

Philadelphia College of Osteopathic Medicine DigitalCommons@PCOM

PCOM Psychology Dissertations

Student Dissertations, Theses and Papers

2013

Youth Treatment Adherence at a Rural Community Mental-Health Clinic

Asma S. Ali

Philadelphia College of Osteopathic Medicine, asmash@pcom.edu

Follow this and additional works at: http://digitalcommons.pcom.edu/psychology_dissertations

 Part of the [Clinical Psychology Commons](#)

Recommended Citation

Ali, Asma S., "Youth Treatment Adherence at a Rural Community Mental-Health Clinic" (2013). *PCOM Psychology Dissertations*. Paper 254.

This Dissertation is brought to you for free and open access by the Student Dissertations, Theses and Papers at DigitalCommons@PCOM. It has been accepted for inclusion in PCOM Psychology Dissertations by an authorized administrator of DigitalCommons@PCOM. For more information, please contact library@pcom.edu.

Philadelphia College of Osteopathic Medicine

Department of Psychology

YOUTH TREATMENT ADHERENCE AT A RURAL COMMUNITY
MENTAL-HEALTH CLINIC

Asma S. Ali

Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Psychology

June 2013

**PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE
DEPARTMENT OF PSYCHOLOGY**

Dissertation Approval

This is to certify that the thesis presented to us by Asma Ali
on the 22nd day of May, 2013, in partial fulfillment of the requirements for the degree of
Doctor of Psychology, has been examined and is acceptable in both scholarship and
literary quality.

Committee Members' Signatures:

Susan Panichelli-Mindel, PhD, Chairperson

Barabara A. Golden, PsyD, ABPP

Josephine White, PhD

Robert A. DiTomasso, PhD, ABPP, Chair, Department of Psychology

Acknowledgements

My sincerest thanks outstretch to all the important people in my life, who have been patient, understanding, and supportive while I have worked on this study. Specifically, I would like to thank my loving husband. He whole-heartedly understood the time, effort, and attention this took, and always provided support and motivation to encourage my hard work, and for that, I love him even more. I would also like to thank the rest of my family for being so patient and always understanding why phone conversations had to end prematurely. I love you all very much too. I would also like to thank my dissertation chair for her guidance and mentorship from day one to the very end. She was exceptional at providing her expertise and was always available for consult, never letting me down. Additionally, my second and third chairs were gracious in allowing me to work with them and receive their support and feedback, fostering further critical thinking. Lastly, I am very appreciative to have been granted permission to complete this study at a clinic that strives to provide mental health services to those in need in hopes of learning information that can be provided back to the clinic in order to facilitate treatment adherence to those truly in need.

Abstract

This study examined the relationships between youth and adult psychopathology, and sociodemographic factors and treatment adherence for youth attending outpatient treatment at a rural community mental-health clinic. “Adherence” was defined as attending more than five sessions, while “non-adherence” was defined as attending fewer than or equal to five sessions. Results revealed no significant differences between youth adhering or not adhering to treatment depending on the relation of caregiver to youth or the mode of transportation taken to the clinic. Furthermore, caregiver and youth psychopathology and caregiver’s estimated travel time to the clinic did not predict treatment adherence. Incidentally, examination of sociodemographic variables revealed that caregivers and youth who spoke Spanish in the home were more likely to adhere to treatment. Additionally, supplemental analyses examining psychopathology and treatment adherence using a “total treatment” operational definition found that higher levels of youth anxiety predicted adherence to treatment. Implications of these results are discussed.

Table of Contents

List of Tables	vi
Introduction.....	1
Statement of the Problem	1
Literature Review	2
Community Mental-Health Clinics (CMHCs)	2
Barriers-to-Treatment Model.....	4
Nonadherence and Effects of Variables	5
Purpose of the Study	10
Hypotheses	12
Method	13
Overview	13
Participants	13
Inclusion Criteria.....	14
Exclusion Criteria.....	15
Recruitment of Subjects	15
Measures.....	15
Beck Anxiety Inventory	15
Beck Depression Inventory, Second Edition.....	16
Behavior Assessment System for Children, Second Edition.....	16
Demographic Questionnaire.....	16
Agency Intake Form	16
Procedure.....	17
Results	19
Caregiver/Youth Psychopathology and Travel Hypotheses, Logistic Regressions	19
Caregiver Relation and Mode of Transportation Hypotheses, Chi-Square Tests	20
Primary Language Spoken, Chi-Square Tests.....	20
Sociodemographic Analyses, Chi-Square Tests.....	21
Exploratory Analyses, Linear Regressions	22
Discussion.....	25
Findings	25
Proposed Hypotheses.....	25
Caregiver/Youth Psychopathology and Continuous Sessions.....	27
Sociodemographic Results	28
Implications for CMHC	30
Benefits of the Study	31
Limitations	32
Future Direction	33
References	36
Appendices.....	43
Appendix A. Data Checklist.....	43
Appendix B. Demographic Questionnaire	44
Appendix C. Agency Intake Form	48
Appendix D. Instructions	54

