

Symposium:

Alternatives to the Hospitalization of Youth Presenting Psychiatric Crises

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.

Chair:

Scott W. Henggeler, Ph.D.

*Professor & Director, Family Services
Research Center
Department of Psychiatry and
Behavioral Sciences
Medical University of South Carolina
Charleston, SC 29425
803/792-8003 Fax: 803/792-7813*

Participants:

Mary E. Evans, Ph.D.

*Interim Director,
Bureau of Evaluation & Services
Research
New York State Office of Mental Health
44 Holland Avenue, 7th Floor
Albany, New York 12229
518/474-7209 Fax: 518/474-7361*

Albert J. Duchnowski, Ph.D.

*Deputy Director, Research & Training
Center for Children's Mental Health
Depart. of Child and Family Studies
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612
813/974-4661 Fax: 813/974-4406*

Discussant:

Barbara J. Burns, Ph.D.

*Professor
Department of Psychiatry
Duke University Medical Center
Box 3454
Durham, NC 27710
919/684-3719 Fax: 919/684-4564*

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

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).

Presenter:

Scott W. Henggeler, Ph.D.

*Professor & Director, Family Services Research Center
Department of Psychiatry and Behavioral Sciences
Medical University of South Carolina
Charleston, SC 29425
803/792-8003 Fax: 803/792-7813*

Co-Authors:

Alberto B. Santos, M.D.

*Professor
Director, Div. of Public Psychiatry
Department of Psychiatry and Behavioral Sciences
Medical University of South Carolina
Charleston, SC 29425
803/792-8582 Fax: 803/792-2885*

Susan G. Pickrel, MPH, M.D.

*Assistant Professor
Division of Child & Adolescent Psychiatry
Family Services Research Center
Department of Psychiatry and Behavioral Sciences
Medical University of South Carolina
Charleston, SC 29425
803/792-8003 Fax: 803/792-7813*

Barbara A. Trout, Ph.D.

*Director, Child & Adolescent Division
Charleston/Dorchester Community Mental Health Center
3346 Rivers Avenue, Suite D1
N. Charleston, SC 29405
803/740-6136 Fax: 803/740-6141*

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Thomas G. Hiers, Ph.D.

Executive Director
Charleston/Dorchester Community
Mental Health Center
3346 Rivers Avenue, Suite D1
N. Charleston, SC 29405
803/727-2000 Fax: 803/727-2083

Joseph J. Zealberg, M.D.

Director, Emergency Psychiatry
Services
Associate Professor
Division of Public Psychiatry
Department of Psychiatry and
Behavioral Sciences
Medical University of South Carolina
Charleston, SC 29425
803/792-8582 Fax: 803/792-2885

Lisa D. Hand, M.D.

Assistant Professor
Division of Child & Adolescent
Psychiatry
Department of Psychiatry and
Behavioral Sciences
Medical University of South Carolina
Charleston, SC 29425
803/792-0135 Fax: 803/792-0069

Melisa D. Rowland, MD

Clinical Instructor
Division of Public Psychiatry
Department of Psychiatry and
Behavioral Sciences
Medical University of South Carolina
Charleston, SC 29425
803/792-6941 Fax: 803/792-6944

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

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.

Mary E. Evans, RN, Ph.D., F.A.A.N.
Interim Director
Bureau of Evaluation and Services
Research
518/474-7209, Fax 518/474-7361
SREVANS@IRIS.RFMH.ORG

Roger A. Boothroyd, Ph.D.
Research Scientist III
Bureau of Evaluation and Services
Research
518/474-2541, Fax 518/474-9965
SRBOOTH@IRIS.RFMH.ORG

Mary I. Armstrong, M.S.W., M.B.A.
Director
Bureau of Children and Families
518/474-8394

Anne D. Kuppinger, M.Ed.
Program Implementation Specialist
Bureau of Children and Families
518/474-8394

Paul E. Bellair, M.A.
Research Scientist I
Bureau of Evaluation and Services
Research
518/473-9599, Fax 518/474-7361
New York State Office of Mental Health
44 Holland Avenue
Albany, NY 12229

As of October, 1995, correspondence to Mary Armstrong should be addressed to Mary Armstrong, Director of the Division of State and Local Support, Department of Child and Family Studies, Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Blvd., Tampa, FL 33612-3899

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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

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.

