gender-specific Needs. In response to the first question, participants identified 65 unique needs, issues or concerns which were then aggregated into 14 topical categories. Table 1 presents the seven top prioritized categories for both females and males. Three issues were seen as important to both females and males: (1) the Lack of Adolescent Services; (2) Violence; and (3) Provider Knowledge.

Recommendations. In response to the second question, participants generated 72 unique recommendations which were aggregated into five topical areas. Table 2 exhibits the five areas in which participants believed changes needed to be made to ensure gender appropriate service provision. The data clearly indicate that professionals believe that the biggest obstacles to meeting the gender-specific needs of adolescents are the lack of services and barriers at the macro-level.

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Implications

Building on the results of the present study, we have begun to identify the components of a Gender Competency Model for Adolescents. The Gender Competency Model can provide a framework for understanding the assessment results as well as a process for mobilizing service delivery systems toward gender sensitivity and competence. This inductively grounded model promotes the perspectives of the participants, and rejects any pre-existing categorization.

The Gender Competency Model for Adolescents embraces five domains: (1) Systems Change; (2) Human Resource Development; (3) Community Relations/Public Education; (4) Service Enhancement; and (5) Service Development (see Figure 1). These domains suggest that steps toward gender competency must take place both within and outside of traditional mental health and substance abuse treatment systems. Participation by other systems, including Education, Public Health, Juvenile Justice, and Child Welfare is essential. Community involvement in and endorsement of changes are vital to the successful development of a gender competent system of care for our youth. Most importantly, the identified needs of adolescents can effectively be viewed within the framework of this model.

Another important characteristic of the model is that there is no single approach to developing gender competency. For instance, the road toward competency can begin at the macro-level&shyp;Systems Change&shyp;by adopting legislation designed to address gender issues. These policies can in turn result in increased variety and flexibility in non-treatment based education (Community Relations and Public Education). Another approach may be to inform community members about adolescent issues and the need for gender competent services. Community awareness can then provide impetus for grass roots advocacy for increased provider knowledge and skill development (Human Resource Development).

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Conclusion

The nominal group process provides a highly structured, interactive way to generate ideas and solutions rich in information. However, it is important to recognize the limitations of this particular methodology:

- *Sample size.* The group format restricts the number of participants, and participants must be willing and able to commit a significant block of time to the process.
- *Representation.* Our sample did not reach particular subpopulations with valuable perspectives, such as parents of adolescents with emotional, mental and behavioral problems. In addition, Nebraska, a frontier state, has a heavy concentration of rural communities. Site selection reflected this population density.
- *Response Bias.* We noted a potential recency effect from statewide trainings in the area of sexual perpetration. It will be important to triangulate our results with family perspectives, contemporary research, and survey results of current policies, services, training and personnel.

We have argued that the concept of gender competency recognizes the role gender plays in referral, service delivery, differential diagnosis and clinical interventions. The Gender Competency Model is based on the premise that gender responsive services differ from those ignoring the gender-specific needs of our youth. It is developmental, for it recognizes that services, agencies and professionals develop gender competency over time. Gender competent services and systems are those that evolve in gender consciousness by recognizing the centrality of gender in the development, enhancement and provision of services. The next challenge is to use the Gender Competency Model framework to develop specific recommendations regarding systems change, service development, service enhancement, community relations/public education, and human resource development.

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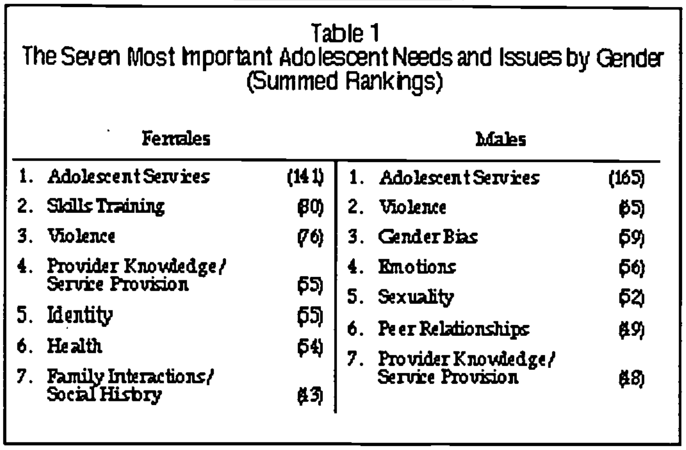

Table 1
The Seven Most Important Adolescent Needs and Issues by Gender (Summed Rankings)