List of Tables

Table 1. Contribution of Variables to the Prediction of Nonadherence/Adherence	19
Table 2. Cross Tabulation: Primary Language Spoken and Nonadherence/Adherence	20
Table 3. Chi-Square Tests: Primary Language Spoken and Nonadherence/Adherence....	21
Table 4. Cross Tabulation: Sociodemographic Factors and Nonadherence/Adherence....	22
Table 5. Contribution of Youth Variables in the Prediction of Sessions Attended	23
Table 6. Contribution of Caregiver Variables in the Prediction of Sessions Attended	24

Introduction

Statement of the Problem

There is a dearth of research investigating nonadherence in community mental-health clinics (CMHCs) where treatment endpoints are undefined. Instead, research often examines nonadherence in patients participating in randomized clinical trials in a university-based setting (Kazdin & Wassell, 1999; Nock & Kazdin, 2005; Werba, Eyberg, Boggs, & Algina, 2006). Randomized clinical trials often use manualized treatments for an allotted number of sessions (Miller, Southam-Gerow, & Allin Jr., 2008). Generalizing results from randomized clinical trials to community-based clinics can be problematic, since differences have been found among those individuals being treated in a randomized clinical trial versus at a community-based clinic (Miller, et al., 2008; Southam-Gerow, Chorpita, Miller, & Gleacher, 2008;).

Randomized clinical trials typically provide grant-supported treatment at a university-based setting to individuals who have been referred by a practitioner to treat a single disorder (Southam-Gerow, et al., 2008). In contrast, community-based clinics typically provide public-funded treatment to individuals who have comorbid diagnoses after being referred to treatment by governmental agencies (e.g., social services, courts); (Southam-Gerow, et al., 2008). CMHCs were created to provide treatment to a population typically comprised of ethnic minorities and persons of low socioeconomic status (Miller, et al., 2008). CMHCs provide services for minorities and people who are economically disadvantaged because they are the most likely to withdraw from treatment (Barrett, Chua, Crits-Cristoph, Gibbons, & Thompson, 2008).

Literature Review

Approximately 6,000,000 adults, youth, and families seek treatment from CMHCs each year (Sherman, Barnum, Nyberg, & Buhman-Wiggs, 2008). On average, individuals seek out treatment at CHMCs for four sessions (Fraps, McReynolds, Beck, & Heisler, 1982; Hansen, Lambert & Forman, 2002). Research suggests that continuing treatment beyond the first few sessions and for the recommended duration of treatment are associated with treatment gains (Hansen, et al., 2002; Miller, et al., 2008). When psychotherapy ends earlier than recommended, individuals do not receive effective delivery of therapeutic services to alleviate psychological distress (Barrett, et al., 2008). If left untreated, these psychological symptoms and/or distress may be exacerbated. The implications of mental-health issues left untreated include impaired social functioning (Weissman et al., 2006). Research suggests that disruptive behaviors during childhood and adolescence predict delinquent behaviors in the future and, if left untreated, may lead to poor prognoses (Boggs et al., 2004). Focusing on nonadherence for youth receiving services at a CMHC is important because these youth are at risk for dropping out of treatment and not receiving services, possibly leading to difficulties (Barrett et al., 2008; Weissman et al., 2006).

Community Mental-Health Clinics (CMHCs).

CMHCs were created to provide services for minorities and people who are economically disadvantaged, specifically because this population was the most likely to withdraw from treatment (Barrett et al., 2008). Research has shown that minority youth have a high rate of admission to outpatient mental-health treatment centers, 719.5 per 100,000 individuals (Bui & Takeuchi, 1992). Moreover, social agencies and schools refer

African American and Latino youth for mental-health treatment at higher rates than they refer Caucasian youth (McMiller & Weisz, 1996). Since minorities have a higher rate of admission and referral to outpatient services, CMHC fulfill a crucial need as existing service providers available to this population (Bui & Takeuchi, 1992).

