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Addressing the Barriers to Mental Health Services for Inner City Children and Their Caretakers

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ABSTRACT: This paper will outline a series of three research studies meant to identify factors related to child mental health service usage and barriers to help seeking for urban minority children and their caretakers. In addition, this paper will describe the systematic development and evaluation of a telephone intervention strategy aimed towards increasing overall attendance at initial intake appointments at an urban child serving agency. The first study explores differences in demographic variables, for two groups of children (n=450), those that came to an initial intake interview and those that requested child mental health services, but failed to come to any scheduled appointments. The second study evaluates a telephone engagement intervention meant to increase initial attendance (n=54). Finally, the third study, more rigorously evaluates the impact of an intensive telephone intervention on initial attendance rates by randomly assigning families to the more focused telephone intervention or a "business as usual" telephone screening (n=108).

Developing the means to address barriers to help seeking is critical given that lower income, minority children are at greater risk for the

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development of psychopathology. The prevalence of psychiatric disorders among children has been found to range from 17% to 26% (Brandenburg et al., 1987; Landsverk et al., 1994; Tuma, 1989). It has been estimated that two thirds of children in need of mental health services never receive them. Of the youth who are referred, 50 to 75% do not initiate treatment or drop out prematurely (Kazdin, 1993). There are clear indications that the most vulnerable client populations, particularly poor, minority children and families are less likely to be met by responsive service providers and relevant intervention modalities (Kazdin, 1993; Tuma, 1989; Brandenburg et al. 1987; Cheung & Snowden, 1989; Flaskerud, 1986; Gary, 1982; Jacobs, 1979; Sue, 1977). This paper will outline a series of three research studies meant to identify factors related to child mental health service usage and barriers to help seeking for urban, minority children and their caretakers. In addition, this paper will describe the systematic development and evaluation of a telephone intervention strategy meant to increase overall attendance at initial intake appointments at an urban child serving agency. The first study explores differences in demographic variables, for two groups of children (n=450), those that came to an initial intake interview and those that requested child mental health services, but failed to come to any scheduled appointments. The second pilot study evaluates a telephone engagement intervention meant to increase initial attendance (n=54). Finally, the third study, more rigorously evaluates the impact of an intensive telephone intervention on initial attendance rates by randomly assigning families to the more focused telephone intervention or a "business as usual" telephone screening (n=108).

All three studies were conducted at the Institute for Juvenile Research (IJR), the Child Psychiatry Division of the University of Illinois at Chicago. IJR is an inner city, child mental health agency, with 67.3% of the children living with their mothers as single parent households. Approximately, 85% of the 450 families who requested services last year were supported by Public Assistance. Almost two thirds of children seen at the agency are African American, 12% are Hispanic and the remaining portion are White.

REVIEW OF SIGNIFICANT LITERATURE

There are clear indications that the most vulnerable client populations in terms of the seriousness of presenting problems or complexity of their social situation, are less likely to be retained beyond the first

mental health session or to discontinue services early in the process (Cohen, 1993; Bui et al., 1992; Kazdin, 1989; Wahler & Dumas, 1989; Miller & Prinz, 1991; Russel, Lang & Brett, 1987; Armstrong et al., 1984). Studies have also documented tendencies for lower income clients to rely on emergency services and more intensive treatment modalities, such as residential care, rather than outpatient mental health services (Zahner, et al., 1992).

To some extent, barriers to the utilization of mental health services by lower income, minority clients have been explored. Underutilization has been explained by the stigma associated with counseling services; lack of information regarding available services; inaccessible locations; unresponsive service providers and reliance on alternative methods of help (Wallen, 1992; Sue et al., 1991; Flaskerud, 1986; Muecke, 1983; Acosta, 1980; Sue & Morishima, 1983; Lin, 1983; Keefe et al., 1979; Aponte et al., 1991; Boyd-Franklin, 1993).

Traditionally, engagement within the helping fields have been addressed in terms of "compliance," (Mull, Wood, Gans & Mull, 1989; Steffenson & Colker, 1982) and "resistance," (Birchler, 1988; Stanton & Todd, 1981). Strategies to address client reluctance to change are often offered (Schlosberg & Kagan, 1988; Anderson, 1980).