Females		Males	
1. Adolescent Services	(141)	1. Adolescent Services	(165)
2. Skills Training	(80)	2. Violence	(65)
3. Violence	(76)	3. Gender Bias	(59)
4. Provider Knowledge/ Service Provision	(55)	4. Emotions	(56)
5. Identity	(55)	5. Sexuality	(52)
6. Health	(54)	6. Peer Relationships	(49)
7. Family Interactions/ Social History	(43)	7. Provider Knowledge/ Service Provision	(48)

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Table 2

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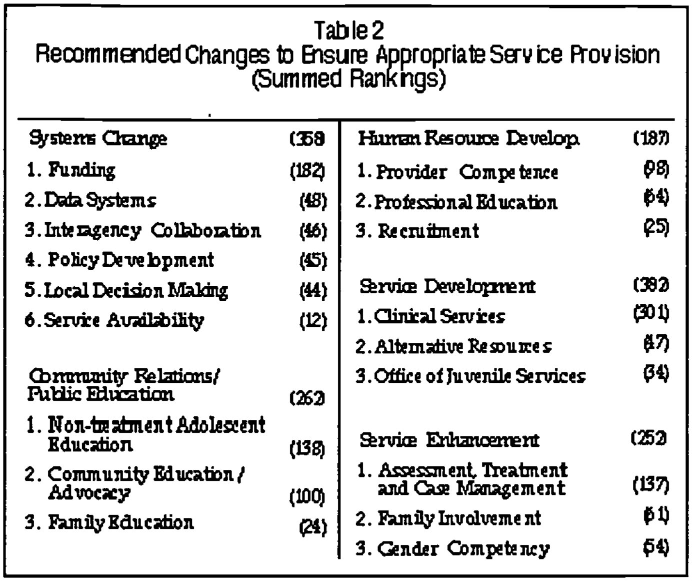

Table 2
Recommended Changes to Ensure Appropriate Service Provision
(Summed Rankings)

Systems Change	(358)	Human Resource Develop.	(187)
1. Funding	(182)	1. Provider Competence	(98)
2. Data Systems	(48)	2. Professional Education	(64)
3. Interagency Collaboration	(46)	3. Recruitment	(25)
4. Policy Development	(45)		
5. Local Decision Making	(44)	Service Development	(382)
6. Service Availability	(12)	1. Clinical Services	(301)
		2. Alternative Resources	(47)
Community Relations/ Public Education	(262)	3. Office of Juvenile Services	(34)
1. Non-treatment Adolescent Education	(138)	Service Enhancement	(252)
2. Community Education / Advocacy	(100)	1. Assessment, Treatment and Case Management	(137)
3. Family Education	(24)	2. Family Involvement	(61)
		3. Gender Competency	(54)

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Figure 1

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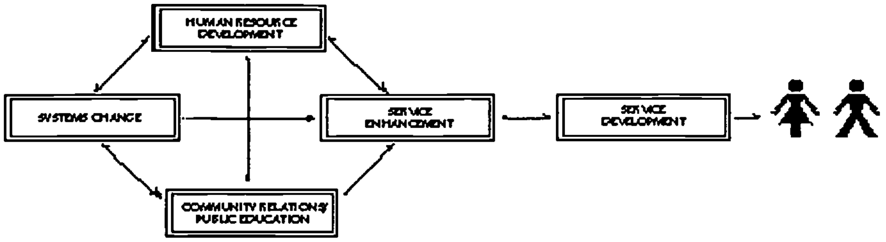
Figure 1
Gender Competency Model



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8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies,
Florida Mental Health Institute, University of South Florida,1996

Multicultural Mental Health Training Program: A Comprehensive Training Program for Improving Service Delivery to Ethnic Minority Children and Families

Authors

Introduction Methods Discussion References
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Background

Current trends within the mental health field highlight a disproportionately high percentage of minority utilization of services as compared with minority provision of those services (McHolland, Lubin, & Forbes, 1990). Many minority clients do not have access to quality services. In an analysis of the types of mental health services Americans receive, Redick (1994) reported a decrease in the inpatient status of non-minorities and an increase in the inpatient status of minorities. According to the U.S. Department of Commerce (1994) and the 1990 Census Bureau, one third of the United States population will be made up of minority persons in the year 2000.

Researchers have repeatedly reported that minority clients prefer minority counselors; seek counseling more often from non-European-American counselors; terminate prematurely with European-American counselors; perceive mental health institutions as "White Institutions," and are suspicious and/or resistant to treatment; and that minority professionals are more likely to render higher quality services to minorities because of their understanding of the customs and the language of their own minority group (Boyd-Franklin, 1989; Thompson & Cimbolic, 1978; Comas-Diaz & Griffith, 1988; Terrell & Terrell, 1984). However, the impact of minority professionals is limited if their role at policy and administrative levels of mental health programs is overlooked. Zane, Sue, Castro, and George (1982) called for minority representation within the mental health field at higher than para- and practicing-professional levels to ensure the development of innovative services and the broadening of the minority mental health research base. Minority mental health training programs are one avenue toward meeting these challenges.