Hansen et al. (2002) completed a review of clinical trial research by gathering data from 2,971 individuals at six therapeutic sites. These researchers assessed the average number of sessions attended and the rate of therapeutic improvement based on an outcome questionnaire. Results from this review indicated that more than 33% of individuals receiving treatment in an applied setting (e.g., training CMHC, state CMHC), attended only one session. Furthermore, data from these six therapeutic sites indicated that, on average, an individual was seen for treatment at a CMHC for four sessions (Hansen et al., 2002). The percentage of patients who met criteria for improvement when the average number of sessions (four) was attended was less than 25% (Hansen et al., 2002). Typically, most evidence-based treatments utilize more than eight sessions, and if on average four sessions are attended, youth may be receiving insufficient treatment, leading to decreased levels of improvement (Hansen et al., 2002; Miller et al., 2008).

Armbruster and Schwab-Stone (1994) conducted a study examining the sociodemographic characteristics (e.g., socioeconomic status, minority status, and parental status) of families who discontinued treatment in an urban, university-based youth guidance clinic. This study included 555 youth over a 2-year period. Researchers categorized patients into two groups: either dropouts or continuers of treatment. Dropouts were defined as patients who did not show up for their sessions, cancelled repeatedly with no additional contact with the agency, or refused to follow treatment

recommendations, whereas continuers were defined as patients who agreed to follow treatment recommendations. Results indicated that 41% of families discontinued treatment and were considered dropouts (Armbruster & Schwab-Stone, 1994). Additionally, 50% of minorities discontinued treatment, whereas 38% of nonminorities discontinued treatment (Armbruster & Schwab-Stone, 1994). Minorities were also more likely to come from families of lower socioeconomic status and single-parent households. Based upon this study, salient sociodemographic characteristics, specifically socioeconomic status, minority status, and parental status may be associated with nonadherence to treatment (Armbruster & Schwab-Stone, 1994).

Barriers-to-Treatment Model. According to Kazdin, Holland, and Crowley (1997), a barriers-to-treatment model was used to conceptualize treatment adherence in a study evaluating nonadherence of youth receiving treatment at an outpatient facility. According to this model, families who experience barriers to treatment are more likely to drop out. The barriers-to-treatment model also suggests that families going to treatment are burdened by the seeking of treatment in and of itself, which contributes to an additional stressor in their lives. Furthermore, attending treatment and adhering to the application of treatment techniques have the potential of creating discord within the family. In turn, barriers can cause increased stress, thus reducing the likelihood of adhering to treatment (Kazdin & Wassell, 2000). The authors conceptualized barriers as encompassing three domains: practical obstacles, treatment demands and irrelevancy of treatment, and poor therapeutic alliance (Kazdin et al., 1997).

Nonadherence and Effects of Variables.

Kazdin et al. (1997) evaluated how family/parent/child characteristics, parental experiences with therapy, and the existence of practical barriers influenced nonadherence in a group of 242 youth receiving services at an outpatient treatment clinic. Participants were assessed with multiple measures: a general information sheet, Risk Factor Interview, Adverse Family Child-Rearing Practices Scale, Child History of Antisocial Behavior Scale, Parent History of Antisocial Behavior Scale, Parenting Stress Index, Life Stress Scale, and Barriers-to-Treatment Participation Scale.

Overall, results indicated that young maternal age, single-parent households, harsh parental practices, parental history of antisocial behavior, and severe reports of youth antisocial behaviors predicted dropping out of treatment (Kazdin et al., 1997). Families were also more likely to drop out of treatment if practical barriers to treatment increased (e.g., obstacles coming to treatment, child-care issues). Additionally, parents were more likely to drop out of treatment if they perceived treatment as irrelevant or if they had a poor therapeutic relationship with the therapist (Kazdin et al., 1997).

