# *Chapter Nine*

**Issues in Serving Adolescents**

# Predicting Adolescents' Willingness to Seek Help for Mental Illness from Formal versus Informal Sources

**Ajlana Music**
**Susan L. McCammon**
**Christy Mangione Walcott**

## Introduction

Adolescence is a crucial period for the development of mental illness. At least one in five youth suffers from a developmental, emotional, or behavioral problem, and many adolescent-onset disorders persist into adulthood leading to chronic mental health concerns (Evans et al., 2005). For many reasons, adolescents may avoid seeking help for their mental health concerns, which may result in more severe symptoms or the development of co-occurring mental illnesses. Therefore, it is important to examine adolescents' willingness to seek help for mental illness and to identify barriers to help-seeking.

Sheffield, Fiorenza, and Sofronoff (2004) examined variables that promoted and prevented help-seeking for mental illness in a sample of Australian adolescents. Results suggested that adolescents with greater adaptive functioning, fewer perceived barriers, and greater psychological distress were more willing to seek help from both formal and informal sources. Greater level of social support was found to predict willingness to seek help from informal sources. The current study is modeled after Sheffield et al. (2004); however, participants were American high school adolescents rather than Australian adolescents. Research on this population in regard to help-seeking for mental health issues is lacking, as most of the research studies focusing on adolescent help-seeking have been conducted in New Zealand and Australia.

The purpose of this study was to extend the research literature by examining American adolescents' knowledge of and attitudes toward mental illness, and examining the influence of these factors on willingness to seek psychological help. Factors such as knowledge of mental illness, sex, prior history of help-seeking, level of social support, psychological functioning, and perceived barriers to help-seeking and their role in adolescents' willingness to seek help were examined.

## Method

Participants were 162 high school students between the ages of 13 and 19 (*M* = 16.31 years, *SD* = 1.53) recruited through public and private schools as well as a local church youth group in eastern North Carolina. The final sample consisted of 93 females and 69 males. The ethnic composition was 51% White, 36% Black, 3% Asian, 7% Hispanic, 1% Native American, and 2% mixed or other ethnic background. The 16-item questionnaire, modified from the questionnaire used by Sheffield and colleagues (2004), examined adolescents' willingness to seek help from formal and informal sources. Each help source was scored on an 11-point Likert-type scale from 0 = *not at all*, to 11 = *very*, with higher scores indicating greater willingness to seek help from that source. The questionnaire also measured knowledge of mental illness, perceived barriers to help-seeking, degree of social support, and prior history of help-seeking. A modified version of the *Opinions of Mental Illness Scale* (OMI-19; Cohen & Struening, 1962) assessed adolescents' attitudes toward mental illness. The 21-item version of the Depression Anxiety Stress Scales (DASS-21; Lovibond & Lovibond, 1995) was used to screen for factors of depression, anxiety, and stress.

High school students whose parents consented to their participation in the study were asked to complete the 16-item questionnaire, OMI-19, and DASS-21. Each participant received a student information sheet that explained the study in detail and encouraged the students to see a school-based counselor or psychologist if they experienced any distress related to participation in this survey project.

## Results

### Relationship between Knowledge & Attitudes

Results revealed a significant negative correlation ($r = - .43$, $p < 0.01$) between total amount of knowledge about mental illness and one's attitude toward mental illness. *Greater* knowledge about mental illness was associated with more positive attitudes toward mental illness, as revealed by lower scores on the OMI-19 scale.

### Willingness to Seek Help from Informal versus Formal Sources

A paired samples *t*-test revealed a significant difference between willingness to seek help from formal versus informal sources, such that adolescents were more willing to seek help for mental illness from informal sources ($M = 6.04$, $SD = 2.66$) compared to formal sources ($M = 5.35$, $SD = 3.21$), $t = - 2.88$, $p < .001$. Adolescents were most likely to seek help from parents or family members if they were to experience a mental illness, followed by a doctor and psychologist/psychiatrist, respectively (see Figure 1).

**Figure 1**
**Mean Willingness to Seek Help for a Mental Illness from Informal and Formal Sources**
**(0 = *not at all*, 11 = *very willing*)**
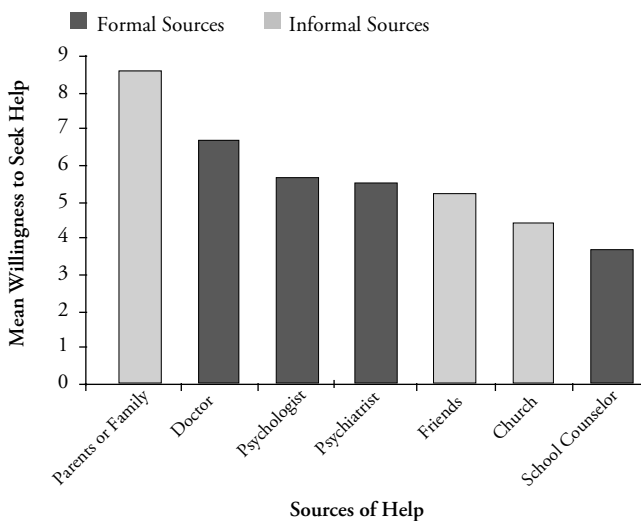


### Predicting Willingness to Seek Help for Mental Illness

Sex, amount of social support, levels of depression, prior history of help-seeking, total knowledge, and number of perceived barriers were simultaneously entered as predictors in two regressions, with formal and informal sources as dependent variables, respectively. The first simultaneous multiple regression showed a significant overall relationship between the proposed variables and willingness to seek help from formal sources, $F (6, 160) = 21.7$, $p < .001$, explaining 46 % (adjusted $R^2 = 44\%$) of the variance in willingness to seek help. Significant predictors of willingness to seek help from formal sources were perceived social support ($\beta = 0.63$, $t = 10.3$, $p < .001$) and sex ($\beta = 0.15$, $t = 2.44$, $p < 0.16$). Thus, female adolescents and those with greater perceived social support were more willing to seek psychological help from formal sources. Levels of depression, prior history of help-seeking, total knowledge of mental illness, and number of perceived barriers to help-seeking were not significant predictors in this model.

A second simultaneous multiple regression showed a significant overall relationship between the proposed variables and willingness to seek help from informal sources, $F (6, 160) = 6.81$, $p < .001$,

explaining 21% (adjusted $R^2$ = 18%) of the variance in willingness to seek help scores. The only significant individual predictor of willingness to seek help from informal sources was perceived social support ($\beta$ = 0.45, $t$ = 6.07, $p$ < .001). Therefore, adolescents with greater perceived social support were more willing to seek psychological help from informal sources.

Adolescents were most likely to seek help for mental illness from informal sources, such as parents or family members, than from formal sources. Several barriers to seeking help from formal sources were identified by the adolescents. For example, perceived barriers to seeking help from a psychologist include not knowing where to receive help from a psychologist and concern about affordability (see Figure 2). Such perceived barriers are consistent with those reported by adolescents in the Sheffield et al. study (2004) .

**Figure 2**
**Percent of Students Indentifying Barriers to Seeking Help from a Psychologist/Psychiatrist**
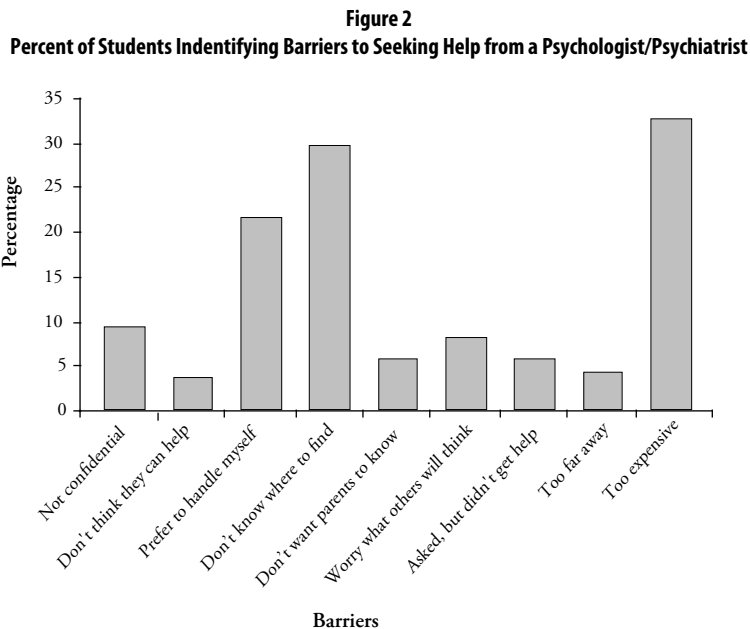


## Conclusion

Greater social support and female status predicted greater willingness to seek formal help. Social support was the only significant predictor of willingness to seek informal help. These results are consistent with Sheffield et al. (2004) who also found that self-reported social support was a significant predictor of informal help-seeking. This finding makes sense given that the primary sources identified by adolescents for informal help were members of their social support networks (e.g., family & friends). Additionally, it highlights the importance of social support as a strategy for coping with mental health problems. The opposite trend is important to investigate as well. That is, those adolescents who lack social support networks may be more reluctant or lack the contacts needed to seek help for their problems. Future investigators should examine additional factors that may affect adolescents' help-seeking intentions and behaviors, especially for those without adequate social support networks.

Overall, the findings reveal reluctance among adolescents to seek help, with many reporting that they prefer to handle problems on their own. As such, mental health providers are charged with the task of increasing adolescents' willingness to seek psychological help, predominantly for adolescents at-risk for mental health problems and those who lack social support from family and friends. These results suggest that routine mental health screenings among adolescents could serve as a viable method to identify those at-risk because many adolescents will not seek help on their own. In addition, mental health providers

should increase education efforts to promote awareness of mental health issues, to suggest outlets for help, and to reduce stigmatizing attitudes related to mental health problems.

We encourage future researchers to investigate willingness to seek help among other adolescent populations and to continue to examine factors that affect adolescents' help-seeking intentions and behaviors. Further investigations should assess whether adolescents' desire to handle problems on their own is a function of stigma related to help-seeking, or more a developmentally predictable striving for autonomy and independence.

## References

Cohen, J., & Struening, E. L. (1962). Opinions about mental illness in the personnel of two large mental hospitals. *Journal of Abnormal and Social Psychology, 64,* 214-218.

Evans, D. L., Foa, E. B., Gur, R. E., Hendin, H., O'Brien, C. P., Seligman, M. E. P., & Walsh, B. T. (2005). *Treating and preventing adolescent mental health disorders: What we know and what we don't know, a research agenda for improving the mental health of our youth.* New York: Oxford University Press.

Lovibond, S. H., & Lovibond, P. F. (1995) *Manual for the Depression Anxiety Stress Scales* (2nd ed.). Psychological Foundation, Sydney, Australia. [Monograph].

Sheffield, J. K., Fiorenza, E., & Sofronoff, K. (2004). Adolescents' willingness to seek psychological help: Promoting and preventing factors. *Journal of Youth and Adolescence, 33,* 495-507.

**CONTRIBUTING AUTHORS**

**Ajlana Music, MA, CAS**
*email: AM0828@ecu.edu*

**Susan L. McCammon, PhD**
*252-328-6357, fax: 252-328-6283, email: McCammons@ecu.edu*

**Christy Mangione Walcott, PhD**
*252-328-1378 fax: 252-328-6283, email: Walcottc@ecu.edu*

*All Authors: East Carolina University, Department of Psychology, 104 Rawl Building, Greenville, NC 27858-4353*

# Utilization of Individual versus Family Therapy Among Adolescents with Severe Emotional Disturbance

Kelly N. Graves
Terri L. Shelton
Maria E. Fernandez
Nadine J. Kaslow

## Introduction

One innovative model of community mental health service delivery lies within the system of care philosophy (Graves, 2005; Graves & Shelton, in press; Holden, Friedman, & Santiago, 2001; Taub, Tighe, & Burchard, 2001; Stroul & Friedman, 1986, 1996). Individual-based treatments encompass treatment modalities that focus on targeted youth for therapeutic change. Regardless of the specific therapeutic orientation, meta-analytic reviews report that youth psychotherapies produce both specific improvements directly related to the presenting problems as well as global improvements on development over time (Weisz, Weiss, Alicke, & Klotz, 1987; Weisz, Weiss, Han, Granger, & Morton, 1995), with effect sizes ranging from .71 to .79, and the average treated child functioning better than 75% of control group children. Furthermore, the effect sizes of individual therapy were not largely different across internalizing and externalizing disorders. Given these promising estimates, it is surprising to find that only about 5%-10% of children and their families utilize outpatient individual-based therapy services (Burns, Hoagwood, & Mzazek, 1999). Family-based treatments include "any modality involving parents as essential participants in treatment" (Diamond & Josephson, 2005, p. 874). Although there are many types of family-based treatments (see Kaslow, Dausch, & Celano, 2003, for a full review), most family-based treatments fall within a general systems theory perspective with the recognition that the behavior of one family member can influence the behavior of other family members (Haley, 1976; Minuchin, 1974; Rutter, 2002; von Bertalanffy, 1968).

The purpose of the study was three-fold. First, the study determined the rates of service utilization of individual and family therapy among children with serious emotional disturbances (SED) receiving community-based mental health services. It was hypothesized that children would be more likely to receive individual therapy than family therapy. Second, the study explored how different combinations of these services relate to changes in functioning (i.e., internalizing and externalizing behaviors) over a six-month period. It was hypothesized that children would benefit more when they receive a combination of family and child therapy compared to child therapy alone. Third, the study examined how the utilization of individual and family therapy influenced caregiver functioning (i.e., caregiver depression and empowerment). It was hypothesized that caregivers who participated in family therapy also would achieve treatment gains in terms of a decrease in depressive symptoms and an increase in empowerment.

## Method

*Participants.* Participants were 102 children with SED and their families who were enrolled in a North Carolina system of care program in one Center for Mental Health Services (CMHS)-funded grant site as part of the Comprehensive Mental Services for Children and their Families Program. Of those 102 families, 13 dropped out of the longitudinal program evaluation within the first six months (12% attrition), resulting in a final sample of 89. Analyses indicated that the only demographic variable on which the groups differed was age, $t(100) = -2.48$, $p < .05$, with those dropping out tending to be older ($M = 13.67$, $SD = 2.46$) than those remaining in the program ($M = 11.83$, $SD = 2.40$). No group differences were noted on other key demographics (e.g., gender, race, income), clinical characteristics of the child (child internalizing or externalizing symptoms), or caregiver depression or family empowerment. Demographic information describing the sample is depicted in Table 1.

