



Children Who Drop Out of Treatment

**Final
Report**

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**Louis de la Parte
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Children Who Drop Out of Treatment **Final Report**

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Abstract

Among children receiving mental health services, a large proportion terminates services after only one or two contacts with a mental health professional. While some of these children may be appropriately triaged into other settings or service modalities, a large number simply cease to return or drop out of services. Estimates suggest that anywhere from 28% to 85% of children receiving services drop out (Novick, Benson, & Rembar, 1981). For the purpose of this study a dropout was defined as a child under the age of 19 who had no more than one contact with the mental health system within six months of the initial intake with the service provider.

The purpose of this study was to investigate the characteristics and experiences of children who drop out of mental health services prematurely. By implementing a **mixed method analysis** including **surveys**, **record reviews**, and **interviews** we are beginning to better understand the reasons for early terminations from the perspective of the children themselves and their parents or caregivers. The experience of this study suggests that the mobility of the population greatly impacts the families' ability/willingness to continue in services. The population of interest was extremely difficult to identify and contact during this study.

The factors that most strongly influence the decision to discontinue service were: the **waiting time** before and between early appointments, the **convenience** of the appointments in relation to work and school, the **perceived appropriateness** of mental health services, and the **disconnect** between the services that families believed they needed and those that were offered to them. In short, **caregivers and children had trouble with both accessing mental health services and receiving appropriate services**. This project is but one step toward listening to consumers about their early experiences with mental health provider agencies and working toward decreasing dropouts. □



1.0 Introduction

1.1 Background

Among children receiving mental health services, a large proportion terminates services after only one or two contacts with a mental health professional. While some of these children may be appropriately triaged into other settings or service modalities, a large number simply cease to return or drop out of services. Estimates suggest that anywhere from 28% to 85% of children receiving services drop out (Novick, Benson, & Rembar, 1981). A meta-analysis of 125 studies reported a mean dropout rate of nearly 47% (Wierzeicki & Pekarik, 1993). It is not clear if these children fail to return because the presenting problem has resolved itself, if the proffered services are inconsistent with the perceived needs of the caregivers, if caregivers or the children themselves are dissatisfied with the treatment or the provider, or if some other reason is responsible. Premature and unexplained dropouts impact **practitioners** who may experience the dropout as a personal failure (Novick et al., 1981), **agencies** who have invested considerable staff time to the treatment process, and most importantly, the **children** who are at a disadvantage because they do not receive needed services (Weisz, Weiss, & Langmeyer, 1987).

Previous research has attempted to identify characteristics of children and families who leave service early. Consistently, child variables, such as age (Baekland & Lundwall, 1975; Viale-Val, Rosenthal, Curtiss, & Marohn, 1984; Kazdin, 1990) and race (Kazdin & Mazurick, 1994), have not been shown to be significant predictors of dropping out. Child factors that have significantly contributed to the occurrence of treatment dropout have included moderate to severe conduct disorder symptoms (Baruch, 1998; Kazdin, 1990), greater externalizing problems, such as aggression and delinquency (Baruch, 1998), and school truancy in relation to educational problems (Ross & Lacey, 1961).

In exploring family characteristics associated with dropout rates, Kazdin and Mazurick (1994) found that if the parent is single, non-biological, or stressed, dropout is more likely to occur. They also found that the younger the mother and/or the lower her educational status, the greater the chance the child will not remain in therapy. Lack of family involvement in the treatment process has also been explored as a potential contributing factor. Sirles (1990) reports that children are more likely to terminate at intake if there is not a combination of interview compositions (child, parent, and family). In fact, 55% self-terminated when involved in a child only or family unit only interview structure.

While a number of studies have compared demographic and socioeconomic variables of children who drop out, few studies have investigated the caregivers' perspective regarding early terminations from service. Chung, Pardeck, and Murphy (1995) found that over 60% of the respondents interviewed in their study did not feel the therapist was professional and caring in dealing with their family. Approximately 67% reported that the child's treatment plan was not adequately explained and 72% felt the plan did not meet the child's needs. Terrell and Terrell (1984) examined whether the counselor's race impacted the decision to drop out. They found that African-American clients in their study were more likely to terminate from counseling prematurely when seen by a white counselor.