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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.

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.

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.

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.

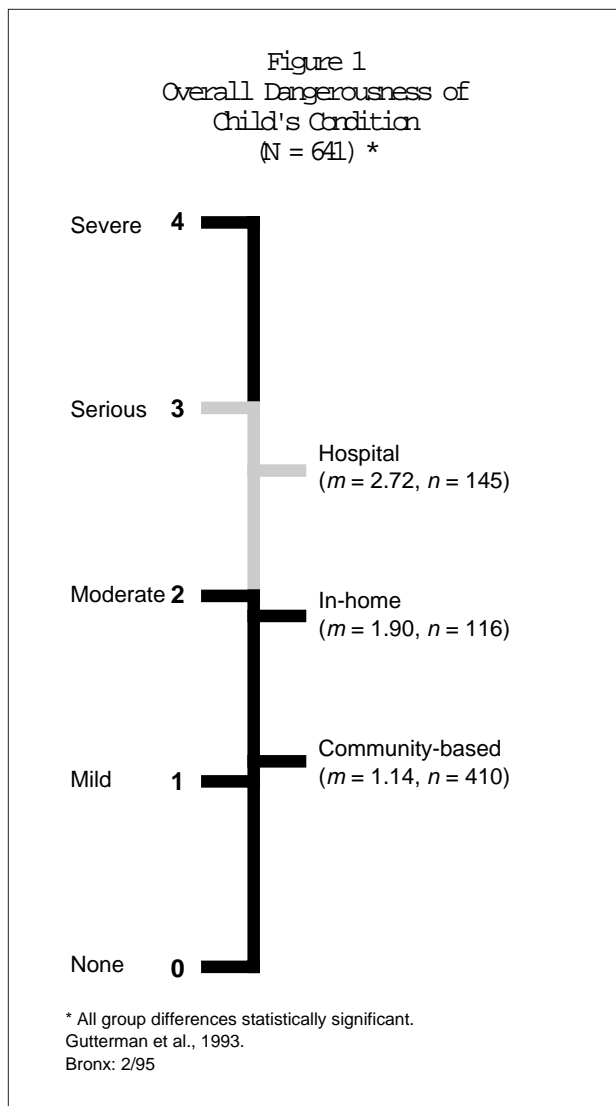
Regarding family data, scores on cohesion and adaptability, as measured by the Family Adaptability and Cohesion Scales (Olsen, Portner & Lavee, 1985) increased significantly from admission to discharge (see Figure 2).

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.

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.