The intensive telephone intervention developed for the second study to be presented is based on the investigator's previous work examining the process of engagement of inner city children and their families from an ecological perspective (Tolan, McKay et al., 1995; Germain, 1980; Bronfenbrenner, 1979). From this perspective, barriers to engagement are not seen as exclusively resulting in a clients "unwillingness to change." Rather, barriers of engagement can be found within a child's behavior, the beliefs and experiences of the family and, lack of sensitivity by workers and, agency procedures. Under utilization of mental health services has been explained by concrete obstacles, such as inaccessible locations and lack of information about available services (Acosta, 1980; Baekeland & Lundwall, 1975; Sue & Morishima, 1982; Windle, 1980). In addition, family attitudes about professionals as opposed to more informal sources of help has been identified as critical to the engagement of minority families (Lin, 1983; Keefe et al., 1979; Leaf et al., 1985; Maduro, 1983; Snow, 1983).

The potential usefulness of a telephone intervention was supported by the literature, where there were indications that more focused telephone intake procedures can increase engagement and utilization of mental health services. Shivack & Sullivan (1991) reported a 32% increase in attendance when the client was simply reminded of their appointment. Szapocznik (1988) achieved significant success engaging

adolescent substance abusers and their families through use of an intensive, structural family therapy intervention via telephone. Of the families that were randomly assigned to the "business as usual" engagement process, 57.7% failed to come to their first clinic appointment. In comparison, 7.1% of families in the experimental condition failed their intake appointment. There are also indications that their engagement method had impact beyond attendance at intake. In the control group, 41% of cases that were engaged eventually dropped out of treatment prematurely, whereas only 17% of the families intensively engaged later dropped out of treatment.

Caretakers' experiences with service providers appears to be critical in understanding service utilization, since their involvement is necessary if children are to receive services. A therapist's ability to assess client expectations for treatment and offer services that were perceived to match these expectations has been found to significantly relate to treatment engagement and outcome (Crane, Griffin & Hill, 1986). The need for minority families to be met with sensitivity and respect by service providers is stressed continually within the clinical literature (Boyd-Franklin, 1993; Aponte, 1991).

METHODS

The series of studies were conducted to meet the following objectives: 1) to document demographic characteristics of those children and families who requested mental health services at an urban agency; 2) to explore differences between those children and families that requested services and those that actually came for an intake appointment; 3) to identify factors that would predict attendance at the initial appointment and; 4) to develop and evaluate a telephone intervention strategy based upon the empirical findings of previous mental health services literature.

Study #1

First, an exploratory study aimed at evaluating differences between children and families who requested an intake appointment and those that actually came for an initial interview was conducted. Of the 450 children who were referred consecutively to IJR and an intake appointment was scheduled, the following demographic information was obtained: age of identified child, gender of child, primary and secondary presenting problem, history of abuse/neglect, primary and secondary caretaker, court involvement, zip code and number of additional children within the home. These children were then tracked through the intake system at the agency.

Study #2

The next study which aimed to systematically develop and evaluate a telephone intervention strategy to address barriers to the utilization of mental health services. Its primary goal was to increase overall attendance at initial intake appointments.

Two master's level interns, under the direction of a clinical faculty member implemented the 30 minute telephone engagement intervention. This intervention was linked to the clinical and empirical literature and focused on clearly defining the process of obtaining services. It was meant to help the primary caretaker invest in the help seeking process by clearly identifying their child's presenting difficulties; framing caretaker's actions as having the potential to impact the current situation and having the caretaker take some concrete steps to address the situation even prior to the initial appointment. In addition, the intervention was meant to systematically explore barriers to help seeking, both within the family and the environment. For example, experience with previous helpers was explored. Issues related to poverty, community violence and racism were raised within the interview. Finally, an active problem solving approach was used to develop the means to address obstacles to contact with the agency.

A sample of twenty-seven telephone intervention cases were compared to the first twenty-seven cases scheduled for intake appointments in the same month of the previous year (n=27).

Study #3

Next, in order to address some of the limitations of the previous study related to sample size and design, the investigator evaluated the telephone intervention strategy by randomly assigning 108 new requests for child mental health services to one of two conditions. In the first condition, 55 telephone intakes were assigned for a thirty minute, intensive engagement intervention with two Master's level social workers. The second condition consisted of a routine telephone screening, lasting approximately 30 minutes, related to presenting problem of child and appropriate fit for agency with a third master's level social worker (n=53).