Of youth seeking mental-health treatment, 40 to 60% do not adhere to treatment (Kazdin, 1996; Wierzbicki & Pekarik, 1993). This high rate of nonadherence highlights the importance of examining which variables influence adherence such as sociodemographic, clinical, and caregiver-child variables (Miller et al., 2008). Youth are usually referred to treatment by caregivers, teachers, or others who might perceive problems or difficulties within the youth; hence, youth are rarely the ones initiating treatment (Kazdin, 1996). Furthermore, youth rely on caregivers to facilitate the continuation of treatment. Given the influence caregivers have in the treatment process

(e.g., bringing the child to treatment and paying for the treatment), caregiver and family characteristics likely impact whether treatment is continued or discontinued (Kazdin, 1996). Studying nonadherence allows one to better understand different sociodemographic, clinical, and caregiver-child variables that may be associated with nonadherence (Kazdin, 1996; Miller et al., 2008).

Nonadherence has been defined and studied several ways in existing literature. According to Kazdin (1996), dropout occurs under three conditions: the patient leaves treatment early on (possibly after the first session), the patient solely makes the decision to leave treatment, and the therapist perceives the decision to leave treatment as a poor choice. Miller et al. (2008) used four definitions to operationalize nonadherence: intake retention, mutual termination, mean treatment duration, and total treatment. Intake retention was defined as individuals who remained in treatment for at least one appointment after the initial intake. Mutual termination was defined as individuals who stopped treatment based on consensual agreement with the therapist. Mean treatment duration was defined as individuals who attended the mean number of sessions before ending therapy. Total treatment was defined as the total number of sessions attended by the individual (Miller et al., 2008).

Based on the definition used by Miller et al. (2008), adherence will be operationally defined in the current study as youth who stay in treatment for more than the average number of sessions attended for this population. Nonadherence will be defined as youth who stay in treatment for less than or equal to the average number of sessions attended for this population.

Parental Psychopathology. The rate of psychiatric disorders has increased in youth who live with caregivers who have affective disorders (Beardslee, Gladstone, Wright, & Cooper, 2003). Approximately 61% of youth who have a caregiver who suffers from major depressive disorder will develop a psychiatric disorder as they age, and these youth are four times more likely to suffer from an affective disorder than youth who do not have a caregiver with an affective disorder (Beardslee et al., 2003). Youth are also at an increased risk for developing an internalizing disorder or externalizing disorder if they have a caregiver who suffers from an affective disorder versus a caregiver who does not suffer from an affective disorder (Beardslee et al., 2003).

Mental illness has been shown to impact parenting within various disorders, specifically depression (Maybery & Reupert, 2009). Caregiver depression is known to be a risk factor for anxiety, disruptive behaviors, and major depressive disorders in youth (Weissman et al., 2006). If a mother has depression, she is more likely to be less affectionate and emotionally responsive than a mother without depression (Maybery & Reupert, 2009). Caregiver depression has also been associated with less familial communication and cohesion (Maybery & Reupert, 2009). Caregiver mood disorders apparently affect youth by predisposing them to developing mental-health issues or resulting in other interpersonal difficulties, but research is needed to assess if caregiver mood disorders also affect youth compliance to treatment.

Literature assessing how caregiver anxiety influences youth nonadherence is lacking. Instead, literature has focused more on adults with anxiety disorders and nonadherence (Issakidis & Andrews, 2004). Specifically, studies on nonadherence among adults with anxiety disorders have indicated that approximately half of patients scheduled

for treatment do not begin or complete treatment (Issakidis & Andrews, 2004). Adults who have anxiety disorders tend to have higher nonadherence rates than those of whom do not have an anxiety disorder. Since caregivers often initiate and decide the outcome for youth continuing treatment, further research is needed to assess if caregiver anxiety may also affect youth nonadherence rates (Nock, Phil, & Kazdin, 2001).

Youth Psychopathology. Evans, Radunovich, Cornette, Wiens, and Roy (2008) noted that youth with high level T-scores on the Child Behavior Checklist, poor functioning, and comorbid diagnoses were more likely than youth with low level T-Scores to miss therapy appointments. Research on attrition with youth has focused primarily on youth with externalizing disorders (Kazdin & Wassell, 1999; Miller et al., 2008). Youth with externalizing disorders often have poor prognoses, which are predicted by lower socioeconomic status, single-parent family status, parental depression, parental stress, and a severity of youth dysfunction (Kazdin & Wassell, 1999). However, limited research has been completed on nonadherence with youth who have internalizing disorders, and the research that exists presents mixed results regarding sociodemographic and clinical variables that may influence nonadherence.