*Procedure.* Consent forms were signed by the primary caregiver (or legal guardian if different from the caregiver) and by the child, if age 11 or older. Trained evaluators conducted in-home interviews lasting approximately two hours for caregivers and one hour for children. Families received $25 for T1 interviews and $30 for T2 interviews; children received gift certificates donated from local fast food restaurants at both T1 and T2.

**Measures**

***The Descriptive Information Questionnaire*** (DIQ; CMHS, 1997). This questionnaire is a 37-item caregiver-reported questionnaire that was completed at T1.

***Multi-sector service contact.*** Caregivers reported on the mental health services received over the past six months using the Multi-Sector Service Contact (MSSC; CMHS, 2000). Only three items were used in the present study in order to focus exclusively on the combination of individual and family therapy to predict changes in child symptoms. These items include: "Did your child receive medication treatment?" (as a control variable); "How many individual therapy sessions did he/she receive during the last six months?", and "How many family therapy sessions did you receive during the last six months?"

***Internalizing and externalizing behaviors.*** Both caregivers and youth aged 11 and older completed a measure of internalizing and externalizing behavior. Caregivers completed the Child Behavior Checklist (CBCL; Achenbach, 1991a) at both assessments, and youth completed the Youth Self-Report (YSR; Achenbach, 1991b) at both assessments.

***Caregiver depression.*** Caregivers reported their own levels of depression using the Center for Epidemiological Studies-Depression (CES-D) inventory derived from Radloff (1977).

***Family empowerment.*** Caregiver-reported family empowerment was obtained at both T1 and T2 using the Family Empowerment Scale (FES; Koren, DeChillo, & Friesen, 1992).

**Table 1**
**Descriptive Statistics Describing the Sample[a]**

| Indicator | % | Mean | SD | Range |
|---|---|---|---|---|
| Age | | 11.83 | 2.40 | 6.00 - 17.00 |
| Male | 75 | | | |
| Minority | 42 | | | |
| Custody Status | | | | |
|     Single Parent Family | 43 | | | |
|     Two Parent Family | 29 | | | |
|     Grandparents | 3 | | | |
|     Adoptive/Foster Parents | 5 | | | |
|     State Custody | 20 | | | |
| Family Income | | | | |
|     Less than $15,000 | 43 | | | |
|     Above $15,000 | 57 | | | |
| Clinical Diagnoses | | | | |
|     AD/HD | 32 | | | |
|     Mood Disorder | 26 | | | |
|     Oppositional Defiant Disorder | 14 | | | |
|     Anxiety Disorder | 8 | | | |
|     Disruptive Behavior Disorder | 7 | | | |
|     Conduct Disorder | 6 | | | |
|     Adjustment Disorder | 5 | | | |
|     Co-morbid Disorders | 85 | | | |
| Individual Therapy | 67 | | | |
| Family Therapy | 37 | | | |
| Both Individual and Family Therapy | 30 | | | |
| Individual Therapy Sessions | | 11.44 | 16.57 | 0.00 – 64.00 |
| Family Therapy Sessions | | 5.18 | 12.60 | 0.00 – 60.00 |

[a]All demographic statistics are based on information provided at Time One.

## Results

Descriptive analyses for all independent and dependent variables are presented in Table 2. Because of the number of analyses, we utilized the Benjamini-Hochberg procedure for controlling the false positive rate in multiple comparisons (Thissen, Steinberg, & Kuang, 2002). Caregivers reported significant decreases in their child's internalizing and externalizing behaviors across a six-month period. Children also endorsed marked decreases in both internalizing and externalizing behaviors. In contrast, there were no significant changes in levels of caregiver depression or family empowerment.

Paired sample $t$-tests revealed that children received a higher number of individual therapy (IT) sessions ($M = 11.44$, $SD = 16.58$) than family therapy (FT) sessions ($M = 5.43$, $SD = 12.86$) over a six-month period, $t(88) = 3.31$, $p < .01$ (B-H corrected alpha level of .02). Approximately 67% received at least one session of IT; 37% received at least one session of FT; and 30% received at least one session of IT and one session of FT (22% did not report receiving any IT or FT).

Regression analyses indicated a main effect of both child-reported and caregiver-reported externalizing behaviors at T1, with higher levels of externalizing behaviors at T1 linked with higher levels of externalizing behaviors at T2. Neither individual nor family therapy was related to change in externalizing behaviors regardless of who reported externalizing behaviors (child or caregiver report). Regressions indicated a main effect of child-reported and caregiver-reported internalizing behaviors at T1, with higher levels of internalizing behaviors at T1 linked with higher levels of internalizing behaviors at T2. Neither individual nor family therapy was related to change in internalizing behaviors when caregivers reported internalizing behaviors. However, when children reported internalizing behaviors, there was a main effect of family therapy, with a greater number of family therapy sessions linked with lower levels of internalizing behaviors at T2. Thus, hypothesis two was partially supported for internalizing disorders when child reports were considered, but did not receive support when caregiver reports were the focus. See Table 2 for these analyses.

Paired samples $t$-tests indicated that there were no significant changes in the family-level variables of caregiver depression or empowerment from T1 to T2 when using the B-H critical value.

## Discussion

Children received more individual therapy sessions than family therapy sessions. However, given the severity of the sample, it was surprising to find that only 67% of children received one session of IT and that 22% of children did not receive IT or FT. Given the research indicating that the average treated child functions better than 75% of control group children (Weisz et al., 1987; Weisz et al., 1995), and that family therapy has been shown to relieve internalizing and externalizing problems, it appears that therapy services were under-utilized in this sample. Regarding family therapy, perhaps it is more challenging to engage families in treatment compared to one individual. This might be the case for multiple reasons, including more preparation time for the clinician, increased need for coordination, less "predictability" of the session, and, at times, family preference for a particular kind of therapy (individual therapy only). In addition, clinicians may have had less training in family therapy or a predilection toward using individual therapy, and systems may have been less supportive of family interventions. The lower utilization of family therapy also was noteworthy when considering that some support was found for the second hypothesis that children would benefit more from a combination of individual and family therapy than individual therapy alone. Support was not found for the third hypothesis that caregivers would achieve treatment gains in terms of a decrease in depressive symptoms and an increase in empowerment.

**Table 2**
**Regression Analyses To Predict T2 Externalizing and Internalizing**
**with Individual and Family Therapy**

| Variables Entered | b | t | β | F | R² | B-H Critical |
|---|---|---|---|---|---|---|
| **Child-Reported Externalizing (*n* = 56)** | | | | | | |
| Block One | | | | 12.22*** | .51 | |
| Ethnicity | -.16 | -.06 | -.01 | | | .025 |
| Medication Use | -.66 | -.26 | -.03 | | | .021 |
| Externalizing (T1) | .65 | 6.90 | .71 | | | .017* |
| Block Two | | | | 8.99*** | .57 | |
| Individual Therapy | .19 | 2.10 | .30 | | | .008 |
| Family Therapy | -.16 | -2.00 | -.26 | | | .013 |
| Block Three | | | | 7.64*** | .58 | |
| IT X FT | .00 | .97 | .18 | | | .017 |
| **Caregiver-Reported Externalizing (*n* = 89)** | | | | | | |
| Block One | | | | 6.36*** | .24 | |
| Ethnicity | .38 | .16 | .02 | | | .025 |
| Medication Use | 3.68 | 1.62 | .18 | | | .021 |
| Externalizing (T1) | .59 | 4.04 | .46 | | | .017* |
| Block Two | | | | 4.07** | .26 | |
| Individual Therapy | .01 | .02 | .01 | | | .013 |
| Family Therapy | .10 | 1.08 | .14 | | | .008 |
| Block Three | | | | 3.33** | .26 | |
| IT X FT | .00 | .02 | .00 | | | .004 |
| **Child-Reported Internalizing (*n* = 56)** | | | | | | |
| Block One | | | | 22.37*** | .60 | |
| Ethnicity | .23 | 1.00 | .01 | | | .025 |
| Medication Use | -2.19 | -.97 | -.09 | | | .021 |
| Internalizing (T1) | .75 | 8.14 | .78 | | | .017* |
| Block Two | | | | 16.43*** | .66 | |
| Individual Therapy | .14 | 1.92 | .21 | | | .013 |
| Family Therapy | -.21 | -2.60 | -.28 | | | .008* |
| Block Three | | | | 13.51*** | .66 | |
| IT X FT | .00 | -.53 | -.07 | | | .004 |
| **Caregiver-Reported Internalizing (*n* = 89)** | | | | | | |
| Block One | | | | 8.44*** | .26 | |
| Ethnicity | 2.94 | 1.17 | .12 | | | .025 |
| Medication Use | -.56 | -.23 | -.02 | | | .021 |
| Internalizing (T1) | .51 | 4.28 | .47 | | | .017* |
| Block Two | | | | 5.31** | .28 | |
| Individual Therapy | .07 | .85 | .10 | | | .013 |
| Family Therapy | .04 | .39 | .05 | | | .008 |
| Block Three | | | | 5.06** | .31 | |
| IT X FT | .01 | 1.75 | .24 | | | .004 |

*Indicates comparisons for which the direction of the difference is confidently interpreted at the α/2 level using the Benjamini-Hochberg (B-H critical) method.

# References

Achenbach, T. M. (1991a). *Child Behavior Checklist for Ages 4-18*. Burlington: University of Vermont, Department of Psychology.

Achenbach, T. M. (1991b). *Youth Self-Report for Ages 11-18*. Burlington: University of Vermont, Department of Psychology.

Burns, B. J., Hoagwood, K., & Mzazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical child and Family Psychology Review, 2*, 199-254.

Diamond, G., & Josephson, A. (2005). Family-based treatment research: A 10-year update. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*, 872-887.

Graves, K. N. (2005). The links among perceived adherence to the system of care philosophy, consumer satisfaction, and improvements in child functioning. *Journal of Child and Family Studies, 14*, 403-415.

Graves, K. N., & Shelton, T. E. (in press). Family empowerment as a mediator between family-centered systems of care and changes in child functioning: Identifying an important mechanism of change. *Journal of Child and Family Studies.*

Haley, J. (1976). *Problem-solving therapy*. San Francisco: Jossey-Boss.

Holden, E. W., Friedman, R. M. & Santiago, R. L.(2001). Overview of the National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program. *Journal of Emotional and Behavioral Disorders, 9*, 4-12.

Kaslow, N. J., Dausch, B. M., & Celano, M. (2003). Family therapies. In. A. S. Gurman & S. B. Messer (Eds.), *Essential psychotherapies: Theory and practice* (pp. 400-462). New York: Guilford Press.

Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1*, 385-401.

Stroul, B. A., & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances* (Rev. ed.). Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Stroul, B. A., & Friedman, R. (1996). The system of care concept and philosophy. In B. Stroul (Ed.), *Children's Mental Health: Creating Systems of Care in a Changing Society*. Baltimore: Brookes.

Taub, J., Tighe, T. A., & Burchard, J. (2001). The effects of parent empowerment on adjustment for children receiving comprehensive mental health services. *Children's Services: Social Policy, Research, and Practice, 4*, 103-112.

Thissen, D., Steinberg, L., & Kuang, D. (2002). Quick and easy implementation of the Benjamini-Hochberg procedure for controlling the false positive rate in multiple comparisons. *Journal of Educational and Behavioral Statistics, 27*, 77-83.

Weisz, J. R., Weiss, B., Alicke, M. D., & Klotz, M. L. (1987). Effectiveness of psychotherapy with children and adolescents: A meta-analysis for clinicians. *Journal of Consulting and Clinical Psychology, 55*, 542-549.

Weisz, J. R., Weiss, B., Han, S. S., Granger, D. A., & Morton, T. (1995). Effects of psychotherapy with children and adolescents revised: A meta-analysis of treatment outcome studies. *Psychological Bulletin, 117*, 450-468.

## CONTRIBUTING AUTHORS

**Kelly N. Graves, PhD**
*Center for Youth, Family, and Community Partnerships, University of North Carolina
at Greensboro, Foundation Place, 330 S. Greene St., Suite 200, Greensboro, NC 27401,
email: kgraves@bennett.edu*

**Terri L. Shelton, PhD**
*Center for Youth, Family, and Community Partnerships, University of North Carolina
at Greensboro, Foundation Place, 330 S. Greene St., Suite 200, Greensboro, NC 27401,
email: shelton@uncg.edu*

**Maria E. Fernandez, PhD**
*North Carolina Division of Mental Health, Developmental Disabilities and Substance
Abuse Services, email: maria.fernandez@ncmail.net*

**Nadine J. Kaslow, PhD**
*Professor and Chief Psychologist, Emory University School of Medicine,
email: nkaslow@emory.edu*

# Symposium
# Addressing Abuse and Mistreatment of Youth Placed in Residential "Treatment" Facilities

## The Context

Lenore Behar, Robert Friedman, Judith Katz-Leavy, Allison Pinto
& William Boyles

*Chair*
Allison Pinto

*Discussant*
Robert M. Friedman

*Authors*
Lenore Behar
William Boyle
Robert M. Friedman
Judith Katz-Leavy
Allison Pinto

### Introduction

A parent's decision to place a child in residential treatment is a serious one, usually fraught with anxiety and based on concerns about the child's difficulties, emotional stability, and/or behavioral problems. The decision is frequently guided by the recommendations of a mental health professional, school counselor, or juvenile probation officer, or judge. In many cases, the decision comes after other, non-residential treatments have failed. The choice of a residential treatment program is a complicated one, and in the best of circumstances, the decision is made by matching the child's needs to the program's strengths, and based on the assumption that the program provides quality treatment, education, medical care, and honors the rights of children and parents.