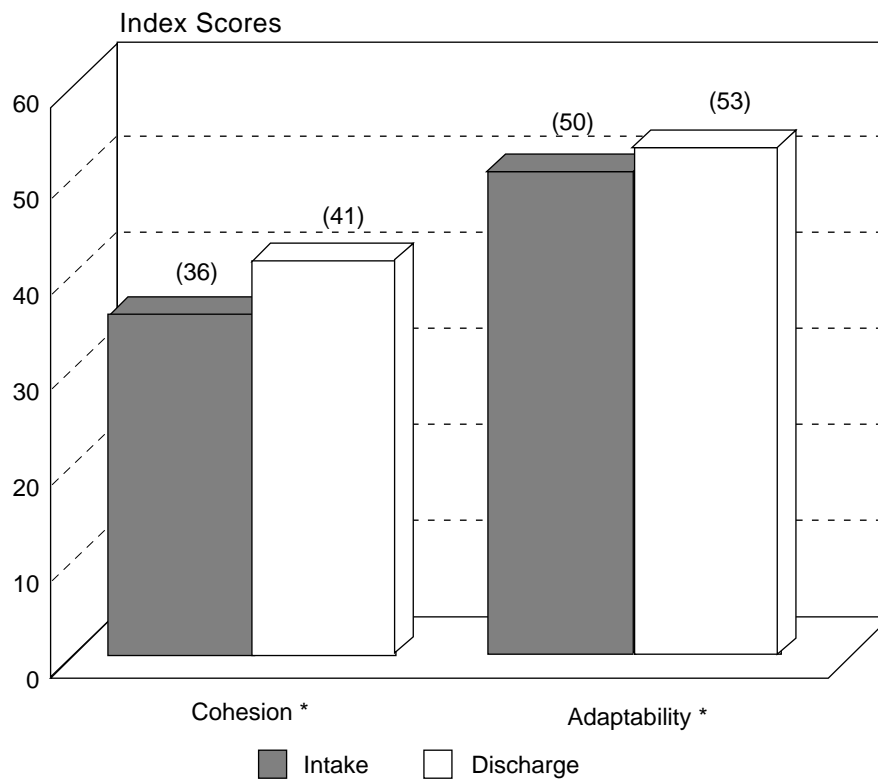


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Figure 2
Family Adaptability and Cohesion
(N = 86)



* Gains from intake to discharge are statistically significant

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The Alternatives to Residential Treatment Study: Initial Findings

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

Presenter:

Albert J. Duchnowski, Ph.D.

*Deputy Director,
Research and Training Center for
Children's Mental Health
Depart. of Child & Family Studies
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612
813/974-4661 Fax: 813/974-4406*

Co-Authors:

Michael K. Johnson, Ph.D.

Kimberly S. Hall, MA
Coordinator

Krista Kutash, Ph.D.

*Deputy Director
Research and Training Center for
Children's Mental Health
Depart. of Child & Family Studies
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3899
813/974-4661 Fax: 813/974-4406*

Robert M. Friedman, Ph.D.

*Chair, Department of Child
and Family Studies
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3899
813/974-4640 Fax: 813/974-4406*

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?

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 emo-

tional 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 clinical 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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Symposium:

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

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

Maryann Davis, Ph.D.*
Director of Research
Charles River Health
Management, Inc.
77 Warren Street,
Brighton, MA 02135

Hewitt Clark, Ph.D.
Professor
Department of Child and
Family Studies
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3899
813/974-6409 Fax: 813/974-4406

Starr Silver, Ph.D.
Assistant Professor
Department of Child and
Family Studies
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3899
813/974-6412 Fax: 813/974-4406

Mieko Smith, Ph.D.
Assistant Professor
Department of Social Work
Cleveland State University
Euclid Ave.
Cleveland, OH 44115
216/687-4738, Fax: 216/687-9366

Ann Vander Stoep, M.A.
Director of Research
Seattle Children's Home
2142 10th Ave West
Seattle, WA 98119
206/284-3300 Fax: 206/284-7843.

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.

Outcomes

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

Mieko Kotake Smith, Ph.D.

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.

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.

**Since the time of submission, the first author has relocated. Address correspondence to: Maryann Davis, Ph.D., Assistant Professor, Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Ave. North, Worcester, MA 01655, phone (508) 793-1550, fax (508)754-5007, e-mail: MaryAnn.Davis@BANGATE.UMMED.EDU*

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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 experimented 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) Effective Transition

Starr Silver, Ph.D.

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.

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.

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.

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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%).

Transition to Adulthood: Issues of Youth with Mental Illness

Ann Vander Stoep, M.S.

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.

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.

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.

Service Utilization

Mental Health Service Utilization by Transitional Youth.

Maryann Davis, Ph.D.

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

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 management as adults. There were no differences in the distribution of those who received services (Adult+) and those who did not (Adult-) across adolescent programs.

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 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.

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	<i>p</i> < .02
Age at adolescent admission	17.8±1.2 yrs.	17.1±1.3 yrs	<i>p</i> < .005
Out-of-home placements	6.1±5.9	3.4±3.2)	<i>p</i> < .01
<i>Diagnoses;</i>			<i>p</i> < .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%	<i>p</i> < .05
Community Services	50%	20%	<i>p</i> < .003
Encounters with case management	16.8±21.9	6.46± 16.9	<i>p</i> < .02
Residential care	41%	22%	<i>p</i> < .05
Psychiatric emergency rooms	26%	9%	<i>p</i> < .05
Inpatient service	39%	20%	<i>p</i> < .05

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

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

Hewitt “Rusty” Clark, Ph.D.

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.

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 requested detailed 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.