In short, there are multitudes of factors that may contribute to a child and/or family's decision to drop out of mental health services. Any attempts at further exploring the issue need to take into account the multiple perspectives of the child, caregiver, and clinician/agency. Also critical in the discussion of early termination is the operationalization of the term "dropout." In their meta-analysis, Wierzbeiki and Pekarik (1993) report that the dropout rates differed significantly according to the definition of a dropout. Studies defining dropout as failure to attend a scheduled session reported lower rates than studies defining dropout as not completing the full course of intervention as deemed appropriate by the practitioner (Wierzbicki & Pekarik, 1993). Novick et al. (1981) demonstrated the need to exclude those clients who were referred elsewhere from the dropout population. This exclusion reduced the dropout rate in their study from 85% to 54%.

1.2 Organization of this Report

This is the final report regarding "Children Who Drop Out of Treatment" as part of the contract between the Louis de la Parte Florida Mental Health Institute (FMHI) and the Florida Agency for Health Care Administration (AHCA). Following the introductory section, methods will be presented (2.0 Methods), findings (3.0 Findings), a discussion of themes and obstacles (4.0 Summary and Discussion), and a reference list. Findings will be organized by methodology as well as by research question.

1.3 Research Questions

1. What are the demographic characteristics of children and families who terminate services from the state mental health system after only one or two contacts with a mental health service provider?
2. From the families' perspective, what are the reasons for discontinuing services prematurely?
3. What policies and procedures are in place at the agency level to reach out to families who are apparently terminating prematurely and to prevent drop out?

2.0 Methods

The purpose of this study was to investigate the characteristics and experiences of children who terminate or drop out of mental health services prematurely. An emphasis is placed on understanding the reasons for early terminations from the perspective of the children themselves and their parents or caregivers. In order to obtain a rich and balanced understanding of the experiences of children and families, a mixed methods approach was developed that included three phases: (1) a mail survey; (2) record reviews, and (3) face-to-face interviews. Each phase takes a more in-depth look at the reasons children and families discontinue services early. It is expected that the results of this study will inform professionals regarding how to engage children and families more effectively in the delivery of mental health services in order to reduce the rate of early service termination.



Methods for the mail survey are presented in two sections since two samples were drawn. The response rate for the first survey was poor (8%) and efforts were made in the second sample to increase the rate of response, raising the response rate to 12%. These efforts are discussed in **Section 2.2 Mail Survey — Sample 2**.

2.1 Mail Survey — Sample 1

Participants: For the purpose of the study a dropout was defined as a child under the age of 19 who had no more than one contact with the mental health system within six months of the initial intake with the service provider. The sample population was drawn from children first admitted for services between July 1, 1998 and December 31, 1998. The history of service contacts and demographic information for children receiving Medicaid- and ADM-funded mental health services were obtained from the Individual Data System (IDS) maintained by the Department of Children and Families (DCF). Addresses were obtained from Medicaid files. Those children for whom there were incomplete records (e.g., Social Security number missing) and incomplete or missing mailing addresses were deleted from the mailing list.

Procedures: A survey was mailed to the parent or caregiver of each of the 485 children whose names remained on the list in January 2000. The survey explained the purpose of the study and asked the parent's or caregiver's cooperation in the study. Enclosed with the survey was a letter of consent explaining the project's purpose and soliciting the family member's participation. Parents and caregivers were offered the opportunity to complete the survey, participate in a personal interview, and provide their permission for the researchers to review agency records regarding their child's services. Parents and caregivers were free to choose to participate in each activity separately. Personal interviews and record reviews were limited to those parents who signed and returned the letter of consent. A business reply envelope was enclosed for the return of the survey and the letter of consent.

Three weeks after the original mailing, a second survey and letter of consent were mailed to a revised list of all parents and caregivers. The second mailing excluded those addresses that had been returned as undeliverable, but included all remaining parents and caregivers who had not responded to the first letter.

2.2 Mail Survey — Sample 2

Participants: Participants in the second sample included children who met the dropout criteria and were first seen for services between January 1, 1999 and June 30, 1999. The history of service contacts demographic information were obtained from IDS, and addresses were obtained from the Medicaid files. Children with incomplete records and incomplete or missing mailing addresses were excluded from the population list. From this group of service recipients, a random sample of 400 children was selected for the study.

Procedures: For the second sample, an adaptation of Dillman's method (Dillman, 1972) was selected to enhance response rates. This method incorporates a small remuneration (\$3.00) and multiple contacts to encourage participation. In total, four mailings (in May and June, 2000) were conducted in the survey process. Parents and caregivers first received a post card informing them of the survey's anticipated arrival. After



approximately two weeks, the survey and consent forms were mailed to all sample members excluding those addresses that had been returned as undeliverable. After another two weeks, a reminder letter was mailed to all participants excluding those that had responded and those that had been returned as undeliverable. After a final two weeks, a second copy of the survey was mailed to remaining participants, with a final request for their cooperation.