Problems can arise when placements are made without verifying that these important elements of residential care are in place. A basic source of verification of program quality is that the program is licensed by the state in which it is located; a higher source of verification is accreditation by a national organization. Neither is foolproof and questionable programs may exist with one or both of these "seals of approval." Alternatively, good programs may exist with neither of these approvals. Thus, the issue of program quality is complex, but extremely important to the well-being and safety of children and precedes any consideration of treatment effectiveness. This symposium addresses the most basic measure of quality—how states handle the issue of licensure; how they review or monitor the programs they license; and how they address problems that arise when the requirements for good child care, good treatment and good education are deficient.

### Uncovering a Problem

A compelling report in the media regarding exploitation, mistreatment, and abuse of minors in unregulated, private residential treatment facilities appeared in July 1999 by Lou Kilzer in the Denver Rocky Mountain News. Following his report, there have been additional shocking media reports. Most notable are a series of articles by Tim Weiner, the *New York Times* (May through September 2003); Bonnie Miller Rubin, The Last Resort: Therapeutic Education Industry Booms as Parents Seek Programs for Troubled Children, *Chicago Tribune* (January 14, 2004); and Maia Szalavitz, The Trouble with Tough Love, *Washington Post* (January 29, 2006). Szalavitz has further captured the unsavory tactics of some programs in her recent book; *Help at Any Cost* (Szalavitz, 2006). Youth who attended such programs, parents, and former staff have also made powerful public statements about abusive experiences with some of these facilities. These issues have been discussed in publications of the American Psychological Association: Public Interest Directorate (Pinto, Friedman & Epstein, 2005) and the American Association of Orthopsychiatry (Friedman, Pinto, Behar, Bush, Chirolla, Epstein, Green, Hawkins, Huff, Huffine, Mohr, Seltzer, Vaughn, Whitehead & Young, 2006) and in presentations at meetings of the American Bar Association (Davidson, 2006), American Psychological Association (Pinto, Epstein, Lewis & Whitehead, 2006), and Research and Training Center for Children's Mental Health (Friedman, Pinto, Behar, Bush, Epstein, Green, Lewis, Whitehead & Young, 2006).

Collectively, these reports describe:

- human rights violations including (1) youth deaths; (2) inhumane, degrading discipline; (3) inappropriate, often dangerous, use of seclusion and restraint; (4) medical and nutritional neglect; and (5) severe restrictions of communication with parents, lawyers and advocates;
- substandard psychotherapeutic interventions and education by unqualified staff;
- failure to assess individual needs of residents;
- denial of access by parents to their children in residence;
- financial opportunism and misrepresentations to parents by program operators; and
- financial incentives to "educational consultants" who serve as case finders and recruiters of families.

Investigations have been conducted of abuse and neglect at several private unregulated residential programs and lawsuits have been filed as a result; some lawsuits have led to criminal convictions of the programs' officials or expensive civil case settlements (Hechinger & Chaker, 2005; Dukes, 2005; Rock, 2005).

Some unregulated programs mislead parents to believe that "creative programming" that rises above regulation and above sound medical and psychological practices is necessary for their "difficult" children. Attractive advertisements, particularly on the Internet, are aimed at parents who are struggling to find help for their "troubled" children. Some parents make these placements at their own expense, without seeking professional evaluations of the youth's problems; and the programs do not require professional assessment prior to placement. Some programs offer to connect the family with an "escort service" to transport a child whom parents anticipate would not otherwise choose to go to the program, which essentially means that two or more strong adults physically control the youth and force him or her to go to the treatment facility. In some cases, the parents have not seen the programs, which may be hundreds if not thousands of miles away from home, and they have no independent data, other than promotional material, to attest to the effectiveness of the programs. Many programs severely limit parental contact, by phone and visits, sometimes for as long as a year. This year, the American Bar Association Center on Children and the Law, using data reported by Rubin and Szalavitz, reported an annual estimate of ten to fifteen thousand American youth being placed by their parents in these privately run, unregulated residential facilities, which may also include boot camps or wilderness programs (Davidson, 2006).

## Regulation of Residential Programs

Policies regarding regulation of both public and private residential facilities are the responsibility of each state. These policies may be implemented by state legislation, regulation or other administrative action. Although many states do oversee residential programs, in some states private residential treatment facilities for minors are not subject to regulation or monitoring. Yet states regulate other private facilities, such as nursing homes, day care centers, hospitals, and restaurants. Depending on the state, failure to provide state oversight of residential programs for minors may occur because these programs (1) do not accept public funds; (2) are affiliated with religious organizations; or (3) describe themselves (inappropriately) as outdoor programs, boarding schools or other types of non-treatment programs. In some cases, strong lobbying efforts by interested parties have contributed to creating and maintaining these exclusions. An additional problem in some states is that, although regulations exist, there is ineffective monitoring of programs for compliance.

## Beginning to Address the Problem

The Alliance for the Safe, Therapeutic and Appropriate Use of Residential Treatment (A START) was initiated by the Louis de la Parte Florida Mental Health Institute at the University of South Florida to call attention to this problem, and seek solutions that will protect children in these programs. A START now includes advisors who are leaders in psychology, psychiatry, nursing, mental health law, policy and

family advocacy, as well as people with direct experience as director, evaluator, parent or participant in such programs. A START worked with the Committee on Education and Labor of the U.S. House of Representatives to host a press conference regarding these programs at the U.S. Capitol Building on October 22, 2005. Major national organizations which endorsed A START's concerns include the American Psychological Association, American Association of Community Psychiatrists, American Orthopsychiatric Association, Child Welfare League of America, Federation of Families for Children's Mental Health, National Alliance for the Mentally Ill, and National Mental Health Association. Further, A START has worked with the Committee on Education and Labor of the U.S. House of Representatives to request that the Government Accountability Office undertake a national study of unregulated residential programs and several of the other organizations have supported this request The National Conference of State Legislatures (NCSL) shares the belief that state policy is central to addressing this problem and has distributed information, prepared by A START, to the chairs of relevant state legislative committees to inform them of the issues (Herman, 2005).

In addition to A START's efforts to mobilize parents, professionals, and advocates to address this very serious public health issue, another compelling group has formed to further such work. The Community Alliance for the Ethical Treatment of Youth (CAFETY) is a volunteer, youth-run effort supporting the protection of human rights of youth in residential behavior modification programs, boot camps, wilderness programs, private alternative adolescent programs, 'therapeutic' boarding schools and residential treatment centers, with a focus on unregulated facilities. Many CAFETY members had attended residential programs as youths. Their organization offers a space where individuals affected by such facilities can come together cohesively to affirm their grievances pertaining to these issues. CAFETY has spearheaded a youth-initiated 'Care, Not Coercion' campaign to bring attention to problems associated with these facilities such as abusive treatment, treatment for which efficacy has not been proven, and violation of youth rights.

A START has also undertaken two pilot studies, to include: (1) a pilot study of four states to gain understanding of their licensing laws and policies and how these are implemented; and (2) an Internet survey to be completed by youth who attended residential programs and by parents of youth who attended residential programs. The purpose of the second study is to gain understanding of how youth were treated and the impact of their experiences.

## Reference List

Davidson, H. (Conference Reporter). (2006, May). *Challenges for the American Bar Association, State and Local Bars, National Minority Bar Associations, Law Schools, the Judiciary, and Individual Lawyers.* Recommendations from the ABA youth at risk initiative planning conference, Hempstead, NY. Retrieved January 26, 2006 from http://www.abanet.org/initiatives/youthatrisk/docs/aba_yarrecs_and_action_plan_final.pdf.

Dukes, L. (2005, March 26). Financial troubles shut down CEDU schools. *Bonner County Daily Bee.* Retrieved April 15, 2005 from http://bonnercountydailybee.com

Friedman, R. M., Pinto, A., Behar, L., Bush, N., Chirolla, A., Epstein, M., et al. (2006). Unlicensed residential programs: The next challenge in protecting youth. *American Journal of Orthopsychiatry, 76*, 295-303.

Friedman, R. M., Pinto, A., Behar, L., Bush, N., Epstein, M., et al. (2006, February). *Unregulated residential treatment facilities: A present-day threat to youth, families and the field of children's mental health.* Presented at the 19th Annual Conference of the Research and Training Center for Children's Mental Health, Tampa, FL.

Hechinger, J. & Chaker, A. M. (2005, March 31). Boarding-school options shift for troubled teens—shutdown of Brown schools shows challenge of selecting a 'therapeutic' program. *The Wall Street Journal.* Retrieved April 7, 2005 from http://online.wsj.com

Herman, M. (2005, September 19). Behavioral health news—When is "tough love" too tough? States scrutinize boarding schools. *National Conference of State Legislatures State Health Notes: Forum for State Health Policy Leadership.* Retrieved September 20, 2005 from http://www.statehealthnotes.org

Kilzer, L. (1999, July 18). Desperate measures. *Denver Rocky Mountain News*. Retrieved December 28, 2004 from http://www.denver-rmn.com

Pinto, A., Epstein, M., Lewis, P., & Whitehead, K. (2006, August 12). *Exploitation of youth & families: Perspectives on unregulated residential treatment*. Presented at American Psychological Association Annual Meeting, New Orleans, LA.

Pinto, A. Friedman, R.M. & Epstein, M. (2005, Summer). Exploitation in the name of "specialty schooling" What counts as sufficient data? What are psychologists to do? *American Psychological Association: Public Interest Directorate, Children, Youth and Families Division News*. Retrieved September 29, 2005 from http://www.apa.org/pi/cyf/specialty_schooling.pdf

Rock, S. (2005, January 23). Referral agency's connection to boot camp angers parents. *The Kansas City Star*. Retrieved April 15, 2005 from http://kansascity.com

Rubin, B. M. (2004, January 14). The last resort: Therapeutic education industry booms as parents seek programs for their troubled children. *Chicago Tribune*. Retrieved April 15, 2005 from http://www.chicagotribune.com

Szalavitz, M. (2006, January 29). The trouble with tough love. *Washington Post*, p. B01. Retrieved October 30, 2006 from http://www.washingtonpost.com/wp-dyn/content/article/2006/01/28/AR2006012800062.html.

Szalavitz, M. (2006). *Help at any cost: How the troubled-teen industry cons parents and hurts kids*. New York, NY: Riverhead.

Weiner, T. (2003, June 17). Parents divided over Jamaica disciplinary academy. *The New York Times*. Retrieved January 19, 2005 from http://nytimes.com

Weiner, T. (2003, May 24). Owner of private discipline academy in Costa Rica is arrested. *The New York Times*. Retrieved January 19, 2005 from http://www.nytimes.com

Weiner, T. (2003, May 9). Parents, shopping for discipline, turn to harsh programs abroad. *The New York Times*. Retrieved May 9, 2003 from http://www.nytimes.com

## A Pilot Study of State Regulations Pertaining to Residential Treatment Programs for Youth

**Judith W. Katz-Leavy, Lenore Behar, Robert M. Friedman & Allison Pinto**

### Introduction

A study of four states was undertaken as a pilot effort for a larger, national state-by-state study through a partnership of four organizations: The Alliance for the Safe, Therapeutic and Appropriate Use of Residential Treatment (A START), based at the Louis de la Parte Florida Mental Health Institute; the American Bar Association Center for Children and the Law; the National Disability Rights Network; and the Federation of Families for Children's Mental Health. The two-year study will involve (a) an in-depth review of state laws, policies and practices regarding regulation and oversight of residential programs, (b) education of and technical assistance to state lawmakers and leaders to bring about needed policy reform, and (c) guidance for parents about placing children in residential centers. The preliminary findings from the pilot study are presented because, even with such a small number, it is clear that there are problems of state policy that contribute to the problem of mistreatment of children and their families.

### Method

While the authors acknowledge that there are several approaches to remedying the problems that are described in the previous paper by Behar, Friedman, Katz-Leavey, Pinto & Boyles, they believe the wisest course of action is to first systematically gather information about how states handle the issue of licensure/regulation of residential treatment programs for minors, as well as information on monitoring and quality assurance requirements. In order to begin this process, the authors developed a brief protocol designed to elicit the desired information from state administrators responsible for licensure of these programs and for ensuring quality of care, state child mental health administrators, and other key stakeholders such as the protection and advocacy administrators. The protocol was designed as a telephone interview and was expected to take between forty-five minutes to one hour to complete.

The study was conducted in Connecticut, Missouri, Utah, and California. These states were selected in order to achieve geographic diversity as well as diversity in size and history/experience in regulating residential programs for minors. Respondents were from the Protection and Advocacy agency, child welfare, education, juvenile justice and mental health. The authors intended to assess the degree to which respondents were knowledgeable of the regulations and the monitoring process and the degree to which they agreed with each other, and the extent to which there were laws, regulations and policies in place to address this issue. Because the intent was to get an overview of what problems might exist regarding regulation (rather than to determine which states did this well or badly), the findings are not reported by specific state.

### Results

Most respondents deferred to the individual who was in charge of licensing for the state. In some states, representatives from other agencies did not seem to have a working knowledge of how programs were regulated. The person with this responsibility was variously located in child welfare, social services, or human services. In general, the child mental health administrators were less familiar with the state regulations governing licensure and monitoring and didn't see this as part of their domain. Representatives from the Protection and Advocacy agency saw this as an important issue, but had not become directly involved.

All four states had legislation requiring the executive branch to issue rules/regulations regarding the operation of residential treatment facilities for minors. However, there was variance as to which kinds of programs the regulations applied. In one state, the rules applied only to facilities in which a governmental agency placed youngsters. In some states, there was an attempt to define levels of residential care, with

more stringent treatment standards applying to the most restrictive group homes and community treatment facilities.

All four states reported that there were several pathways to residential placements for minors. Placement could occur through social services/mental health (into therapeutic foster care, group homes, community treatment facilities, or hospitalization); juvenile justice (into boot camps); through special education; and through private placement. Respondents also stated that licensing and monitoring of juvenile justice, mental health and special education residential programs were the purview of their respective agencies. None of the states were able to report how many children were placed privately by their parents or how many children were placed out of state by local agencies or by parents. Nor was there any attempt to monitor the effectiveness of those placements.

Programs were able to opt out of the licensing requirements established for the purpose of providing mental health treatment in facilities for minors in several ways. In some states, if the programs were considered to be religious institutions, they were exempt. Also, in some states, if a program accepted only private placements, it did not require licensure. In some states, if a program defined itself as a boarding school or educational facility, it could be exempt from regulation, even though the services provided were described as "emotionally corrective" or "therapeutic."