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Program Description

In 1987, the Florida Legislature established a culturally based mental health training program at the Florida Mental Health Institute (FMHI) at the University of South Florida (USF), to serve the state's minority population. The aim was to increase the number of minorities in the mental health professions and to address the mental health needs of minority communities of the state. The original bill proposed a training program emphasizing practical techniques applicable to mental health service delivery in minority communities. In response to this need, FMHI initiated the Multicultural Mental Health Training Program (MMHTP) in 1989. This student fellowship program emphasizes clinical/professional development and cultural diversity training to improve mental health service delivery in the state. Before the establishment of the MMHTP, FMHI started a paid internship program with Florida Agricultural & Mechanical University (FAMU) in Tallahassee, the state's historically black institution of higher education.

The MMHTP is unique in that it combines career development programs with training in culture-specific mental health service delivery.
The program has three general objectives:

1. to interest minority students in mental health careers,
2. to provide students and professionals with training that enhances their effectiveness in serving minority communities, and
3. to provide professional development training that will facilitate minority advancement to positions of influence within Florida's system of mental health services.

The MMHTP consists of a one semester fellowship, full-time internship placement with FMHI. Fellows receive a stipend, averaging $2,000 - $2,500 per semester, to assist them with living and tuition expenses. Fellows spend approximately 32 hours per week (i.e., four 8-hour days) in their practicum. An additional eight hours per week are spent participating in formal training and other activities with MMHTP staff. This summary reviews the fellowship training over the past five years. The training program has three principal components.

Mental Health Practicum
Field work experience is provided in residential and outpatient clinical settings in the students' chosen areas of interest (e.g., with children, adults, or elderly populations). FMHI, other departments at USF and community agencies serve as practicum sites. The fellows learn by experiencing the actual work environment and becoming familiar with the operations of everyday service delivery. Fellows participate in practicum-based internship experiences, develop valuable insights, and learn practical skills for making career choices and facilitating career advancement. The training program allows fellows to explore potential career options, to test theories and practices learned in the classroom, and to develop skills fundamental to successful careers in the multifaceted mental health field. The fellowship training involves demonstration of methods plus opportunities to learn by practice. A feature of the program is the emphasis on marketable employment skills. Fellows must acquire specific skills, (e.g., interviewing clients, group techniques, clinical record keeping), and are evaluated on their performance.

Cultural Diversity Training
The training program is designed to provide fellows with a comprehensive learning experience in the field of mental health services from a multicultural perspective. The training program is intended to prepare ethnic minority students to become mental health professionals by concentrating of the mental health needs of ethnic minority and underserved populations. Through a 13-week, classroom-based training module focusing on self-awareness, knowledge of culture and its functions, and mental health issues affecting ethnic groups, fellows learn to recognize and address cultural barriers to service delivery effectiveness.

Professional Development Training
The professional development component provides fellows opportunities to learn marketable leadership, supervisory, and administrative skills for long-term career advancement. Fellows receive training in such areas as: (1) leadership skills; (2) communication skills; (3) interpersonal skills; (4) career development; staff management, (6) time management; (7) resume writing; and
(8) organizational management. Professional development training includes lectures, written assignments, exercises and role playing. The program includes educational, practical, personal, and organizational instruction; program staff support fellows to help them make short and long term vocational decisions to best meet their interests, needs, experience, and training. Participants receive training to facilitate advancement to positions of influence in the mental health and human services fields.

Other Activities
The program also provides fellows, departmental and university staff with training opportunities such as the Cultural Diversity Workshops for Mental Health Professionals. Additionally, the MMHTP

collaborates with the Multicultural Child and Family Project within FMHI's Department of Child and Family Studies on various research and technical assistance projects (Briscoe, 1993). In these activities, the fellows assist in providing technical assistance and training to various community programs that serve ethnically diverse children and families. In this manner, students directly observe and gain exposure to community service and needs (Briscoe, Yang and Wright, 1993). Initially, the program primarily focused on working with undergraduate fellows but has expanded to graduate levels. As a pilot project, the MMHTP evolved from an emphasis on speakers and lecture series to a stronger curriculum-based training approach.