Instruments: The mail survey for both samples was designed to elicit information from the parent or caregiver of the child regarding their experiences with the mental health system and their reason for terminating services for their child (see **Appendix A**). The survey was based on a review of the critical literature on terminations from services and included questions regarding current service status, service access, service appropriateness, and satisfaction with interpersonal experiences between professionals and the child and family members.

The survey is divided into five sections. The first section solicits general demographic information to confirm information retrieved from IDS and Medicaid file (e.g., birthdate) and to collect additional information regarding caregivers and the mental health experience. The second section instructs respondents to rate a series of 11 items from “1” indicating strong agreement to “5” indicating strong disagreement. These items reflect possible perceptions the caregiver may have had relative to the early interactions with agency staff members. The third section of the survey lists a series of 17 items and the respondents are instructed to rate how important each of the factors were in the decision to discontinue services. Items are rated from “1” indicating very important to “5” indicating very unimportant. The fourth section presents four items about the similarity between family and agency staff member and asks the respondent to indicate “Yes” or “No”. The final section asks respondents to indicate what service option(s) they desired for their child and what option(s) were offered by the service provider.

2.3 Record Reviews

Caregivers were given the opportunity to consent to the review of their child’s records at the time of survey completion. The purposes of the record reviews were to (1) gather additional information regarding the children such as diagnostic impressions and reasons for referral, (2) explore the provider perspective as to reasons for non-return, and (3) gather policies and procedures around follow-up for no shows and efforts to re-engage families who have left services. Project staff involved in the record review process also attempted to collect policies and procedures related to the prevention of premature termination.

Instruments: The protocol for the record reviews (**Appendix B**) was developed by the project staff and was focused on the agency’s documentation of early contact and efforts to follow-up subsequent to missed appointments. Record reviews took approximately thirty minutes to complete.

2.4 Interviews

At the time of survey completion, caregivers were also given the opportunity to consent to participate in face-to-face interviews. The purpose of the face-to-face interviews was to offer the caregivers and the children an opportunity to describe their early



experiences with mental health agencies, and to discuss their decision to discontinue services. For those families who consented to an interview, project staff attempted to interview both the caregiver and the child recipient of services. The decision of whether or not to interview children was based on their age, availability and their level of cooperation. Interviews were scheduled at locations selected by the caregivers (e.g., in their homes or local McDonalds).

Instruments: Two semi-structured interview formats (**Appendix C**) were developed — one for the caregiver and one for the child. Each respondent was interviewed separately. The caregiver interviews took approximately one hour to complete, while the child interviews lasted approximately thirty minutes. The caregivers were each given \$10.00 in exchange for their participation.

3.0 Findings

3.1 Survey Returns

Returns for the first sample were low, due greatly to a high undeliverable rate, reflecting the high mobility of the population. Of the 485 surveys mailed in the first sample, 135 (28%) were returned as undeliverable. The return rate for the first sample adjusted for undeliverable surveys was 8% (28 completed surveys). The rate of undeliverable surveys for the second sample was 25%, with 99 of the 400 surveys returned as undeliverable. The return rate for the second sample adjusted for undeliverable surveys was 12% (37 completed surveys). A total of 65 surveys were completed. Thirty-four participants from the combined samples agreed to allow record reviews and/or face-to-face interviews.

3.2 Characteristics of the Sample Populations

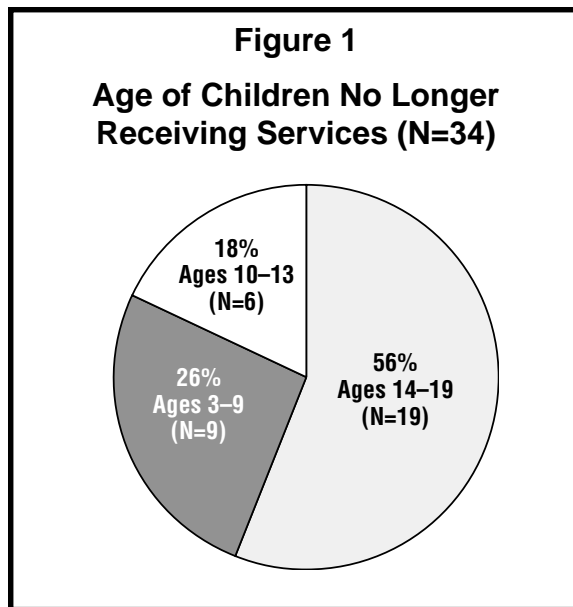
Among all children potentially participating in the study, ages ranged from 2 to 18 with an average of just over 12 years old. The majority of the children were male (63%). Approximately 48% of the sample was white and 38% was Black. (It is important to note that the race categories available in IDS are white, Black, American Indian, Asian/Pacific Islander, Alaskan Native, and other. Hispanic consumers are captured under either white or Black.) Of all surveys returned, ages ranged from 3 to 19 years of age, with an average age of 12.66 years of age — slightly older than the population. Approximately 65% of the children were male. Approximately 49% of the respondents were white and 32% were Black. The demographic characteristics of the children regarding whom surveys were completed closely mirrors the populations from which they were selected.