Despite the plan to describe the states with anonymity, it is important to mention Utah; this is a state that has had substantial problems with questionable existing programs which were previously exempt from regulation. In 2005, the state legislature amended the licensure law to ensure that all programs, except legitimate private residential schools, be subject to state regulation and monitoring. The rule-making process has taken over a year, which is not unusual given the importance of public review and comment. Commendably, Utah is now implementing its new, more stringent regulations that address how programs will be included in licensure requirements and will be monitored for compliance with those requirements. Although it is too early to understand the impact of new regulations in Utah, this state certainly bears watching.

All four states reported that they have in place regulations establishing standards for treatment services, educational services, and child care/supervision; however, as noted above, these requirements do not apply to all programs in the state. The basic requirements included such elements as (a) each child must have an individualized treatment plan; and (b) the provider must be able to meet the needs identified in the plan. Monitoring includes assessing (a) the individualized treatment plans, (b) the individualized educational plans, and (c) quality of services. In some of the states, there were requirements related to child care and supervision but these treatment aspects were not specified except for at the higher end (i.e., more restrictive programs).

For programs to which the rules and regulations apply, all four states reported that specific rules regarding children's rights, parental rights, punishment, and use of seclusion and restraints are in place. All four also stated that there are procedures in place for reporting abuse. These included reporting abuse to a child welfare hotline and requiring that abuse laws be posted in every facility. Children must have access to a phone and employees of residential programs must be trained about the different kinds of employee behaviors that are not permitted.

While all four states have established licensure requirements and standards for at least some types of residential treatment facilities providing services to minors, their ability to monitor compliance was of concern. Some states monitor requirements which govern such things as staff qualifications, staffing patterns, and number of hours of psychotherapeutic service per week/per child.

In some states, following application for licensure, there is an onsite review of requirements and interviews with staff and management. There may be unannounced licensing monitoring visits, as frequently as quarterly. There also may be a requirement for an annual inspection, which comes with the renewal process. Additionally, onsite visits may be made if a complaint is made from staff, clients, family,

or citizens. However, respondents reported that monitoring is compromised by the number of staff to do the job. In one state, the monitoring agency is staffed to visit a 10% random sample of licensed facilities, and this is not as frequent as once per year. States vary as to whether they provide licensing and monitoring at no cost to the program or whether they charge to cover these services.

## Conclusion

While the authors recognize that four states are too small a number upon which to draw conclusions, it was apparent that there is an absence of data about how effective current laws are. Most agency respondents deferred to the person who was in charge of licensing and didn't see licensing, or in some cases even the monitoring of quality of care delivered, as part of their responsibility. There appeared to be an assumption that providers will obey the laws, but there were no safeguards in place to protect children who are placed privately by their parents. Staff from the responsible state agencies are already stretched in their ability to monitor the safety and the effectiveness of the quality of care delivered for the children already in their custody.

## CONTRIBUTING AUTHORS

**Judith W. Katz-Leavy, MEd**
*Consultant, Child and Family Mental Health, 3053 Porter Street, NW, Washington, DC 20008, 202-362-8298, email: jkatzleavy@gmail.com*

**Lenore Behar, PhD**
*Director, Child & Family Program Strategies, 1821 Woodburn Rd., Durham, NC, 919-489-1888 Fax: 919-489-1832, email:lbehar@nc.rr.com*

**Robert M. Friedman, PhD**
*Professor and Director, Research and Training Center for Children's Mental Health, Dept. of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, 13301 Bruce B. Downs Blvd., Tampa FL 33612, 813-974-4671, email: friedman@fmhi.usf.edu*

**Allison Pinto, PhD**
*Assistant Professor, Dept. of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, 13301 Bruce B. Downs Blvd., Tampa FL 33612, 813-974-9179 Fax: 813-974-7743, email: apinto@fmhi.usf.edu*

**William Boyles**
*9964 Dean Oaks Court, Orlando, FL 32825, 407-506-8380, email: bill.boyles@gmail.com*

# Psychotropic Medication Utilization at a Group Home Residential Facility

**Michael Handwerk**
**Gail L. Smith**
**Ron Thompson**
**M. Beth Chmelka**
**Brigid K. Howard**
**Dan Daly**

## Introduction

Utilization of psychotropic medication in pediatric populations has been increasing over the last several decades (Hunkeler et al., 2005). Despite these trends and concerns over the large number of children being prescribed psychotropic medications, relatively little is known about psychotropic medication utilization for children and adolescents in out-of-home placement. The relative absence of studies for this population is striking given that these children represent some of the most seriously emotionally and behaviorally disturbed children that enter treatment. This problem is further exacerbated by the restrictive nature of this treatment environment, as children in out-of-home care are a potentially more vulnerable population than children served in the community.

Although sparse, there are a handful of studies that have examined psychotropic utilization for youth in out-of-home placement. In general, these studies have found high rates of psychotropic medication utilization. For example, Breland-Noble et al. (2004) reported that youth in group-home residential care had higher utilization rates of psychotropic medication than youth placed in treatment foster care (77% and 67%, respectively). A couple studies have reported utilization of psychotropic medication over the course of residential treatment. Najjar et al. (2004) reported that the percentage of children prescribed psychotropic medication increased from 46% at admission to 75% at discharge for three child and adolescent inpatient programs. Connor & McLaughlin (2005) reported that 79% of 141 children and adolescents admitted to a longer-term residential treatment facility were on psychotropics, while 71% were discharged on psychotropic medication, with substantial decreases in polypharmacological (i.e., utilization of two of more psychotropic medications) over the course the youths' stay.

Although there have been a few recent studies examining psychotropic medication utilization for youth in residential care, the majority of these studies have involved acute inpatient facilities. While critical to the understanding of psychotropic utilization for youth in out-of-home placement, a large percentage of youth placed in residential care reside in non-acute facilities. The high psychotropic medication utilization rates in acute hospitalizations may not be indicative of psychotropic medication utilization patterns for youth in group-home residential facilities. This study examined psychotropic medication utilization over the course of treatment for adolescents admitted to a large residential group-home for youth with emotional and behavioral disorders.

## Method

Participants were 706 children and adolescents consecutively admitted to a large group-home residential treatment facility in the Midwest during 2001-2004. The facility utilizes the Teaching Family Model, a skill-based behaviorally-oriented treatment approach where trained married couples provide treatment to 6-8 youth who reside in each home (Handwerk, Field, & Friman, 2000). The age of the residents ranged from 9 to 18 with an average age of 15.0. Sixty-two percent of the youth were male. Ethnic composition of the residents was: 55% Caucasian, 21% African-American, 11% Hispanic, and 13% other. Mean length of stay was 17 months. Youth who had been initially admitted to the treatment program at a higher level of care within the same organization (e.g., in-patient hospitalization) and later were transferred to the Family Home Program were excluded from these analyses.

Utilization groups were created based on the pattern of psychotropic medication usage over the youths' stay at the facility. Youth were counted as utilizing a medication if they took at least one medication in a particular class. Youth were divided into seven groups based on psychotropic medication usage at admission, during treatment, and departure (see Table 1). Medication during placement

was coded positively if: (a) a youth was admitted not taking psychotropics but was later prescribed a psychotropic medication, or (b) if a youth was admitted on psychotropic medications, but later was prescribed a medication from a different category (e.g., a youth was admitted taking a stimulant, and was later prescribed an anti-depressant). We chose to utilize this coding scheme to emphasize whether youth were being prescribed novel medications, as well as to try to better capture polypharmocological prescribing tendencies. Medications were grouped into categories based on consultation with several psychiatrists: anti-anxiety (i.e., benzodiazepenes), anti-psychotics (both typical and atypical), anti-depressants (SSRIs and tricyclics), stimulants (including Strattera), and mood stabilizers (Lithium and anti-convulsants).

**Table 1**
**Percentage of Youth in Each Medication Utilization Category**

| Groups | Admission | During | Departure | % (n) |
|--------|-----------|--------|-----------|-------|
| 1 | No | No | — | 55.6% (366) |
| 2 | Yes | No | No | 13.1% (86) |
| 3 | Yes | Yes | No | 4.2% (28) |
| 4 | Yes | No | Yes | 15.2% (100) |
| 5 | Yes | Yes | Yes | 1.4% (9) |
| 6 | No | Yes | No | 5.6% (37) |
| 7 | No | Yes | Yes | 4.9% (32) |

Socio-demographic variables were retrieved from a computerized database, and included ethnicity, referral source (courts, social services, parents, mental health referrals, and other), number of formal placements, and history of suicide attempt. Also, as part of the admission process, the caretaker of the youth completed the Child Behavior Checklist (CBCL; Achenbach, 1991). We examined Internalizing and Externalizing scores on the CBCL. On the first day at the program, each youth completed the Suicide Probability Scale (SPS). We examined the four SPS subscales: Suicide ideation, Negative self-evaluation, Hopelessness, and Hostility. Each youth also completed the Diagnostic Interview Schedule for Children (DISC) within seven days of being admitted. We analyzed differences in psycho-social variables between youth on medications at admission, during treatment, and departure.

## Results

Table 1 lists the numbers and percentages of youth in each medication utilization category. Overall, 33.9% of youth were admitted on psychotropic medication. More females than males (38.9% and 31.4%, respectively) were admitted to the facility on psychotropic medication, $\chi^2(1, N = 706) = 4.67$, $p < .05$. There were significant gender differences with regard to specific type of medication at admission as well, $\chi^2(4, N = 395) = 16.71$, $p < .05$. Examination of residuals indicated males had higher rates of stimulant utilization at admission than females (33% and 20%, respectively), while a greater proportion of females than males were admitted on anti-depressants (47% and 32%, respectively). There were no differences between males and females in the rates of anti-psychotics (18.4 and 15.6%, respectively) or mood stabilizers (13.2 and 16.8%, respectively) at admission.

There were significant differences on psychosocial variables between youth admitted to the facility on psychotropic medication and those not admitted on medications. Youth on medications at admission were more likely to be Caucasian, $\chi^2(3, N = 706) = 59.24$, $p < .05$, and have previously attempted suicide, $\chi^2(1, N = 637) = 9.97$, $p < .05$. There were also differences in referral source, $\chi^2(4, N = 644) = 19.34$, $p < .05$, with youth on medication at admission more likely to be referred by social service agencies as well as mental health providers.

Youth on medication at admission also had more formal placements prior to admission, $t(641) = 3.77$, $p < .05$. Youth admitted on psychotropic medication scored higher on the CBCL Internalizing and Externalizing scales than those youth not on psychotropics at admission, $F(2, 554) = 13.84$, $p < .05$. Youth on psychotropic medications at admission also scored higher on the SPS, $F(4, 638) = 4.36$, $p < .05$. Follow up univariate tests indicated those on psychotropics scored higher on the SPS Suicide Ideation ($p < .01$), Hopelessness ($p < .05$), and Hostility ($p < .001$) scales than those not on psychotropics at admission, but not the Negative Self-evaluation scale, $p > .05$. Those on psychotropic medication at

admission were also more likely to have an affective disorder (depression, dysthymia), $\chi^2(1, N = 692) =$ 7.43, $p < .001$; Attention Deficit-Hyperactive Disorder, $\chi^2(1, N = 638) = 4.66$, $p < .05$; or "other," $\chi^2(1, N = 682) = 14.30$, $p < .001$, diagnoses on the DISC. There were no differences with respect to Anxiety disorders, Conduct Disorder, or Oppositional Defiant Disorder.

Of the sample of 706, 16.1% had a medication added during their stay. The majority (65%) of youth who were prescribed a medication during their stay were not admitted on a psychotropic medication (10.5% of the entire sample). Youth put on a medication during treatment were more likely to be male, $\chi^2(1, N = 443)$, and younger, $t (443)= 2.76$, $p < .01$, than those who were never on medication (i.e., group 1 versus groups 6 and 7). There were no other differences between those prescribed medications during their stay and those who were never on medication.

Overall, 22.9% of the youth left the program taking a psychotropic medication. Of youth admitted to the facility on psychotropic medication, less than half (47.5%) were discharged on psychotropic meds. As illustrated in Figure 1, there was a significant reduction in the proportion of youth on psychotropic medication at admission to departure, $\chi^2(1, 658) = 35.5$, $p < .01$. Reductions in utilization were evident for the proportion of youth taking anti-psychotics, $\chi^2(1, N = 658) = 7.0$, $p < .01$, as well as the number of residents taking psychotropic medications from two or more classes of medications, $\chi^2(1, N = 658) = 28.9$, $p < .01$, where rates of polypharmacology went from 17.3% at admission to 9.2% at departure. At departure, no psychosocial variables were significantly different between those leaving who were on or off medications.

**Figure 1**
**Rates of Psychotrophic Medication Utilization at Admission and Departure**
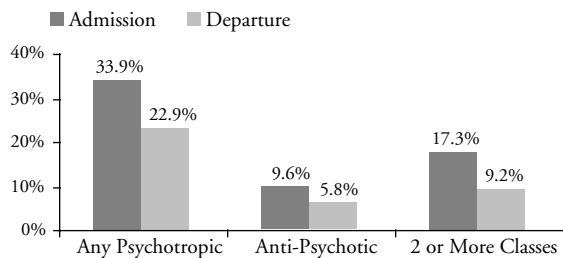


## Conclusions

On average, youth at the facility were more likely to experience a reduction in psychotropic medication usage over the course of treatment. More than half the youth admitted on psychotropic medication were no longer taking medications at the time of departure. Although a few youth (12.5%) who were admitted to the program not on psychotropics were later placed on psychotropic medications at some point, most of these youth departed from the program not taking psychotropic medication (54%).

Overall, the rate of psychotropic medication utilization was lower at this facility when compared to other reports for youth in out-of-home treatment (cf., Breland-Noble et al., 2004; Connor et al., 1998). This does not appear to be primarily related to the severity of youth problems at the time of admission, as mean CBCL scores at admission for youth at this facility were very similar to those in other investigations. As many of the youth at this facility are referred from social service agencies, it is possible that the lower rates of psychotropic medication usage at admission is the result of fewer of the children coming in contact with mental health providers, and specifically, psychiatrists, prior to admission. The lower rate of utilization in this sample was also related to excluding youth who were coming into the family-style residential care from more restrictive treatment facilities within the same organization.