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Profiles of MMHTP Fellows

A total of 35 students participated in the MMHTP fellowship program that covers 11 semesters from Fall semester 1989 through Fall semester 1993 (see Table 1). Three different colleges and universities, and nine different majors were represented. Four Fellows had double majors and three participated in a two-semester program. A total of six ethnic groups were represented in the program. Of the 35 participants in the MMHTP fellowship program, 24 (65%) were enrolled in degree programs that require internships. The remaining eleven fellows were not required to complete internships to meet departmental requirements and, thus, participated in the program on a voluntary basis.

Student Follow-up

In the Spring of 1993, a follow-up staff survey of former fellows (N=16) showed that 10 were employed in mental health/human services jobs, two were completing post graduate education, two were completing post graduate education, two were in the process of gaining employment, one was in the armed services, and one was employed in a non-related job. Half these fellows had plans for returning to school in the mental health field, with 12.5% completing postgraduate education.

Before entering the program, 37% of the fellows had previous work experience in mental health/human service fields. Overall, response to the program has been positive. The fellows credit the training as helping them attain mental health positions and professional recognition. As one former fellow commented, "the MMHTP was instrumental in getting my career off to a focused and stable start. I credit the program for the recognition I received as a competent clinician."

Recommendations for expanding the program include the following:

1. Increase the continuum of training offered from high school through postdoctoral;
2. Extend fellowships for additional semesters;
3. Increase emphasis on advance research skills for students;
4. Increase recruitment efforts and participation with other universities and colleges;
5. Work with state and local agencies to expand the number of public service settings from corrections, juvenile justice, mental health
6. and human service programs; and
7. Expand training opportunities and information dissemination for mental health professionals in cultural diversity training.

Clearly, in tomorrow's public service delivery systems and work force, the issues of cultural diversity will have increasing relevancy and urgency. The Multicultural Mental Health Training Program has demonstrated that training and leadership can increase the number of minority students who select mental health and human service careers.

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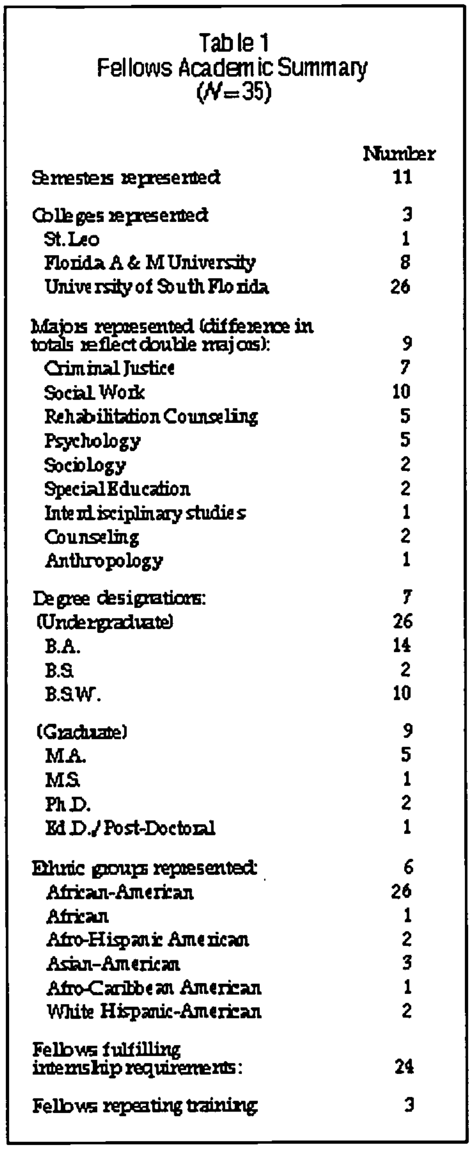

Table 1
Fellows Academic Summary
($N=35$)

	Number
Semesters represented	11
Colleges represented	3
St. Leo	1
Florida A & M University	8
University of South Florida	26
Majors represented (difference in totals reflect double majors):	9
Criminal Justice	7
Social Work	10
Rehabilitation Counseling	5
Psychology	5
Sociology	2
Special Education	2
Interdisciplinary studies	1
Counseling	2
Anthropology	1
Degree designations:	7
(Undergraduate)	26
B.A.	14
B.S.	2
B.S.W.	10
(Graduate)	9
M.A.	5
M.S.	1
Ph.D.	2
Ed.D./Post-Doctoral	1
Ethnic groups represented:	6
African-American	26
African	1
Afro-Hispanic American	2
Asian-American	3
Afro-Caribbean American	1
White Hispanic-American	2
Fellows fulfilling internship requirements:	24
Fellows repeating training	3