RESULTS

Study #1

Only 277 of the 450 children accepted for intake appointments were ever brought in by their caretaker. In relation to gender of the child, 63.5% (n=290) of all children accepted for service at the agency were male, however, only 176 (63.5%) actually came for an intake appointment. In comparison, girls were more likely to be brought to at least one appointment. Of the 160 girls accepted for intake appointments, 101 actually came to at least one appointment. Chi square analyses reveal significant differences in attendance rates by gender ($x=19.19$, $p<.001$). When primary caretaker was considered, 302 children (67.1%) were being cared for by their mothers at the time of the initial call to the agency. Only 170 of these children (61.4%) were ever seen for a first interview. Children who were parented by foster care givers were more likely to come in for scheduled appointments; 119 intakes were scheduled by foster parents and 91 of those appointments were kept. Again, chi square analyses revealed significant

differences between these groups in relation to intake attendance ($x=27.39$, $p<.001$).

In relation to presenting problem, children were most likely to be referred for aggressive behavior (n=106 intakes scheduled) or ADHD symptoms (n=79). However, only 62 of aggressive children and 35 of children presenting with ADHD features ever came for an initial appointment. Children identified as having been severely abused or experiencing severe trauma were more likely to be brought to an appointment (22 appointments scheduled vs. 16 appointments kept). Chi square analyses revealed significant differences in show rates between children with disruptive behavior difficulties and those that presented themselves to the agency after severe trauma ($x=12.81$, $p<.01$). Children who did not have court involvement more often contacted the agency (n=309), but only 173 of these children were ever brought to the agency. Families who were involved with the Juvenile Court were more likely to follow through with a scheduled intake appointment (103 of the 137 intake appointments were kept) $x=15.08$, $p<.001$).

Study #2

Results reveal that the engagement strategy tested increased initial appointment attendance by 29% in comparison to the more traditional telephone intake procedures. Of the intervention families, only 6 did not come to an initial appointment, in comparison to 14 no shows for them in the same month the preceding year. Chi square analyses revealed a significant increase in intake attendance for the intervention children and families ($x=5.08$, $p<.05$).

Study #3

Of the 55 families that received the telephone intervention, 72.7% (n=40) came to the first appointment or called at least a day prior to the interview to reschedule. Of those that underwent the more traditional screening, only 45.3% came to the appointment or called independently. Chi square analyses revealed significant results ($x=8.42$, $p<.01$).

Logistic regression was then used to explore contribution of age of child, court involvement, primary caretaker and gender of the child. However, these demographic variables did not add significant explanation.

Although not significant, some trends did emerge. For example, in relation to children identified as aggressive, only 50% came to the first

appointment, whereas 81% of children with other types of presenting difficulties came to intake. Adolescents (over 12 years) came to the first appointment approximately 50% of the time, while younger children were brought to 63% of the initial appointments.

DISCUSSION

Thus far, the telephone engagement intervention discussed above has demonstrated efficacy for increasing initial attendance by inner city families. However, its impact in relation to ongoing engagement is still being evaluated. Clearly, this type of engagement intervention has increased the efficiency and productivity of intake workers at the agency site. Although no-shows continue to occur, their frequency has noticeably diminished. Further research is needed to accurately estimate the cost effectiveness of this approach and the impact that such a shift in agency procedure has on efficiency, staff morale, etc.

The limitations of the current studies, namely small sample sizes and less rigorous designs, need to be addressed in further studies. The scope of such engagement research also needs to expand beyond the focus of demographic variables. There is a clear need to more systematically evaluate the impact of a range of factors both within individual family units, but also within the larger environments and the mental health agencies themselves. For example, the clinical literature indicates that such variables as the impact of previous mental health service utilization, attitudes about professionalized services, previous experiences with helping institutions, severity of child behavioral difficulties or caretakers expectations of themselves and service providers should be included in future engagement research.

Providing adequate mental health services to those in need has been a national priority for the last twenty years. However, social services continue to be underutilized by vulnerable populations, like minority children (Hu, et al., 1991; Wallen, 1992). During the last decade, mental health practitioners have had to address increasingly complex urban issues related to poverty, homelessness, single parent households, community violence, substance abuse and increases of out of home placements due to abuse or neglect (Minkler, Roe & Price, 1992). Clearly, children are most vulnerable to these serious social problems, yet if they are African-American or from a low income family, they are more likely to experience barriers to social service utilization (Cheung, et al., 1989).

The foundation for any future child mental health services research is the ability to engage children and their caretakers in services. If clients do not access services or remain in service for a sufficient period of time, the efficacy of any mental health treatment cannot be tested. Larger research initiatives are clearly needed if there is to be an increase in quality and access to care by minority children and families. This paper has begun to examine issues related to increased use of outpatient child mental health services. This line of research addresses aspects of the growing concern about the inappropriate use of more costly, restrictive treatment for children (Wallen, 1992).

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