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/

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program evaluation and through the tracking of progress for each consumer across multiple goals.

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 be 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—a primary reason that young adults do not receive 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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Adolescent Suicide: The Implications of Coping, Family Functioning and Their Interactions for Prevention and Intervention

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, enmeshment, 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.

Ronald F. Bobner, Ed.D.
Research Fellow
Gene Radney Center for
Children’s Studies/
Akron Child Guidance Center
Foundation
312 Locust Street
Akron, OH 44302
216/258-0953

David M. Weis, Ph.D.
Professor of Education
Chair, Department of Counseling
and Special Education
The University of Akron
Akron, OH 44325-5007
216/972-7777

Carolyn Benz, Ed.D.
Associate Professor of Education
Department of Educational
Administration
The University of Dayton
Dayton, OH 45369-0530
513/229-3308

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Bobner, Weis, Benz, Gulley Smith, Kormos & Lanpher

Pam Gulley Smith, Ed.D.

Assistant Professor
Department of Counselor Education
and Human Services
The University of Dayton
Dayton, OH 45469-0530
513/229-3677

Kathy Kormos

Graduate Assistant

Ben E. Lanpher

Graduate Assistant

Department of Counseling and
Special Education
The University of Akron
Akron, OH 44325-5007
216/972-7777

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 sexual 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,

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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.

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.

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.

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. 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 ($N = 23$).

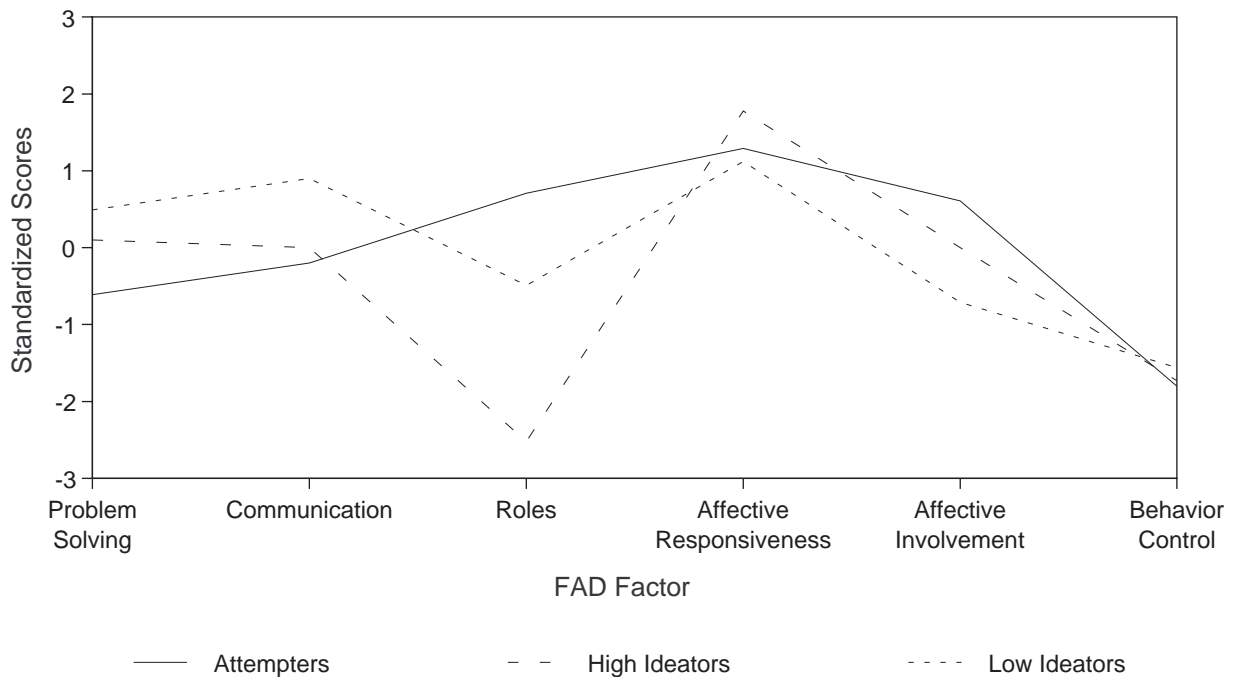
Because of the small sample size, the attempter data were not cross validated. Again, only one profile was identified ($N = 9$). These profiles are presented below.