3.3 Survey Results

The first section of the survey solicits general demographic information about the child recipient of services and the caregivers. Results from this section address the first research question: “What are the demographic characteristics of children and families who terminate services from the state mental health system after only one or two contacts with a mental health services provider?” To be certain that the families that were surveyed had, in fact, terminated from services, a question was asked as to whether or not they were still receiving services. The following demographics describe only the 34 families (52% of the surveys returned) who indicated their child was no longer receiving services.



The ages of children who had “dropped out” of services and currently were receiving no services ranged from 3–19 years of age (mean=12.94). The majority of those children were in the 14–19 year-old age range (see **Figure 1**). These children/youth were predominantly male (71%). The majority of them are white (N=18, 53%), with another 38% (N=13) being Black. As in previous research, age (Baekland & Lundwall, 1975; Viale-Val et al., 1984; Kazdin, 1990) and race (Kazdin & Mazurick, 1994) did not differ for this subgroup.



Contrary to previous literature (Kazdin & Mazurick, 1994), the majority of these children were living with at least one biological parent (N=25, 74%). In addition, the majority (N=21, 62%) of these children were living in households where two caregivers were listed. The households, on average, had three children (ranging from 1 to 7). The majority (74%) of the primary caregivers had at least a high school education, with six (18%) having completed college and two (6%) having completed graduate school.

The majority of these families had self-referred for services (N=14, 41%). The second most frequent referral sources were Child Protective Services (N=4) and courts/Police (N=4). When looking at the referral sources for the entire group of respondents, the second most frequent referral source was the school system. This is interesting to note in that there may be something about the referral from the school that helps facilitate engagement and the continuation of service involvement.

The second and third sections of the survey speak more to the second research question: “From the families’ perspective, what are the reasons for discontinuing services prematurely?” As described earlier, the second section of the survey instructs respondents to rate a series of items from “1” indicating strong agreement to “5” indicating strong disagreement. These items are perceptions the caregiver had of the early interactions with the mental health provider agency. The item most strongly endorsed was the item that reads “I had to wait too long between appointments”, with an average response of 2.87. The second most strongly endorsed item was, “I had to wait too long before attending the first appointment” (2.88).