Consistent with previous reports (c.f., Connor & McLaughlin, 2005), demographic and psychological variables were predictive of psychotropic medication usage. Gender, ethnicity, diagnostic status, level of impairment (i.e., CBCL and SPS scores), and referral source differed between youth on and off psychotropic medication. Most of the variance between those on and off medication occurred at admission, though a few psychosocial variables differed between those placed on medications during their stay (i.e., younger children were more likely to be placed on psychotropic medication). While the data provide evidence regarding predictors of psychotropic medication utilization at admission, during treatment, and at program completion, they do not allow us to know whether medication utilization

corresponded to actual program outcomes. We are currently analyzing behavioral and outcome data collected during the youths stay at the facility to determine whether medication status was differentially related to program effectiveness. Nevertheless, these results indicate that it is feasible to provide residential treatment in a family-style, group-home environment where there are relatively low rates of psychotropic medication utilization.

## References

Achenbach, T. M. (1991). *Manual for the Child Behavior Checklist/4-18 and 1991 profile*. Burlington: University of Vermont, Department of Psychiatry.

Breland-Noble, A. M., Elbogen, E. B., Farmer, E. M. Z., Dubs, M. S., Wagner, H. R., & Burns, B. J. (2004). Use of psychotropic medications by youth in therapeutic foster care and group homes. *Psychiatric Services, 55*, 706-708.

Connor, D. F., & McLaughlin, T. J. (2005). A naturalistic study of medication reduction in a residential treatment setting. *Journal of Child & Adolescent Psychopharmacology, 15*, 302-310.

Connor, D. F., Ozbayrak, K. R., Harrison, R. J., & Melloni Jr., R. H. (1998). Prevalence and patterns of psychotropic and anticonvulsant medication use in children and adolescents referred to residential treatment. *Journal of Child and Adolescent Psychopharmacology, 8*, 27-38.

Cull, J. G., & Gill, W. S. (1988). *Suicide Probability Scale (SPS) manual*. Los Angeles: WPS.

Handwerk, M. L., Field, C. E., & Friman, P. C. (2000). The iatrogenic effects of group intervention for antisocial youth: Premature extrapolations? *Journal of Behavioral Education, 10*, 223-238.

Hunkeler, E. M, Fireman, B., Lee, J., Diamond, R., Hamilton, J., He, C. X., Dea, R., Nowell, W. B., Hargreaves, W. (2005). Trends in use of antidepressants, lithium, and anticonvulsants in Kaiser Permanente-insured youths, 1994-2003. *Journal of Child & Adolescent Psychopharmacology, 15*, 26-27.

Najjar, F., Welch, C., Grapentine, W. L., Sachs, H., Sinischalchi, J., & Price, L. H. (2004). Trends in psychotropic drug use in a child psychiatric hospital from 1991-1998. *Journal of Child & Adolescent Psychopharmacology, 14,* 87-93.

Shaffer, D., Fisher, P., Lucas, C. P., Dulcan, M. K., Schwab-Stone, M. E. (2000). NIMH Diagnostic Interview Schedule for Children Version IV (NIMH DISC-IV): Description, differences from previous versions, and reliability of some common diagnoses. *Journal of the American Academy of Child & Adolescent Psychiatry*, 39, 28-38.

**CONTRIBUTING AUTHORS**

**Michael Handwerk, PhD**
*Director of Clinical Services, Research, and Internship Training, 402-498-3362, fax: 402-498-3375, email: handwerkm@yahoo.com*

**Gail L. Smith, BS**
*Research Analyst, Clinical Service & Research, 402-498-3354, email: smithg@girlsandboystown.org*

**Ron Thompson, PhD**
*Director, National Research Institute, 402-498-3102, email: thompsonr@girlsandboystown.org*

**M. Beth Chmelka, BS**
*Research Analyst, National Research Institute, 402-498-3213, email: chmelkab@girlsandboystown.org*

**Brigid K. Howard, MA**
*Coordinator of DISC Research, Clinical Services & Research, 402-498-3345, email: howardb@ girlsandboystown.org*

**Dan Daly, PhD**
*Vice President and Director of Youth Care, 402-498-1928, email: dalyd@girlsandboystown.org*
*All Authors: Girls and Boys Town, 13603 Flanagan Blvd., Boys Town, NE 68010*

# A Preliminary Logic Model Addressing Suicide Issues in Systems of Care Communities

Sylvia Kay Fisher
Stephen Roggenbaum
Jason H. Padgett
Kristin Williams-Washington
Gary M. Blau

## Introduction

This paper describes a preliminary logic model entitled "Addressing Suicide Issues in Systems of Care Communities" developed as part of a suicide prevention initiative under the auspices of the Comprehensive Community Mental Health Services for Children and Their Families Program of the Child, Adolescent, and Family Branch in the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration. The logic model delineates a comprehensive and detailed roadmap for future activities and interventions that can be implemented at both the national- and community-levels in three major dimensions of this suicide reduction initiative, namely suicide prevention, intervention, and postvention. This initiative is designed to ultimately reduce the likelihood that at-risk children and youth in systems of care (SOC) communities will engage in suicide-related behavior.

## Methodology

The professional and therapeutic literature on the topic of suicide, including available literature about suicide-related behavior of children and youth in SOC, was reviewed to identify information and data about (a) patterns of suicide-related behavior for at-risk youth with mental health challenges, including youth who are receiving SOC services; and (b) community-based interventions designed to reduce suicide-related behavior in at-risk youth.

Discussions were conducted with youth, families, providers, consultants, program partners and program staff at community and national levels who provided the context for the scope of the problem of youth suicide in SOC communities and identified needs, strategies and means of instituting appropriate activities and interventions within SOC communities.

This information was aggregated and distilled, resulting in the development of an initial logic model draft. This initial draft was reviewed and vetted by leading national-level suicide prevention experts and researchers, all of whom provided extensive feedback on various aspects of the model; their feedback was incorporated within a second draft.

Further, additional feedback was received from participants at two meetings (a) Addressing Suicide Issues in Systems of Care, held in Rockville, MD on September 7-8, 2006, which convened expert and knowledgeable individuals about youth suicide to identify effective means of developing and implementing a holistic wraparound approach to delivering services, resources, and strategies within SOC communities in the areas of suicide prevention, intervention, and postvention; and (b) A Special Topics Forum luncheon, "Suicide Issues in Systems of Care," held at the 20th Annual Research Conference: A System of Care for Children's Mental Health—Expanding the Research Base, in Tampa Florida, March 4, 2007. This meeting included research and community-based experts on youth suicide in SOCs.

Feedback from these multiple sources was incorporated into the current draft of the logic model, which is a living document that has undergone continuous revisions while vetted through multiple audiences. The structure, components, and major elements of the logic model have remained consistent throughout various levels of review, but specific suggestions and edits have been incorporated as they are received as part of a continuous quality improvement process.

## Logic Model

### Mission and Vision

The vision for the logic model, "Addressing the issue of suicide through systems of care in the areas of prevention, intervention, and postvention by promulgating an agenda of hope and resilience to ensure all participating children, youth and families receive needed services and supports," specifies the underlying purpose of the initiative to address suicide in SOC communities.

The mission builds upon this vision and specifies the overarching purpose of the logic model in greater detail: "To promote and ensure appropriate and culturally and linguistically competent services and supports to children, youth and families within system of care communities who are at-risk for suicidal ideation and behavior in the areas of suicide prevention, intervention, and postvention." Both the vision and the mission articulate the aim of the SOC suicide reduction initiative, which is to address the needs of children and youth who are at risk of suicide, as well as their families. SOC principles, including an emphasis on strengths-based approaches, cultural and linguistic competence, and community-based services and supports are incorporated in both the vision and the mission.

### Structure and Content

The logic model is comprised of the following components:

*Population of Interest.* While all youth in SOCs represent the population of interest when it comes to the issue of suicide, specific sub-populations of interest are identified, because youth in these groups may be at relatively greater risk of suicide-related behavior. These include youth who (a) are identified as at-risk for suicidal intent and/or suicide-related behaviors, (b) present with previously reported cases of suicide ideation and suicide-related behaviors, (c) are members of demographic groups (e.g., American Indian, Latino, sexual minority, etc.) that have comparatively higher incidences of suicide-related behavior, (d) have a family history of suicide-related ideation and behaviors, and/or (e) are being raised in multi-generational families exhibiting intergenerational trauma, historic grief and/or depression. Interventions are outlined in other components of the logic model that address the needs of youth within these sub-populations who are at-risk for suicide-related behavior.

*Context.* This section identifies a comprehensive series of strengths and challenges that exist within the greater SOC program and within SOC communities in addressing suicide-related issues. Specifically, *Strengths* include acknowledging that identifying at-risk youth is a significant SOC priority that requires the allocation of appropriate interventions and resources, and capitalizing on the commitment and support of SOC communities, families, and the federal-level funding program for a program-wide SOC initiative to identify effective suicide prevention and intervention methods.

*Challenges.* Specific challenges that exist within the context of this suicide prevention initiative include a lack of awareness in SOC communities about the causes and consequences of suicide; considerable variation in ethnicity, geography, and income in SOC communities, which make it difficult to design appropriate interventions; inadequate and incomplete coordination, communication, and collaboration between components of the service delivery infrastructure; and limited resources and support for postvention activities after a death by suicide.

The remainder of the logic model includes four sections that delineate a plan and necessary groundwork for the effective implementation of suicide prevention, intervention, and postvention activities with both youth and family, and the larger system of care community. *Assumptions* emphasize what will need to occur in order to effectively implement this suicide reduction initiative within SOC communities. *Strategies* operationalize specific means of implementing suicide reduction activities within SOC communities. Finally, *Short-* and *Long-term Outcomes* for the successful implementation of this suicide reduction initiative are identified at both the youth and family level and SOC community level.

*Assumptions.* Assumptions at the youth and family level acknowledge the importance of providing resources to reduce suicidal ideation and suicide attempts, while also emphasizing the key role associated with developing suicide prevention activities and messages. At the SOC community level, it is assumed that a coordinated and collaborative effort will involve various SOC constituencies and will emphasize culturally and linguistically competent prevention strategies. In addition, providers are assumed to play a key role in the assessment of at-risk youth, as well as developing intervention activities. Open communication and research and evaluation activities are also essential to developing and implementing effective assessment and intervention protocols, as well as generating continuous feedback on the success of identifying or identified protocols.

*Strategies.* Strategies at the youth and family level focus on cultivating community-based awareness, provision of therapeutic suicide prevention services, and implementation of postvention services, all framed within a culturally and linguistically competent approach. Community-wide strategies include establishment of a community suicide prevention task force, institution of social marketing campaigns, identification of supports, training for providers, utilization of evidence-based interventions, and identifying prevention and stigma reduction activities for vulnerable populations.

*Short-term Outcomes.* Short-term outcomes for youth and families include participation by at-risk youth and affected caregivers in prevention services, knowledge and skill-building activities around suicide prevention and building of resilience and protective factors, decreased suicide-related behaviors, and availability of postvention services to youth and families affected by a suicide death. Short-term outcomes for SOC communities include increased knowledge about occurrence of suicide, as well as effective suicide prevention and intervention strategies, gains in provider knowledge, and increased family and provider involvement in identifying at-risk youth.

*Long-term Outcomes.* Long-term outcomes for youth and families include reduction in suicidal behaviors (including suicide attempts), increased knowledge of suicide-related trajectories, and increased youth and family satisfaction with services provided. For SOC communities, long-term outcomes include increased investment in reduction of suicide-related behavior and associated stigma, as well as continued promotion of resilience factors, and replication and sustainability of effective strategies throughout SOC communities.

## Conclusion

As the logic model continues to be vetted within various SOC constituencies, feedback received from a multiplicity of sources has been incorporated to enhance the relevance and appropriateness of the logic model. This continuous refinement process has resulted in a more comprehensive, integrated, and effective logic model that provides a basis for the successful implementation of suicide prevention, intervention and postvention activities that will expedite the success of this suicide reduction initiative at the national- and community-levels throughout SOCs.

## CONTRIBUTING AUTHORS

**Sylvia Kay Fisher, PhD**
*Director of Evaluation, Child, Adolescent & Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road Room 6-1047, Rockville, MD 20857, 240-276-1923, fax: 240-276-1930, email: sylvia.fisher@samhsa.hhs.gov*

**Stephen Roggenbaum MA**
*Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies, 13301 Bruce B Downs Blvd, Tampa, FL 33612, 813-974-6149, fax: 813-974-7376, email: roggenba@fmhi.usf.edu*

**Jason H. Padgett, MPA**
*Field Development Coordinator, Suicide Prevention Action Network USA (SPAN USA), 1025 Vermont Avenue, NW, Suite 1066, Washington, DC 20005, 202-449-3600, fax: 202-449-3601, email: jpadgett@spanusa.org*

**Kristin Williams-Washington, MA**
*Evaluation Research Analyst, Walter R. MacDonald & Associates, Inc., Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road Room 6-1034, Rockville, MD 20857, 240-276-1934, fax: 240-276-1930, email: kristin.williams@ samhsa.hhs.gov*

**Gary M. Blau, PhD**
*Branch Chief, Child, Adolescent & Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road Room 6-1045, Rockville, MD 20857, 240-276-1980, fax: 240-276-1930, email: gary.blau@samhsa.hhs.gov*

*Chair*
**Christine M. Walrath**

*Discussant*
**Sylvia Fisher**

*Authors*
**Anna Krivelyova et al.**
**Christine M. Walrath**
**Angela K. Sheehan et al.**

# Youth Suicide: Addressing the Issue through Prevention and Intervention

## Symposium Introduction

**Christine M. Walrath**

Suicide claims the lives of nearly 4,000 young persons each year (National Adolescent Health Information Center [NAHIC], 2004) and is the third leading cause of death among 15-24 year old youth and the fifth leading cause of death among those 5-14 years old (SPAN USA). A relatively large percentage of youth enter service systems with suicidal thought and ideation or with histories of suicidal behavior. For example, among a sample of youth entering system of care services, 18.9% were referred for problems related to suicidal behavior and 18.4% had a reported history of suicide attempt—44.1% of which reported an attempt within the six months prior to service entry. The goal of the symposium was to provide information related to the reporting and experience of suicide among youth served within systems of care, to discuss recently funded federal youth prevention efforts and their evaluation, and to discuss the importance of integrating well-evaluated prevention efforts into system-of-care service environments.