Kendall and Sugarman (1997) completed a study examining the difference between completers and terminators for 190 youth seeking individual cognitive-behavioral treatment for anxiety disorders at a university-based anxiety disorder clinic. Results indicated that terminators in this study had sociodemographic characteristics similar to those of youth with externalizing disorders, such as living in a single-parent household and being an ethnic minority. However, youth had fewer anxiety symptoms. Pina, Silverman, Weems, Kurtines, and Goldman (2003) examined sociodemographic

and clinical characteristics of 197 youth completers and noncompleters receiving exposure-based cognitive-behavioral treatment at a university-based anxiety disorder clinic. Findings from their study indicated no differences between sociodemographic and clinical characteristics of youth completers and noncompleters. The results from these studies suggest that differences may exist between sociodemographic characteristics and symptom severity when analyzing youth who suffer from externalizing and internalizing disorders (Kazdin & Wassell, 1999; Kendall & Sugarman, 1997; Pina et al., 2003). More research is needed to assess if and how youth psychopathology and sociodemographic variables influence nonadherence.

Caregivers. Research has suggested that caregivers of youth with emotional and behavioral disorders experience a range of distress caused by their caregiving responsibilities (Brannan & Heflinger, 2006). Strains include, but are not limited to, family disruptions, interruptions at work, limited time availability, fatigue, sadness, guilt, and parental stress (Brannan & Heflinger, 2006). Kinship caregivers (e.g., grandparents, siblings) also experience caregiver strain to a degree similar to that experienced by biological caregivers (Brannan & Heflinger, 2006). Since youth rely on caregivers to facilitate the continuation of treatment, caregiver and family characteristics likely impact adherence to treatment (Kazdin, 1996). McKay and Bannon (2004) noted that nonbiological heads of household are likely to terminate youth treatment within 7 to 14 weeks of therapy. To date, research is limited investigating the possible effects of the caregiver relationship on the child. Given that many youth who seek treatment at a CMHC may be placed in an alternate caregiver home, a consideration of whether

caregiver relationship impacts treatment adherence would be beneficial (Barrett et al., 2008; Cheung & Snowden, 1990).

Location/Transportation. The distance traveled to receive treatment can be more pronounced in rural areas, where patients may have to travel long distances to obtain services. When patients need to travel long distances to receive services, the burden of travel may have an impact on treatment adherence (Swan-Kremeier, Mitchell, Twardowski, Lancaster, & Crosby, 2005). In addition to distance from the location of services, a lack of transportation also can impede one's ability to get to the treating clinic (Brannan & Heflinger 2006; Evans et al., 2008; Kazdin, 1996) Families that do not have a reliable form of transportation may need to rely on family, friends, or public transportation. Adherence to treatment is also negatively impacted if funds for transportation are not readily available because of economic disadvantage (e.g., low incomes, high poverty rates). Moreover, living in a rural area requires traveling longer distances to reach a clinic and subsequently, would cost more in gas mileage, possibly contributing to nonadherence resulting from financial strains (Zhang, Tao, & Andersen, 2003). In contrast, some studies have suggested that longer distances to treatment are not barriers to treatment when estimated miles are calculated (Fraps et al., 1982; Swan-Kremeier et al., 2005; Weisz, Weiss, & Langmeyer, 1987; Werba et al., 2006). More research is needed to examine whether caregiver estimates of distances in minutes traveled to a CMHC influence treatment adherence.

Purpose of the Study

Youth and families should attend therapy regularly and for the recommended duration (Miller et al., 2008). Symptomatic and functional impairment may persist or

exacerbate when therapy ends prematurely because the application of therapeutic skills does not have a chance to develop (Kazdin, 1996; Wierzbicki & Pekarik, 1993).

Additionally, youth who have untreated mental-health issues are more likely to engage in delinquent behavior, partake in activities of violent crime, drop out of school, abuse alcohol and drugs, engage in unsafe sex practices, engage in risky driving behaviors, engage in leisure activities with unfavorable peer groups, and remain unemployed (Nock & Photos, 2006). Furthermore, minority youth who do not receive mental-health treatment have a higher likelihood of being involved with the juvenile justice system (Shelton, 2004).

Nonadherence is also costly for clinics. Clinics often invest considerable time and money into providing treatment to patients, and when patients do not attend sessions, that time and money are lost (Weisz et al., 1987). Furthermore, nonadherence can affect others, as those seeking treatment may not be able to be seen by a therapist right away because appointments are being reserved for individuals who fail to show up or cancel appointments. Productivity of staff also decreases when patients do not show up for appointments, potentially influencing funding that is received from the state (Kazdin, 1996).