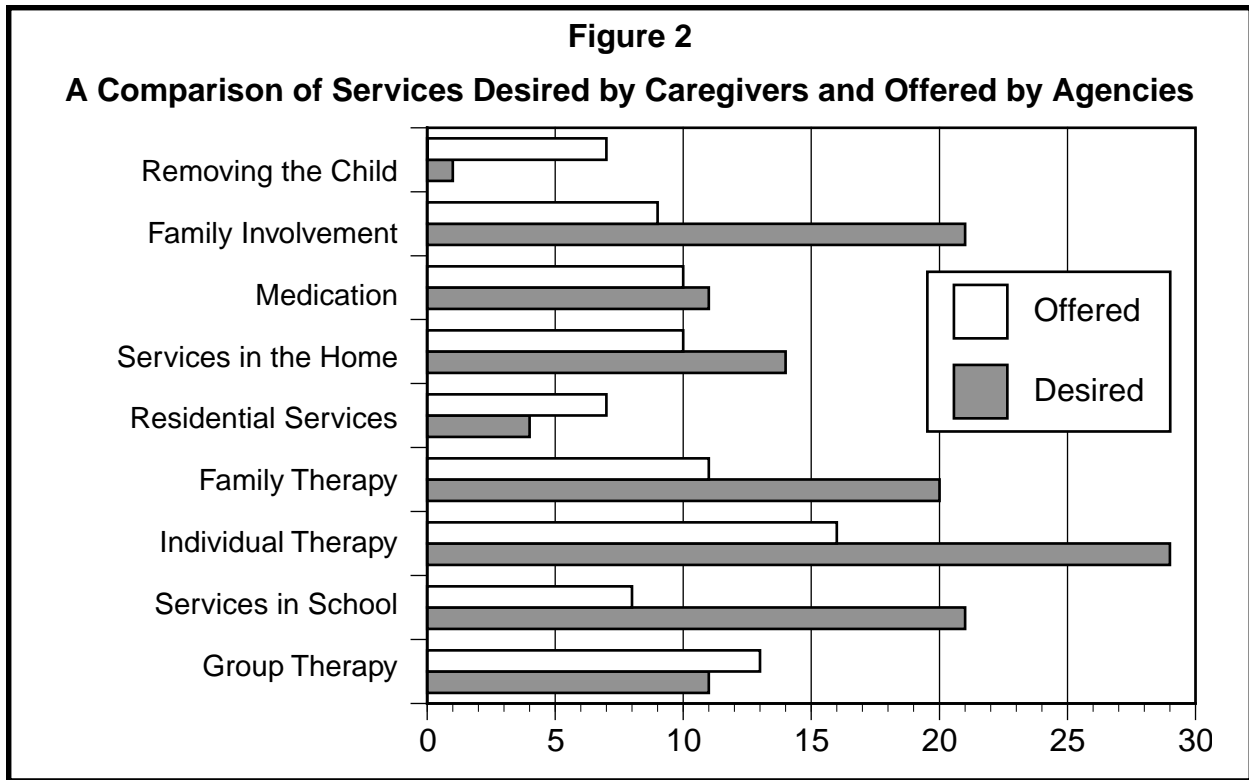
The third section of the survey lists a series of items and the respondents are instructed to rate how important each of the factors were in the decision to discontinue services. Items were rated from “1” indicating very important to “5” indicating very unimportant. The two factors that were rated as most important in the decision to discontinue services were “The time of the appointment in relation to my child’s schooling” (1.7) and “I expected to see a doctor, but saw another type of agency staff” (2.0). The most common factors that reportedly contributed to discontinuation of services are presented in **Table 1**.



Contributing Factor	Average Rating 1= very important; 5 = very unimportant
The time of the appointment in relation to my child's schooling	1.7
I expected to see a doctor, but saw another type of agency staff	2.0
Child not wanting to attend the appointment	2.2
Improvement of child's problem before the appointment	2.5
Appropriateness of mental health services for my child	2.5
Time spent with me or my child	2.6
The time of the appointment in relation to my job	2.6
Transportation	2.6

The fourth section asked four simple Yes/No questions about the gender, race, and age of the agency staff member. None of these variables seem to have had substantial impact on the decision to discontinue services. Of all the questions on the survey, this section had the highest rate of blank responses. It may be the case that these are issues that would more appropriately have been included in face-to-face discussions due to their sensitivity.

The final section of the survey asks respondents to indicate which service option(s) they desired for their child and what option(s) were offered by the service provider. Among the respondents, the most commonly desired services included individual therapy, services in the school, and the opportunity for family involvement (see **Figure 2**). The most commonly offered services were individual and group therapies. The greatest discrepancy between those services desired by the family and those offered by agencies included a greater desire on the part of families for services provided in the school setting and a greater desire for family involvement. The most frequently offered services that were not desired by families included residential treatment and removing the child from the home.



3.4 Record Review Findings

A total of five record reviews were completed. As noted previously, a total of 34 respondents were appropriate for record reviews and/or interviews (i.e., were no longer receiving services). The numbers are much smaller than anticipated due to an inability to identify providers in administrative data sets, and agencies that declined access to their records due to confidentiality rules and insufficient consent/release of information.

Of the five records reviews, three of the children were diagnosed with Attention Deficit Disorder with Hyperactivity (ADHD), one with Major Depression with psychotic features, and one with Psychotic Disorder, NOS. This finding is consistent with literature cited earlier (Baruch, 1998), in that externalizing features are noted. Due to the small sample, however, no generalizations can be made.

The record reviews were designed to address the final research question: “What policies and procedures are in place at the agency level to reach out to families who are apparently terminating prematurely and to prevent dropout?” In only one of the five cases, did the record review indicate a follow-up contact was made with the family. Two of the other records indicated that the family was going to call to reschedule. The families did not call and no attempts were made by the agency to make contact.