## Reference

National Adolescent Health Information Center. (2004). *Fact sheet on suicide: Adolescents and young adults*. San Francisco, CA: Author. Retrieved August 12, 2005 from http://nahic.ucsf.edu/downloads/Suicide.pdf

## Congruence of Caregiver and Youth Reports of Suicidal Ideation and Suicide Attempts

**Anna Krivelyova & Robert L. Stephens**

### Introduction

Youth suicide ranks third among causes of death for youth age 15–24 (Anderson & Smith, 2003), making it one of America's leading public health concerns. From a public health perspective, efforts should be addressed at preventing suicide by increasing awareness of the factors associated with youth suicide, improving effective referral to treatment, and enhancing treatment options (U.S. Public Health Service, 1999). Yet, determining risk for suicide is complex because of respondent-related factors (e.g., reluctance to disclose, minimization of risk) that can limit interpretability of self-reports (Velting, Rathus, & Asnis, 1998).

Measuring youth suicide risk is complicated further by issues related to the source of information (e.g., youth vs. caregiver). This is particularly relevant in systems of care funded through the Comprehensive Community Mental Health Services for Children and Their Families program of the Center for Mental Health Services (CMHS). The system of care program is founded in part on the principle that the ecological context of the family is central to the care of all children (CMHS, 2001). Families often function as advocates and primary decision-makers for their children's treatment. How well families serve that role may depend in part on the level of congruence between caregiver and child perspectives (Siminoff, Rose, Zhang, & Zyzanski, 2005), particularly with regard to the child's behavioral and emotional problems. The current study examines the congruence of caregiver and youth reports of suicidal ideation and suicide attempts and explores predictors of congruence.

## Methods

The sample was derived from the descriptive and outcome studies of the national evaluation of system of care communities funded by CMHS in 2003 and 2004. Final samples included 789 children and families with complete data on suicide ideation and 783 children and families with complete data on suicide attempts. In addition to demographic information, data for this study were drawn from caregivers' responses on four measures: the Behavioral and Emotional Rating Scale (BERS; Epstein, 2004), the Child Behavior Checklist (CBCL; Achenbach, 2001), the Columbia Impairment Scale (CIS; Bird et al., 1993), and the Caregiver Strain Questionnaire (CGSQ; Brannan, Heflinger, & Bickman, 1997).

## Results

Congruence of reporting of suicide ideation and suicide attempts between caregivers and youth were examined for each caregiver-youth dyad. For suicide ideation, four possible categories of congruence were created: (a) *neither* caregiver nor youth reported ideation, (b) *both* caregiver and youth reported ideation, (c) *caregiver* reported ideation and youth did not, and (d) *youth* reported ideation and caregiver did not. The same categories were created for suicide attempts. As Table 1 shows, caregivers were more likely to report ideation when youth did not. Conversely, youth were more likely to report suicide attempts when caregivers did not. There was agreement in only 48% of cases when suicide ideation was reported by at least one of the two respondents. When suicide attempts were reported by at least one of the respondents, only in about 53% of the cases did caregiver and youth both report the history of attempts.

**Table 1**
**Percentage of Dyads in each Congruence Category**

| Ideation (n = 789) | | Attempts (n = 783) | |
|---|---|---|---|
| *Category* | *Percentage* | *Category* | *Percentage* |
| Neither (*n* = 363) | 46.01% | Neither (*n* = 602) | 76.88% |
| Both (*n* = 223) | 28.26% | Both (*n* = 85) | 10.86% |
| Caregiver (*n* = 135) | 17.11% | Caregiver (*n* = 38) | 4.85% |
| Youth (*n* = 68) | 8.62% | Youth (*n* = 58) | 7.41% |

Table 2 compares characteristics of dyads across the three categories: *both*, *caregiver*, and *youth*. Multinomial logit was used to test the univariate differences across the categories using both as a reference category. For suicide ideation, the respondents in the *caregiver* category were significantly more likely to have a female child, had a child with a history of drug use, and report lower subjective internalizing strain. Respondents in the *youth* category were significantly less likely to have a caregiver who was youth's biological parent, and had a history of running away from home. Interestingly, higher strengths and functioning, as well as lower objective and subjective internalizing caregiver strain were associated with an increased likelihood for the respondents to be in the *youth* category. For suicide attempts, analysis of congruence revealed that respondents were significantly less likely to be in the *caregiver* category, if a child was a female and had lower strengths. History of drug use, lower objective strain, higher strengths and functioning were associated with a higher likelihood of respondents being in the *youth* category.

Next, all variables included in the univariate analysis were entered simultaneously into a multivariate model. The analysis of congruence in ideation reports indicated that respondents in the *caregiver* category were significantly less likely to have a female child, be an older caregiver, report lower child strengths, and were more likely have a child who reported having someone their own age to depend on in case of the problem of emergency. The respondents in the *youth* category were significantly less likely to have the caregiver who was youth's biological parent, had older caregivers, came from families who lived below poverty, and had higher strengths according to their caregiver's report.

**Table 2**
**Variable Means across Suicide Ideation and Attempts Reporting Congruence Categories**

| | Ideation (n = 426) | | | Attempts (n = 181) | | |
|---|---|---|---|---|---|---|
| | *Both* | *Caregiver* | *Youth* | *Both* | *Caregiver* | *Youth* |
| Female | 49.78% | 21.48%[a] | 47.06% | 58.82% | 39.47%[c] | 60.34% |
| Biological Parent | 86.10% | 87.41% | 64.71%[a] | 84.71% | 89.47% | 82.76% |
| Child Age | 14.05 | 13.76 | 13.65 | 14.62 | 13.92 | 14.02 |
| Caregiver Age | 40.23 | 41.55 | 45.00[a] | 40.93 | 40.08 | 40.00 |
| Other Adults in the House | 75.78% | 72.59% | 76.47% | 75.29% | 68.42% | 65.52% |
| Total Children in the House | 2.48 | 2.64 | 2.32 | 2.42 | 2.58 | 2.62 |
| Income Below Poverty | 41.26% | 43.7% | 52.94% | 44.71% | 39.47% | 43.10% |
| Caregiver Employed | 59.19% | 60.74% | 60.29% | 54.12% | 52.63% | 63.79% |
| Child Physically Abused | 28.25% | 22.96% | 27.94% | 35.29% | 36.84% | 18.97%* |
| Child Sexually Abused | 24.66% | 19.26% | 17.65% | 31.76% | 31.58% | 24.14% |
| Child Used Drugs | 26.46% | 15.56%[c] | 17.65% | 38.82% | 21.05% | 17.24%[b] |
| Runaway | 41.26% | 31.11% | 27.94%[c] | 51.76% | 47.37% | 39.66% |
| Someone Own Age to Talk to | 3.91 | 4 | 3.81 | 3.84 | 3.53 | 4.16 |
| Adult to Talk to | 4.14 | 4.17 | 3.91 | 4.2 | 3.92 | 4.17 |
| Someone Own Age to Depend on in Case of a Problem | 3.47 | 3.84 | 3.72 | 3.56 | 2.97 | 4.02 |
| Adult to Depend on in Case of a Problem | 4.6 | 4.81 | 4.72 | 4.56 | 4.34 | 4.55 |
| CGS Objective | 3.18 | 2.99 | 2.36[a] | 3.34 | 3.43 | 2.63[a] |
| CGS Subjective Externalizing | 2.61 | 2.65 | 2.27* | 2.49 | 2.68 | 2.53 |
| CGS Subjective Internalizing | 4.05 | 3.83[c] | 3.44[a] | 4.13 | 4.03 | 3.65** |
| Strength Index | 75.41 | 73.92 | 81.68** | 73.26 | 65.8[c] | 79.4[c] |
| CIS in Clinical Range | 88.34% | 87.41% | 75.00%[b] | 89.41% | 86.84% | 75.86%[c] |

[a]$p$-value < 0.001, [b]$p$-value < 0.01, [c]$p$-value < 0.05

The analysis of congruence suicide attempts reporting indicated that respondents in the *caregiver* category were significantly less likely to have a female child, reported lower child's strengths, but higher functioning. Respondents in the *youth* category were significantly less likely to have a history of physical abuse and drug use. Surprisingly, respondents in the *youth* category were more likely to report having an adult talk to.

## Summary

The preliminary results indicate caregivers were more likely to report ideation when youth did not. Conversely, youth were more likely to report suicide attempts when caregivers did not. The analysis of predictors of categories of congruence revealed a number of factors associated with respondents in each category, including child's gender, caregiver's age and relation to the child, poverty status of the family, child's risk factors such as history of physical abuse and drug use. The relationships between the congruence categories and caregiver reports of strain, child's strengths and functioning have to be explored further in a dynamic framework to account for the possible endogeneity problems (e.g., caregivers report lower strain because they do not know about their child's suicidal ideation).

## References

Anderson, R. N., & Smith, B. L. (2003). Deaths: Leading causes for 2001. *National Vital Statistics Reports, 52*(9), 1–85. Retrieved November 7, 2006, from http://www.cdc.gov/nchs/data/nvsr/nvsr52/nvsr52_09.pdf

Bird, H. R., Shaffer, D., Fisher, P., Gould, M. S., Staghezza, B., Chen, J. Y., et al. (1993). The Columbia Impairment Scale (CIS): Pilot findings on a measure of global impairment for children and adolescents. *International Journal of Methods in Psychiatric Research, 3*, 167-176.

Brannan, A. M., Heflinger, C. A., & Bickman, L. (1997). The Caregiver Strain Questionnaire: Measuring the impact on the family of living with a child with serious emotional disturbance. *Journal of Emotional and Behavioral Disorders, 5*(4), 212-222.

Center for Mental Health Services. (2001). *Annual report to Congress on the evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program, 2001.* Atlanta, GA: ORC Macro.

Epstein, M. H. (2004). *Behavioral and Emotional Rating Scale: A strength-based approach to assessment. Examiner's manual (2nd ed.).* Austin, TX: Pro-Ed.

Siminoff, L. A., Rose, J. H., Zhang, A., & Zyzanski, S. J. (2005). Measuring discord in treatment decision-making: Progress toward development of a cancer communication and decision-making assessment tool. *Psycho-Oncology. 15*: 528-540.

U.S. Public Health Service. (1999). *The Surgeon General's call to action to prevent suicide.* Washington, DC: U.S. Department of Health and Human Services. Retrieved August 19, 2005, from http://www.surgeongeneral.gov/library/calltoaction/default.htm

Velting, D. M., Rathus, J. H., & Asnis, G. M. (1998). Asking adolescents to explain discrepancies in self-reported suicidality. *Suicide and Life-Threatening Behavior, 28*(2), 187-196.

## Suicide Attempt Subsequent to Entering System of Care Services: How Often Does It Happen, and To Whom?

**Christine M. Walrath**

### Introduction

Prior suicide attempt is considered a risk factor for future suicidal behavior, and it has been demonstrated that youth who make repeated suicide attempts tend to experience more chronic problems (American Association of Suicidology, 2004). Furthermore, some evidence suggests that keeping children in treatment may indeed reduce the risk of future suicidal ideation and behavior (Levin, 2005). From these perspectives alone, understanding the characteristics of children who attempt suicide after entering a system of care service environment is critically important. Prior research related to suicidal behavior among youth entering system of care service environments has suggested that youth who enter these systems with varying suicide attempt histories have different clinical and psychosocial profiles and differentially improve related to functional outcomes over their first six months of service (Mandell, Walrath & Goldston, 2006; Walrath, Mandell, Liao, Holden, DeCarolis et al., 2001). Specifically, children and youth who enter the systems with prior histories of repeat suicide attempts demonstrate a number of psychosocial problems including physical abuse, sexual abuse, runaway behavior, substance use, and functional impairment. Furthermore, these youth on average demonstrate the greatest improvement in functioning across their first six months of service.

To date, however, little research has been conducted which investigates the suicide rates among youth after entering services, along with the characteristics (caregiver and youth reported) that distinguish those youth with and without suicide attempt, following service entry. This paper uses national evaluation data gathered from system-of-care communities funded in 2002-2004 to better understand these characteristics.

## Methods

### Participants

This study used a subset of baseline and outcome data collected as part of Descriptive and Longitudinal Outcome Studies of the national evaluation between 2002 and 2006 from up to 29 communities across the United States. Children enrolled in the outcome study with valid data on suicide attempt history at six-month follow-up were included in the current study sample ($N$ = 1,001). Of those children in the sample, 15.2% had a suicide attempt history prior to entering the system of care and 5.4% attempted following entry into the system of care. Of those that attempted suicide post-service entry, 46% had a history of attempt and 54% did not. Children and youth in the current study sample were approximately 11.8 years of age on average. Nearly one-third (32%) of the sample was female, and 21.6% reported a Hispanic ethnic origin. The race composition of the sample was predominantly White (42%) and African-American (31.5%).

### Indicators and Measures

The data used in the current study were collected via caregiver and youth interview at the child's intake into system-of-care services and at a six-month follow-up interview. Data were collected on caregiver and youth report of child and family demographic and psychosocial information; child and family behavior and functioning; child and family satisfaction with services; and number of services received. The indicators and measures are described in Table 1.

Suicide attempt during the first six months of services was based on the combined responses (*yes*/*no*) from independent caregiver and youth questions that asked (at six-month follow-up) whether the youth had attempted suicide in the prior six months. A *yes* by either the caregiver or youth classified the youth as a suicide attempt.

### Analysis

Due to the relatively small but critically important number of suicide attempts during the initial six months of service ($n$ = 54), multivariate analyses were not performed. Rather—in an effort to clearly inform clinicians of characteristics of independent importance in the identification, treatment, and prevention of suicide attempt—bivariate analyses were performed. Specifically, the relationships (i.e., *t*-test and chi-square analyses) between suicide attempt during the first six months of services and demographic (five characteristics), psychosocial, and clinical characteristics were independently explored. Bonferroni corrections were utilized for the interpretation of findings due to the large number of independent analyses performed.