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

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



Adolescent Suicide

($t=2.22$, $p = .029$, $N = 106$), 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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Gender Appropriate Services for Adolescents with Serious Emotional Disturbances: A Gender Competency Model

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.

Patricia M. Wilson, Ph.D.
*Child and Adolescent Service
System Program (CASSP)
Research and Evaluation
Specialist
Nebraska Department of Public
Institutions
Office of Community Mental
Health*

Rebecca M. Beardsley, MA
*System Clinician
Nebraska Department of Public
Institutions
Medical Services*

Michelle Hughes Miller, MA
*Research Manager
Nebraska Department of Public
Institutions
Division on Alcoholism and Drug
Abuse*

*Address correspondence to first
author at:
Department of Public Institutions
P.O. Box 94728
Lincoln, NE 68509-4728
402/479-5123 Fax: 402/479-5145*

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—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

Gender Competency Model

programs. The specific questions posed to the participants were as follows:

1. What are the gender-specific needs or issues of adolescents receiving mental health and substance abuse services?
2. 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.

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.

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)

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.

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—Systems Change—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.

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)

Gender Competency Model

Community awareness can then provide impetus for grass roots advocacy for increased provider knowledge and skill development (Human Resource Development).

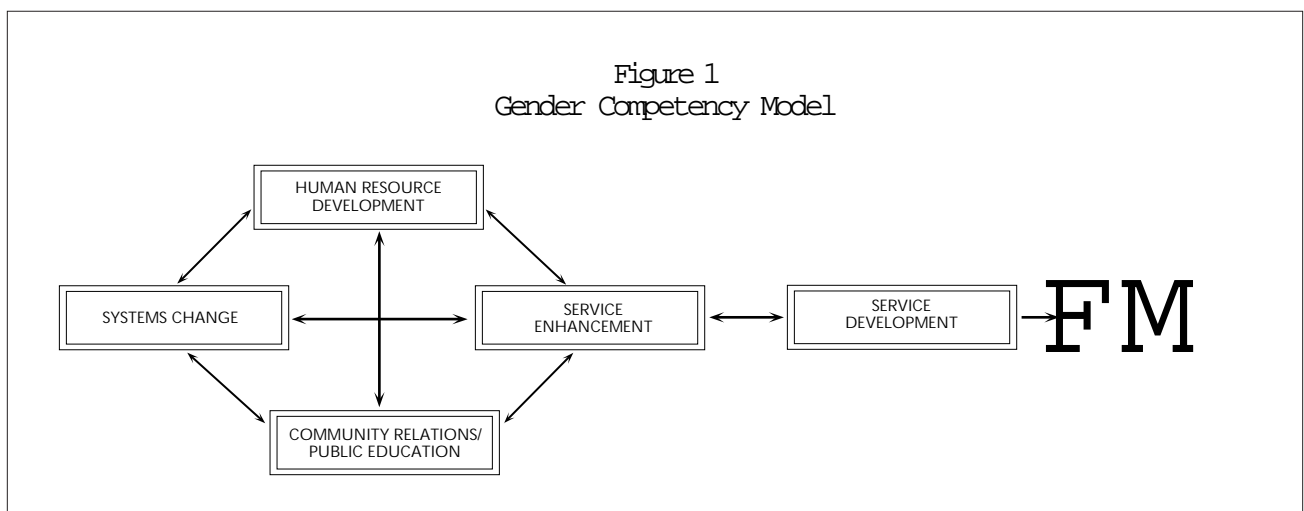
Conclusion

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

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 & Cimboric, 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.

Richard Briscoe, Ph.D.
Elissa Henderson, M.U.A.
*Department of Child and
Family Studies
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612
813/974-6413 Fax: 813/974-4406*

Gail Sedberry, M.S.
*Department of School Psychology
College of Education
University of South Florida
4202 E. Fowler Avenue
Tampa, FL 33620*

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 on the mental health needs of ethnic

Multicultural Mental Health Training Program

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.

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

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

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 and human service programs; and
6. 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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