Two agencies provided policies related to premature terminations. Both policies include a formal letter to be sent to the family from the Office Manager indicating the file will be closed if no further contact is made. One agency requires that the case manager or therapist attempt to reach the family by telephone after a missed appointment.



If no contact is made, the letter will be sent. The other agency mailed the letter after two missed appointments. Two agencies stated they had no policies and the other indicated they were under revision.

3.5 Interview Findings

A total of 12 interviews were conducted (seven caregiver interviews and five child interviews). Two of the children were unavailable for interview — one because she had run away and another because he was in a juvenile justice commitment placement elsewhere in the state. Many of the families who had responded to the survey and who had consented to interview were unable to be reached at the address where they had received the survey. These families could not be interviewed, and again confirms the high mobility of this population.

In some respects the sentiments expressed in the caregiver interviews echoed the survey responses. Caregivers, however, tended to focus on the relationship with the individual provider (e.g., therapist or psychologist) more so than practical matters that may have interfered (e.g., transportation). Four of the caregivers clearly felt that the provider to whom they were assigned was unable to help them and their child. One mother reported “I felt like I was the one seeing the psychologist. The psychologist did not know anything within two sessions. [It] Always boiled down to medication which I feel strongly about.” Another mother felt that the counselor was joking around too much with her son. She described their experiences as “a waste of time.”

Three of the caregivers were referred for services by a physician, two by school personnel, and two self-referred. All of them reported believing that their child was in need of services. Only one of the caregivers believed her child’s needs were understood by the counselor/agency staff. She reported having a great deal of difficulty getting her teenage daughter to attend sessions, and that the agency called on three occasions to offer assistance. This mother felt everyone was concerned about her daughter, but there was nothing they could do. This is the youth who was unavailable for interview because she had run away. One mother reported that the family needs were misunderstood, while another reported being assigned her own counselor (which she found to be helpful).

In spite of their somewhat negative experiences, the caregivers remained generally optimistic about mental health services. One grandmother reported that “I did not see beforehand that mental problems can occur when kids are pushed to a certain point. When my granddaughter was having these problems, I felt everyone was judging my sanity. I’m glad there’s help out there when mental problems occur. I had no close relationship to mental health services prior to this.”

Of the five children interviewed, only three had any reported recollection of attending counseling, and only one would like to go back. The child who reported he would like to return has been diagnosed with ADHD and Asperger’s Disorder, a developmental disorder, is a rule-out diagnosis. His grandmother has been seeking a professional with appropriate expertise and knowledge with no success.

When asked what they did in counseling, the children responded that they “talked”, “played with blocks and asked questions”, and “talked and drew picture for the doctor’s door.” Three of the five children claimed they would suggest counseling for other kids with similar kinds of problems.



4.0 Summary and Discussion

One of the clearest conclusions that can be drawn based on the small sample is that the mobility of the population is a strong contributing factor to service dropouts. This was evidenced both by the high rate of undeliverable mail during the survey portion of the study and the number of respondents who moved between the survey and interview portions of the study. Research suggests that neither the characteristics of the data set nor the survey methodology was responsible for low completion rates. Research using service recipient samples drawn from the same data set had smaller rates of undeliverable mail and higher returns (Boothroyd & Shern, 1998). When the survey methodology was refined using established procedures to increase response rates (Dillman, 1972), results were still disappointingly low. Reminders and incentives offered to increase response rates produced only marginal improvements. Response rates increased from 8% to 12%. Clearly, frequent family relocations hinder continuous contact with the service system. The difficulties in reaching the population for research purposes invariably echoes the problems confronting agencies attempting to provide services and outreach to service dropouts. The lack of continuity in contact with the agency, as might be offered by an integrated system of care (Stroul & Friedman, 1986) may account, in part, for so many families being lost to services through relocation. These results suggest that service dropouts might be both a system wide as well as an agency based problem.

Among survey respondents, the primary contributing factors to service terminations were related to the convenience of appointments in relation to school and work schedules, and the accessibility of services with regard to waiting periods before and between appointments. In addition, there is evidence that families are not always offered services that are congruent with what they are requesting from service providers. Individual therapy was not offered as often as requested, nor was service in the schools or opportunities for family involvement. These issues closely mirror the concepts of accessibility and appropriateness identified in research on consumer oriented report cards (Mental Health Statistical Improvement Program, 1996), and suggest that accessibility and appropriateness of services are important determinants of service continuity. Ensuring that services are accessible and appropriate will influence families to continue to receive the services that their children need. Efforts to improve accountability of services through report cards and performance based program reviews should include those measures of consumer satisfaction that assess the family's perspective of agency performance. □



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Appendix A — Survey

Dear Parent/Caregiver,

Hello, we are conducting a project attempting to identify and describe children who discontinue counseling-related services after only one or two contacts with an agency. You have received this survey because our records indicate that your child, _____, began receiving such services in Florida between January and July of 1999.