## Results

Demographic, psychosocial, clinical, and service experience characteristics appear independently associated with suicide attempt during the first six months. Interestingly, strong relationships exist between suicide attempt after service entry and experiences that occurred prior to service entry. In addition, clinical characteristics measured at intake as well as six-month follow-up are related to suicide attempt during the first six months of services.

Specifically, while race/ethnicity and age do not appear related to attempt after service entry, youth who attempt suicide are more often female than those who do not attempt (52% vs. 30.8%, respectively). Child-related psychosocial characteristics appear more related to suicide attempt post-service entry than family psychosocial characteristics. For example, a larger percentage of youth who attempt suicide during their first six months of service, as compared to those who do not, reported (at intake into service) lifetime experience of sexual abuse (38.3% vs. 16.4%, respectively); physical abuse (41.2% vs. 22.5%, respectively); running away (47.1% vs. 29.4%, respectively); substance use problems (28.0% vs. 15.2%, respectively); and not surprisingly caregiver and youth reported prior suicide attempt (Caregiver: 46.0% vs. 13.5%, respectively / Youth: 65.0% vs. 19.6%, respectively) and ideation

**Table 1**
**Indicators and Measures at Intake and Six Months**

| Indicator Measure | Caregiver Report | Youth Report |
|---|:---:|:---:|
| **Demographic** | | |
| Sex | ✓ | |
| Age | ✓ | |
| Race/Ethnicity | ✓ | |
| **Child and Family Psychosocial Characteristics** | | |
| Child history of sexual abuse | ✓ | |
| Child history of physical abuse | ✓ | |
| Child history of running away | ✓ | |
| Child history of substance use problem | ✓ | |
| Child ever talked/thought about suicide | ✓ | ✓ |
| Child every attempted suicide | ✓ | ✓ |
| Child exposure to domestic violence | ✓ | |
| Child lived in house with criminal | ✓ | |
| Biological family member with substance use problem | ✓ | |
| Biological family member with mental illness | ✓ | |
| Child exposed to violent crime in last six months | | ✓ |
| Child victim of crime in last six months | | ✓ |
| **Clinical Characteristics at Service Entry** | | |
| Columbia Impairment Scale (CIS; Bird et al., 1993) total score | ✓ | |
| Child Behavior Checklist (CBCL; Achenbach, 2001) internalizing and externalizing scores | ✓ | |
| Reynolds Adolescent Depression Scale (RADS) total | | ✓ |
| Reynolds Child and Adolescent Manifest Anxiety Scale (RCMAS) total | | ✓ |
| Behavioral and Emotional Strengths (BERS; Epstein, 2004) index | ✓ | ✓ |
| Caregiver Strain Questionnaire (CGSQ; Brannan et al., 1997) global strain | ✓ | |
| **Clinical Characteristics at 6-month Follow-up** | | |
| Columbia Impairment Scale (CIS; Bird et al., 1993) total score | ✓ | |
| Child Behavior Checklist (CBCL) total problem score (Achenbach, et. al., 2000) | ✓ | |
| Reynolds Adolescent Depression Scale (RADS-2) total (Reynolds, 1986) | | ✓ |
| Reynolds Child and Adolescent Manifest Anxiety Scale (RCMAS) total (Reynolds & Richmond, 1978) | | ✓ |
| Behavioral and Emotional Strengths (BERS-2) index (Epstein, 2004) | ✓ | ✓ |
| Caregiver Strain Questionnaire (CGSQ) global strain (Brannan, et al., 1998) | ✓ | |
| **Service Experience at 6-month Follow-up** | | |
| Number of services received | ✓ | |
| Youth Services Survey (YSS) total | ✓ | ✓ |

(Caregiver: 68.6% vs. 41.1%, respectively / Youth: 73.2% vs. 38.1%, respectively). Caregiver related lifetime experience (e.g., family mental illness, substance problems, etc.) appear unrelated to the suicide attempt in a youth post-service entry.

Youth who attempt suicide post-service entry demonstrate higher average scores on the internalizing scale of the Child Behavior Checklist (CBCL; Achenbach, 2001) as compared to those who do not attempt, whether measured at intake into services (Intake: 70.7 vs. 65.9, respectively / six-month Follow-up: 70.0 vs. 63.1, respectively) or at six-month follow-up. In addition, these youth also demonstrate higher average externalizing scores on the six month CBCL when compared to those who do not attempt (71.7 vs. 68.0). Furthermore, youth who attempt suicide post-service entry also demonstrate higher average Reynolds Adolescent Depression Scale (RADS) scores (Intake: 60.1 vs. 52.6, respectively / six-month Follow-up: 58.3 vs. 50.3, respectively) and Reynolds Child and Adolescent Manifest Anxiety Scales (RCMAS) scores (Intake: 60.7 vs. 54.5, respectively / six-month Follow-up: 58.6 vs. 52.3, respectively) when compared to those who do not attempt when measured at intake and six months. Strengths, caregiver strain, and life functioning—at intake into service or six-month follow-up—do not significantly differ as a function of suicide attempt status post-service entry. Finally, while youth and caregiver perception of the care received during the first six months does not appear related to suicide attempt during that same time, those children who attempted suicide received more services on average than those who did not (7.2 vs. 5.5).

## Conclusion

While more controlled and multivariable analysis with larger sample sizes are warranted, these findings appear to suggest that a range of characteristics, both clinical and non-clinical, appear related to suicide attempt after service entry—and each of these must be seriously considered in the context of intervention and prevention. In addition, the findings suggest that the deleterious lifetime exposures of children prior to entering a system of care may not be immediately ameliorated through the comprehensive service system environment. Furthermore, it appears that the children who are attempting suicide after entering services may have complicated, severe and chronic problems that are not immediately responsive to the numerous services they receive. These findings suggest the need for heightened clinical awareness and attention to youth entering service systems with suicide attempt histories, and indicate the potential benefit for a systematic suicide risk assessment upon entry into services and then periodically thereafter. Furthermore, these findings indicate the need for provider training, in-service or otherwise, around not only suicide risk assessment but also the delivery of appropriate services to suicide attempters, survivors and their families. Finally, potentially crucial additions to existing service arrays include postvention services both for the families of youth who die by suicide and their service providers.

## References

American Association of Suicidology (2004). *Youth suicide fact sheet*. Retrieved October 15, 2006 from http://www.suicidology.org/associations/1045/files/Youth2003.pdf

Bird, H. R., Shaffer, D., Fisher, P., Gould, M. S., Staghezza, B., Chen, J. Y., et al. (1993). The Columbia Impairment Scale (CIS): Pilot findings on a measure of global impairment for children and adolescents. *International Journal of Methods in Psychiatric Research, 3*, 167-176.

Brannan, A. M., Heflinger, C. A., & Bickman, L. (1997). The Caregiver Strain Questionnaire: Measuring the impact on the family of living with a child with serious emotional disturbance. *Journal of Emotional and Behavioral Disorders, 5*(4), 212-222.

Epstein, M. H. (2004). *Behavioral and Emotional Rating Scale: A strength-based approach to assessment. Examiner's manual (2nd ed.)*. Austin, TX: Pro-Ed.

Levin, A. (2005). Keeping Youth in Treatment Reduces Suicide Attempts. *Psychiatric News, 40*(8), 45.

Mandell, D.S., Walrath, C.M., Goldston, D.B. (2006).Variation in functioning, psychosocial characteristics and six-month outcomes among suicidal youth in Comprehensive Community Mental Health Services. *Suicide and Life-Threatening Behavior, 36*(3), 349-362.

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

## Suicide Prevention: The Garrett Lee Smith Youth Suicide and Early Intervention Program

**Angela Sheehan & Christine M. Walrath**

### Introduction

The Garrett Lee Smith (GLS) Memorial Suicide Prevention Initiative is a federally funded initiative that provides support to States, Tribal communities and Campuses across the country to implement youth suicide prevention activities. The GLS Suicide Prevention Initiative was a culmination of several federal efforts to address suicide as a preventable public health problem and is administered by the Center for Mental Health Services (CMHS) of the Substance Abuse Mental Health Services Administration (SAMHSA). The GLS Suicide Prevention Initiative includes three primary evaluation components, including self-evaluations, a cross-site evaluation, and performance measurement and accountability. The presentation provided an overview of the GLS Suicide Prevention Initiative, including purpose and primary activities, as well as an overview of the cross-site evaluation design; the presentation particularly focused on what information exists related to suicide prevention activities, what information is still needed, and how the cross-site evaluation was designed to address those gaps.

### The GLS Memorial Early Intervention and Suicide Prevention Program

The Garrett Lee Smith (GLS) Memorial Suicide Prevention Initiative is the first federally funded initiative developed to support States, Tribes, and University/College campuses across the country in implementing suicide prevention strategies and programs. The Garrett Lee Smith Memorial Act (GLSMA), which created the GLS Suicide Prevention Initiative, was signed into law by President Bush on October 21, 2004 after several efforts in recent years to focus on suicide as a public health problem and develop a national strategy. These efforts were included in *Reducing Suicide: The Surgeon General's Call to Action* (U.S. Public Health Service, 1999), the *National Strategy for Suicide Prevention* (U.S. Public Health Service, 2001), and *The President's New Freedom Commission on Mental Health - Achieving the Promise: Transforming Mental Health Care in America* (New Freedom Commission on Mental Health, 2005), all of which consider suicide as a preventable public health problem and call for a national strategy to prevent suicide.

In October 2004, the GLSMA authorized the use of $82 million over three years to support States, Tribal communities, and Colleges and Universities to develop and implement various suicide prevention initiatives and in 2005, an additional $27 million was authorized. The result of this legislation was the creation of the GLS State/Tribal Youth Suicide Prevention and Early Intervention Program and the GLS Campus Suicide Prevention Program administered by the Center for Mental Health Services (CMHS) of the Substance Abuse Mental Health Services Administration (SAMHSA).

As part of the State/Tribal Early Intervention and Suicide Prevention Program (State/Tribal Program), SAMHSA awarded cooperative agreements to 22 States and Tribal communities in FY 2005 and 14 States and Tribal communities in FY 2006 to support the implementation of State Suicide Prevention Strategies. The primary objective of the State/Tribal Program is to support suicide prevention activities ranging from early intervention and assessment for youth at risk for mental or emotional disorders; information and awareness campaigns to inform gatekeepers, family members, peers, and others about

the risk factors associated with youth suicide; to training physicians, educators, and providers to identify youth who exhibit at-risk behavior for youth suicide.

SAMHSA awarded cooperative agreements to 22 Campuses in FY 2005 and 35 Campuses in FY 2006 as part of the Campus Suicide Prevention Program (Campus Program). Activities funded under the Campus Program can include educational seminars, training programs for students and faculty, preparation of educational materials for families, preparation of informational materials for students and faculty/staff, the operation of suicide prevention hotlines and development of Campus infrastructures to link students to mental health care. Campuses funded under the GLS Suicide Prevention Program can implement any of these fundable activities.

In addition to providing funding for suicide prevention activities, the GLSMA in recognition of the need for research and evaluation of suicide prevention programs mandated a cross-site evaluation, which serves as the primary mechanism through which the initiative will be understood, improved, and sustained. Although evaluations of specific suicide prevention programs have demonstrated positive proximal outcomes, such as the impact of programs on provider knowledge or provider behaviors in identifying risk factors, little is known about intermediate outcomes, such as whether youth identified at risk are able to access treatment and if so, the type of treatment accessed, and even less is known about the impact of suicide prevention efforts on long-term outcomes, such as suicide attempts and deaths by suicide. In response to this federal mandate, SAMHSA contracted Macro International Inc. to design and implement the GLS State/Tribal and Campus Suicide Prevention cross-site evaluation. The cross-site evaluation builds on what is known about proximal outcomes and includes evaluation components designed to capture intermediate outcomes, which hopefully will lead to a better understanding of long-term outcomes such as suicide attempts and deaths and related data collection.

What follows is a description of the GLS Suicide Prevention Initiative as well as the cross-site evaluation. The cross-site evaluation approach is discussed in the context of the need for information on intermediary factors so that suicide prevention can be better understood.

## Cross-site Evaluation Design

The GLS Suicide Prevention cross-site evaluation includes four evaluation stages encompassing seven data collection or information gathering activities, all designed to capture process, proximal and intermediate outcomes.

*Context Stage*. The purpose of the context stage is to assess contextual information related to suicide prevention program plans and implementation, as well as to assess the availability and accessibility of existing data sources. The information gathered through the context stage will be used to provide context for interpretation of evaluation findings and to highlight successes and challenges associated with suicide prevention program implementation.

*Product Stage.* The purpose of the product stage is to describe the development and utilization of products and services to support each State/Tribal and Campus suicide prevention program. It will be important not only to document the types of products and services utilized, but also to assess whether any relationships exist between the types of products and services utilized and proximal outcomes, such as change in knowledge or awareness of suicide.

*Process Stage.* The process stage of the cross-site evaluation will assess progress on key activities related to implementation of each grantee's suicide prevention plans. The process stage for the State/Tribal Suicide Prevention Program includes an assessment of training activities, including a quantitative and qualitative component, and an assessment of referral networks and local collaboration to support early identification and treatment services for at risk youth. The process stage for the Campus Suicide Prevention Program includes a quantitative and qualitative component. The quantitative component provides descriptive information on the types of training participants and activities implemented on

each campus and an assessment of exposure to suicide prevention activities, knowledge and awareness of suicide related factors among students and faculty/staff on campuses. The qualitative component includes key informant interviews to assess the campus culture as it relates to suicide.

To further assess progress on key suicide prevention activities among State/Tribal grantees, the cross-site evaluation will analyze existing suicide prevention program information, which is tracked locally. The Early Identification, Referral and Follow-up (EIRF) Analysis will analyze existing program information that tracks the number of youth identified at risk as a result of early identification activities, the youth who are referred for services, and the youth who present for services. This information is tracked locally as part of suicide prevention program activities and will be shared with the cross-site evaluation team for analysis to determine the impact of suicide prevention program activities. This is a key component of the cross-site evaluation because it tracks critical prevention program activities. However, because it utilizes existing data there is no data collection instrument and no respondent burden. Therefore, we are not requesting Office of Management and Budget (OMB) clearance for the EIRF but included it in this statement for background purposes.