We are very interested in better understanding the experiences, both positive and negative, of caregivers and children that lead them to decide not to continue services. If you are the full-time caregiver of the child noted above we would like your help.

If you are willing to participate in this survey, please complete and return in the envelope provided.

We would also like your help in future activities related to this project (for example, record reviews and face-to-face interviews). Please read the consent form, and if you are interested in participating, sign the consent form and return it with the survey. If you have any questions, please feel free to call Mary Ann Kershaw at (813) 974-6419. Thank you in advance for your help.

Kim Falk
Shani Hannah
Mary Ann Kershaw
O. Thomas Massey

Child's date of birth: ____/____/____ Child's Gender: _____ Male _____ Female

Agency where your child received services: _____

How did your child become involved with counseling-related services?

- ___ I chose to seek services for my child.
- ___ Someone other than myself recommended services for my child.
- ___ I was required to seek services for my child.

Who referred you and your child for counseling-related services?

- ___ Child protection services
- ___ School
- ___ Self
- ___ Police / Probation Officer
- ___ Courts
- ___ Other _____

What is your relationship to the child receiving counseling-related services?

- ___ Biological parent
- ___ Foster parent
- ___ Adoptive parent
- ___ Other _____

What is the relationship of the second caregiver to the child receiving services?

- ___ No second caregiver
- ___ Biological parent
- ___ Foster parent
- ___ Adoptive parent
- ___ Other _____



Your Gender:

Male Female

Your Marital Status:

Married
 Marriage-like arrangement
 Divorced
 Single

Highest Level of Education Completed by Primary Caregiver:

Middle School
 High School
 College
 Graduate School
 Technical School

Your occupation:

Second Caregiver's Gender:

Male Female

Marital Status of Second Caregiver:

Married
 Marriage-like arrangement
 Divorced
 Single

Highest Level of Education Completed by Second Caregiver:

Middle School
 High School
 College
 Graduate School
 Technical School

Occupation of Second Caregiver:

How many children are in your care? _____

How many of those children are in need of mental health services? _____

Our records show that your child began counseling-related services between January and July of 1999.

Is your child still receiving such services? Yes No

⇒ If you answered *yes*, thank you for your help. You can stop completing the survey and mail it back in the envelope provided.

⇒ If you answered *no*, please complete the rest of this survey and return it in the envelope provided. Thank you for your participation.

If you answered *yes*, do you have comments you would like to make about your experiences with services? _____

Now we would like to ask you some questions about your experiences with the service agency. To what extent do you agree with the following statements? Write the corresponding number in the spaces provided to the right.

1=strongly agree 2=agree 3=uncertain 4=disagree 5=strongly disagree

1. I had to wait too long before attending the first appointment.
2. I had to wait too long between appointments.
3. When I came to the appointment, no one was available to help me?
4. When I arrived, I had to wait too long before the appointment began.



5. There was a language barrier between the agency staff and myself.
6. The staff member who spoke with me over the phone did not seem interested in my child.
7. The staff member who spoke with me over the phone did not seem capable of helping me.
8. I felt uncomfortable with the reception staff because they did not give me adequate instruction on what to do or where to go.
9. I did not like my child receiving mental health services because it made me feel inadequate as a parent.
10. I did not like my child receiving mental health services because it might result in my child feeling inadequate.
11. The agency staff member seemed unable to deal well with my child's problem.

**How important were the following factors in your decision to discontinue services?
Write the corresponding number in the spaces provided in the column for each statement.**

1=very important 2= important 3=mixed 4=unimportant 5=very unimportant

12. The time of the appointment in relation to my child's schooling.
13. The time of the appointment in relation to my job.
14. Directions to the agency.
15. Travel time to agency.
16. Transportation.
17. Gender of agency staff member.
18. Child not wanting to attend the appointment.
19. Lack of family support.
20. Race of agency member.
21. Child not living with me at the time.
22. I did not feel that my child had a problem.
23. Improvement of child's problem before the appointment.
24. Agency fees.
25. I expected to see a doctor, but saw another type of agency staff.
26. Age of agency staff.
27. Appropriateness of mental health services for my child.
28. Time spent with me or my child.

Write YES or NO to the following questions in the spaces provided to your right.

29. Was the gender of the agency staff member the same as your child's?
30. Was the race of the agency staff member the same as your child's?
31. Was the age of the agency staff member too young?
32. Did your child believe he/she had a problem?



**In the appropriate columns
check every option that applies**

**Option(s) I desired
for my child**

**Option(s) offered by
the agency**

Group therapy	_____	_____
Services provided in the school	_____	_____
Individual child therapy	_____	_____
Family therapy	_____	_____
Residential treatment	_____	_____
Services provided in the home	_____	_____
Use of medication	_____	_____
Family involvement	_____	_____
Removing child from home	_____	_____

Any additional comments regarding your decision to discontinue services:

Thank you for your help. Please return the completed survey and/or consent form in the envelope provided



Appendix B — Record Review Protocol

Children Who Drop Out of Treatment Record Review Protocol	Child's name _____ (first name and last initial)
Agency Information	Child's date of birth ____/____/____
Date of review ____/____/____	Agency _____ Reviewer's name _____
Contact(s)	
Date of first contact ____/____/____	
Stated reason for first contact	
Referral source _____	
Diagnosis (if available)	
Axis I _____	
Axis II _____	
Axis III _____	
Axis IV _____	
Axis V (GAF or CGAS) _____	
Note any indication of cancellations _____	
Date of subsequent contact (if applicable) ____/____/____ Total number of contacts _____	
Note any reasons indicated for discontinuation	
Follow-ups	
Describe any attempts at follow-up (e.g., notes reflecting phone call or copy of a letter)	
Ask for agency's policy regarding attempts at follow-up and attach copy if available	



Appendix C — Interview Protocols

Interview Questions — Caregiver

Interview Instructions

This interview is intended to provide the caregiver the opportunity to discuss their experiences with seeking mental health services for the children in their care. We already know from their survey responses that they had, at most, two contacts with a mental health agency in Florida.

Read Aloud to Caregiver

Thank you for talking with me today. We are trying to identify and describe children who terminate counseling-related services after only one or two contacts with an agency. We understand from the survey you completed that

_____ (insert child's name) is one of those children.

We're going to interview several families. When we're finished with all of our interviews we will write a report about what we learned, but we will not use anyone's name in the report. You do not have to answer any questions and you may stop this interview at any time. During our conversation together everything will remain confidential unless I have reason to believe you or anyone else is being harmed or is at danger of being harmed. Under those circumstances I am required to report the potential abuse.

Is there anything you would like to ask before we begin?

1. What led you to discontinue services for your child?

2. Did you feel like counseling was necessary for your child? Do you still feel like it is necessary?

3. Who referred you and your child for counseling-related services? Were they related in any way to you discontinuing?

4. How do you feel you were treated upon first arriving at the agency? Did this play a role in you discontinuing services for your child?



Interview Questions — Caregiver (Continued)

5. How do you feel you were treated during the counseling process? Did this play a role in you discontinuing services for your child?

6. What were some positives and negatives of your experience?

7. Do you feel the counselor/agency staff understood your child's needs?

8. Did you make any effort to follow up after the last visit? Did the agency make a follow up call to you?

9. Looking back at the entire experience, has the way you perceive mental health services been affected? In what way?

10. If you knew a family with a similar problem, would you recommend this agency/provider to them?

11. Any additional comments regarding your decision to discontinue services?



Interview Questions — Child

Interview Instructions

This interview is intended to provide the child the opportunity to discuss their experiences with mental health services. We already know from the survey their caregivers completed that they had, at most, two contacts with a mental health agency in Florida.

Read Aloud to Child

Thank you for talking with me today. We are talking with kids who have gone to talk with counselors but only went one or two times. You filled out a survey telling us that you are one of those kids. We want to know more about what that was like for you.

We're going to interview several families. When we're finished with all of our interviews we will write a report about what we learned, but we will not use anyone's name in the report. You do not have to answer any questions and you may stop this interview at any time. During our conversation together everything will stay between us unless I have reason to believe you or anyone else is being harmed or is at danger of being harmed. If you tell me anything like that I am required to tell someone.

Is there anything you would like to ask before we begin?

1. Do you remember going to counseling? Do you remember why you went or who you talked with?

2. What did you do in counseling?

3. Did you like it or not?

4. Did you want to go back?

5. Do you think other kids with similar kinds of problems should go to counseling?