***Impact Stage.*** The purpose of the impact stage is to assess the intermediary factors that lead to prevention, such as early identification and receipt of appropriate services. Information on youth referred for services and service receipt as a result of early identification activities will be analyzed to assess whether early identification activities such as gatekeeper training or screening activities result in referrals and receipt of services. In addition, this stage of the evaluation will provide a better understanding of the results of each suicide prevention activity for comparison purposes.

## Conclusions

The GLS Suicide Prevention Initiative and cross-site evaluation are important efforts designed to support States, Tribes and University/College campuses in implementing youth suicide prevention activities, and to learn from those efforts to further advance the field of suicide prevention. This initiative will promote the existence and quality of collaborations and infrastructures to support youth suicide prevention and will specifically result in increased community capacity, via gatekeeper training and screening efforts, to identify at risk youth and link them to appropriate service options—some of which will likely be sought in system of care environments. The cross-site evaluation of this initiative will provide valuable information about the specific suicide prevention efforts being implemented across the United States and its territories, the collaborations being foraged, linkages made, and youth referred into treatment. The ground breaking effort to apply federal funding to community-based suicide prevention programming results in critical resources at the community level which are now available to inform, augment, and support existing community-based service dollars such as the systems of care in their effort to provide support to high risk youth.

## References

Garrett Lee Smith Memorial Act, Public Law 108-355 (2004).

New Freedom Commission on Mental Health. (2005). *Achieving the promise: Transforming mental heath care in America*. Final report (DHHS Pub No. SMA-03-3832). Rockville, MD: U.S. Department of Health and Human Services.

U.S. Public Health Service. (1999). *The Surgeon General's call to action to prevent suicide*. Washington, DC: U.S. Department of Health and Human Services. Retrieved August 19, 2005, from http://www. surgeongeneral.gov/library/calltoaction/default.htm

U.S. Public Health Service. (2001). *National strategy for suicide prevention: Goals and objectives for action. Rockville, MD: U.S. Department of Health and Human Services*. Retrieved August 19, 2005, from http:// www.mentalhealth.samhsa.gov/suicideprevention/strategy.asp

## *Symposium Discussion*

**Sylvia K. Fisher**

These important papers provide significant clinical and diagnostic information about youth at risk for suicide to help identify significant systems of care (SOC) community level interventions for these youth.

Walrath's study finds that youth who have attempted suicide prior to entering SOCs are more likely to attempt suicide after entering SOC services. Although suicide attempt history alone should alert providers to at risk youth, these youth also report physical and sexual abuse histories, running away, drug/alcohol use, and significantly higher levels of depression, anxiety, and internalizing behavior. This profile of diagnostic and clinically significant behavior should raise a red flag to SOC communities in identifying at risk youth. The author recommends instituting suicide risk assessment and reassessment procedures in SOC communities and providing appropriate training to SOC providers to ameliorate the risk of repeated suicide attempts by youth.

Krivelyova & Stephens' study identifies discrepancies in the congruence between caregiver and youth reports about youth suicide attempts. The authors are encouraged to more acutely define what constitutes an actual "suicide attempt;" that is, what behavior do youth classify as an "attempt?" Do youth engage in suicidal ideation and speculation, but define this behavior as a "suicide attempt"? Some anecdotal evidence substantiates this view and accounts for why caregivers do not report the youth's suicidal ideation as constituting a "suicide attempt"—this may help explain the discrepancy between caregiver and youth reports. The authors are commended for identifying a potentially fruitful area of future suicide research.

Sheehan & Walrath document their use of the context, process, product, and impact approach as the basis for the cross-site evaluation of the Garret Lee Smith (GLS) initiative, which incorporates extensive collection and tracking activities assessing various program dimensions. The authors might consider the following in interpreting study findings: (a) Do previously existing agencies, resources, and services within GLS communities constitute a "baseline" of services requiring the effects of the GLS initiative to be "teased out" from the effects of these other independent suicide prevention initiatives? (b) Are gatekeeper training programs and screening procedures applied equally across sites or should the effect of "dose" be considered in interpreting results and program effectiveness? (c) Do prevention efforts "spill over" into intervention and postvention activities and affect the interpretation of study findings? This evaluation is likely to be a milestone in the area of evaluation of suicide prevention programs.

Future research efforts should examine whether: (a) the intersection of the suicide and trauma literatures can identify and spotlight "heightened risk"; (b) anecdotal data, such as provider's clinical impressions, sibling reports, etc. provides a more comprehensive clinical profile of at risk youth; and (c) the clinical trajectory of youth attempters who "age out" of systems of care can be tracked so outcomes are better documented.

## CONTRIBUTING AUTHORS

**Sylvia Fisher, PhD**
*Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Room 6-1047, Rockville, MD 20857, 240-276-1923, email: Sylvia.Fisher@samhsa.hhs.gov*

**Anna Krivelyova, MA**
*Project Manager, Macro International Inc., 3 Corporate Square, Suite 370, Atlanta, GA 30305, 404-321-3211, email: Anna.Krivelyova@macrointernational.com*

**Angela Sheehan, MPA***
*Project Manager, Macro International Inc., 116 John Street, Suite 800, New York, NY 10038, email: aksheehan@yahoo.com*

**Robert L. Stephens, PhD, MPH**
*Technical Director, Macro International Inc., 3 Corporate Square, Suite 370, Atlanta, GA 30305, 404-321-3211, email: Robert.L.Stephens@macrointernational.com*

**Christine M. Walrath, PhD**
*Vice President, Macro International Inc., 116 John Street, Suite 800, New York, NY 10038, 212-941-5555, email: cwalrath@macrointernational.com*


*\*At the time of presentation and writing Ms. Sheehan was affiliated with Macro International, however she has since left the organization.*

# Researching the Needs of Gay, Lesbian, Bisexual, Transgendered, Questioning, Intersexed, and Two-Spirit (LGBTQI2-S) Youth in Systems of Care

Sylvia K. Fisher
Jeffrey M. Poirier

## Introduction

Lesbian, gay, bisexual, transgendered, questioning, intersexed, and two-spirit (LGBTQI2-S) youth (sometimes referred to collectively as *sexual minority* youth) are frequently underserved in all mental health services, including systems of care (SOC). This is partly because considerable social censure exists for this population of youth, resulting in a climate that is not conducive to LGBTQI2-S youth seeking needed assistance from mental health providers. In addition, LGBTQI2-S youth may not receive appropriate and culturally and linguistically competent mental health interventions because of the limited availability of useful resources and practice guides for providers within SOC communities.

The Child, Adolescent and Family Branch (CAFB) in the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration recognizes that useful and appropriate materials are needed for SOC communities seeking to identify appropriate strategies and interventions for this underserved population. Accordingly, CAFB is currently developing a Promising Practice Brief for SOC program directors based upon the results of interviews conducted with LGBTQI2-S youth in this study. Recommendations for future research and practice interventions with LGBTQI2-S youth are included in this summary of findings.

## Methods

*Recruitment and compensation.* We used a snowball sampling method to identify LGBTQI2-S youth in SOC communities. To recruit youth, SOC staff posted information about the sessions and interviews and spoke with youth who might be interested. Individual or group information sessions were held with participating youth, recruited from various parts of the country including the northeast, midwest, south, and southwest. We obtained informed consent from all youth and parental consent and assent for youth 17 years old or younger. Youth participants received a $25 honorarium.

*Data collection.* A detailed semi-structured interview protocol was developed to conduct in-depth interviews with nine[1] sexual minority youth. Youth were queried about their experiences, attitudes, and beliefs regarding: (a) self-identification, coming out, and related experiences; (b) cultural and linguistic competence issues; (c) SOC services and supports that helped them; (d) barriers to care and SOC services for LGBTQI2-S youth that could be improved; and (e) other insights they wanted to share.

*Self-reported characteristics of participating youth.* Four of the nine youth were under 18 years of age; five were 18 years or older. Youth identified their sexual orientation as: gay; homosexual; lesbian; came out as a lesbian but still trying to identify a label; varies between gay and bisexual; queer; asexual; and, "no word to describe it." Youth identified their gender identity as: male; female; non-gendered on the masculine side; sometimes male, sometimes female trapped inside a male body; gender is fluid; biologically female but "gender queer"; butch (female sex but dresses like a boy); nongendered; and unsure.

## Findings

*Challenge of identification.* Participants verified that a LGBTQI2-S youth culture exists and that sexual minority youth often adopt norms unique to their community (e.g., vernacular, style of dress, participation in social events) when identifying as LGBTQI2-S youth. However, some sexual minority youth prefer not to self-identify, choosing to avoid recognized labels about either their sexual orientation and/or their gender identity. They may choose to leave their identity unnamed or use a unique term that is meaningful to them, but which may not be recognized by others. They may also be less likely to

---

[1]*Having nine subjects eliminated the need for OMB approval.*

participate in groups or attend events that emphasize LGBTQI2-S identity, which are frequently drawn upon by researchers to identify study participants.

*Cultural and linguistic competence issues.* LGBTQI2-S members of racial and ethnic minorities often have a cultural filter that moderates their experience, which can reflect multiple and often conflicting norms, values, and beliefs. Stigma associated with being LGBTQI2-S is compounded in youth who also have mental health challenges, resulting in double stigmatization; LGBTQI2-S youth of color with mental health needs can suffer from triple stigmatization. Youth advised SOC communities to (a) screen foster care families to ensure that they will accept and treat LGBTQI2-S youth appropriately; (b) make training available to treatment and non-treatment staff on sexual minority issues, including cultural and linguistic issues; (c) ensure appropriate services are available for sexual minority youth that are sensitive to the multiple needs of these youth, including peer and family relations, emerging sexuality and dating, and physical and mental health; and (d) facilitate these youths' access to appropriate services.

*System of Care/treatment issues.* Youth raised concerns about the lack of privacy and confidentiality relative to their sexual minority status. One youth reported that the idea of confidentiality in foster care and therapy "is a joke." Youth shared concerns about the roles of youth advocates (YA), reporting that YAs are not easily accessible and that treatment staff become upset when youth approach YAs with issues. Youth reported that they fear judgment from others.

*Mental health challenges and physical health issues.* Youth recommended that SOC communities be aware that mental health challenges are sometimes intensified when youth experience difficulties after they come out. While there is a need for support during the coming out process, there is often a concurrent negative response and removal of sources of support that can affect the youth's physical and mental health. They also recommended that resources and information on sexually transmitted diseases and infections be provided freely to interested youth.

*Reported hopelessness and helplessness among youth.* Some youth identified the following triggers for hopelessness: coming out; internal conflict with gender role and body that do not fit; and, lack of a strong support system. Triggers not related to gender identity or sexual orientation included: college plans; relationships with foster parents; and expectations and pressures from others including therapists, caseworkers, peers, and teachers. One youth resorted to "cutting" and attempting suicide, whereas others sought help from therapists. About half of the youth reported never feeling hopeless or helpless.

## Youth Recommendations for Improving SOC Services for LGBTQI2-S Youth

Youth made a number of suggestions for improving SOC services, including:

- Provide opportunities for youth to receive services not connected to SOCs (e.g., a gay youth group), so youth can speak openly about their identity and exert some control over their lives and what others know about them.
- Provide a community center for LGBTQI2-S youth to come together and/or safe places for youth to get information within their communities; online resources are helpful, but youth also need "a face to talk to."
- Provide resources, information, and trainings on sexual minority issues to SOC social workers, physicians, psychiatrists, and therapists.
- Ensure that agency forms have gender-neutral language and "safe" (non-gendered) bathrooms for transgender youth.
- Educate and train staff before they work with youth; do not rely on youth to teach agency staff about LGBTQI2-S issues or provide them with resources (this way, youth can feel less guarded and receive more effective therapy).
- Therapists should openly discuss LGBTQI2-S identity issues with youth.
- Providers should not automatically assume that youth are dating opposite-sex persons.
- Providers should be more supportive and sometimes just listen without judgment.

**Recommendations for Researchers**

Conducting data collection activities with LGBTQI2-S youth who may perceive themselves to be at risk regarding their sexual orientation and/or gender identity requires sensitivity and ingenuity. Researchers working with this population also need to be culturally and linguistically competent, as these youth have idioms and cultural mores, as do many other youth sub-groups. Because more youth are choosing not to identify using terms such as LGBTQI2-S, the recruiting process of these youth for interviews and research studies can be complicated. Researchers should consider youth culture and new forms of self-identification and examine alternate ways to identify sexual minority youth to participate in future research.

## Conclusions

LGBTQI2-S youth have challenges in response to their sexual orientation and/or gender identity status that are compounded when they have mental health challenges. Peer and family rejection as a result of the youth's sexual minority identity can affect the youth's mental and physical health and intensify mental health challenges. These youth need supports and resources for themselves and their families. Further, families need information and supports, which are currently very limited, when youth come out. Providers and SOC communities also need accessible resources to serve these youth and their families. Youth who do not self-identify as LGBTQI2-S may be less likely to obtain support from sources geared to LGBTQI2-S youth and may have fewer supports available for them. All youth need peer supports and information about developmental milestones.

Future activities designed to address the needs of LGBTQI2-S youth include the development of (a) a second Practice Brief for LGBTQI2-S youth; (b) a support guide for caregivers and families of LGBTQI2-S youth that answers questions, addresses misconceptions, and suggests ways to meet the needs of LGBTQI2-S youth; and, (c) a trauma curriculum to address the needs of LGBTQI2-S youth who have been traumatized as a result of their identity (including specialized modules for two-spirit, transgendered, and foster care youth). Finally, the CAFB is instituting a National Advisory Group on LGTBQI2-S issues in SOC communities to provide guidance, expertise, and oversight in addressing the needs of LGBTQI2-S youth and their families in SOC communities.

## CONTRIBUTING AUTHORS

**Sylvia Kay Fisher, PhD**
*Director of Evaluation, Child, Adolescent & Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road Room 6-1047, Rockville, MD 20857, 240-276-1923, fax: 240-276-1930, email: sylvia.fisher@samhsa.hhs.gov*

**Jeffrey M. Poirier, MA**
*Senior Research Analyst, American Institutes for Research, 1000 Thomas Jefferson St., NW, Washington, D.C. 20007, 202-403-5368, fax: 202-403-5001, email: jpoirier@air.org*