Clinical and sociodemographic variables may have an impact on treatment adherence. Consistent with the barriers-to-treatment model, parent and child characteristics (e.g., parental psychopathology) and practical barriers (e.g., obstacles coming to treatment) may impede treatment adherence (Kazdin, et al., 1997). Examining these variables may assist in discerning the factors that contribute to adherence and

nonadherence and, as a result, may encourage the development of strategies to foster treatment adherence.

Hypotheses

The present study examined the relationship between clinical and sociodemographic factors and treatment adherence for youth brought by their caregivers for treatment at a rural CMHC. Factors considered include caregiver internalizing symptoms, youth psychopathology, differences between the statuses of the caregiver relationship to the youth, and information concerning transportation to the clinic.

Five hypotheses were created to examine treatment adherence. First, caregiver anxiety and depression scores will predict youth treatment adherence of youth. Second, youth psychopathology scores (e.g., levels of anxiety, depression, aggression, and hyperactivity) will predict treatment adherence. Third, there will be a difference in whether youth adhere/do not adhere to treatment depending on the relation of caregiver (e.g., mother, grandmother, adoptive parent) to the youth. Fourth, there will be a difference in whether youth adhere/do not adhere to treatment depending on the mode of transportation (e.g., car, medical transportation) taken to the clinic. Fifth, the time taken to travel to the clinic (i.e., caregiver estimate of distance in minutes to the clinic) will predict treatment adherence.

Method

Overview

This study examined the relationship between various clinical and sociodemographic factors and treatment adherence for youth who were receiving counseling services at a local CMHC. Factors considered included caregiver internalizing symptoms, youth psychopathology, caregiver relation to youth, the mode of transportation taken to the clinic, and the estimated time of travel to the clinic.

Participants

The sample was comprised of families seeking outpatient counseling services for their respective youth at a rural CMHC in Southern New Jersey for various mental-health or behavioral issues. Sixty-seven caregivers consented to participate in this study; however, 18 of the 67 met exclusionary criteria. Therefore, a total of 49 families completed the study.

Of the 49 caregivers who brought their youth in for treatment, 65.3% were mothers, 20.4% were fathers, and 14.3% were comprised of grandmothers, aunts, adoptive mothers, or “other.”

Regarding education levels, 48.2% of caregivers graduated high school or obtained a general educational development diploma, 10.2% attended some college, 18.4% obtained some type of college degree, and the remainder had less than a high school level of education.

In regards to the ethnicity of the caregivers, 53.1% were Caucasian, 26.5% were Latino, 16.3% were African American, 2% were biracial, and 2.1% were identified as “other.” Additionally, 87.8% of the caregivers identified the primary language spoken in

the home as English, whereas 12.2% of caregivers identified the primary language spoken as Spanish.

Of the youth brought in for treatment, 55.1% were male and 44.9% were female, and they ranged in age from 6 to 17 years old. A total of 38.7% of youth were between the ages of 6 to 9 years old, 40.8% were between the ages of 10 to 13 years old, and 20.5% were between the ages of 14 to 17 years old.

In regards to the ethnicity of the youth, 44.9% were Caucasian, 28.6% were Latino, 14.3% were African American, 10.2% were biracial, and 2% were identified as “other.”

Of the families participating, 77.6% reported arriving to the clinic via a personal vehicle, 12.2% were driven by a family member or friend, and 10.2% arrived via medical transportation services or through other methods of transportation.

In terms of driving time, 18.3% of families indicated they traveled between 5 to 10 minutes to arrive to the clinic, 61.2% of families traveled between 11 to 20 minutes to arrive to the clinic, and 20.5% of families traveled between 21 to 30 minutes to arrive to the clinic.

Inclusion Criteria

Families were eligible to participate in the study if caregivers had a youth who was between the ages of 6 to 17 years old, and both the caregiver and youth were present during the intake. The caregiver was required to provide consent for the youth to receive counseling services for the treatment of a Primary Axis I diagnosis. All caregivers and youth were required to be fluent in English or Spanish.

Exclusion Criteria

Families were excluded from the study if youth were seeking only medication-monitoring services. Families were also excluded from the study if their youth were recommended for a higher level of care at initial intake or during the course of treatment, counseling services were already being obtained from another agency, drug or alcohol abuse was the primary diagnosis, intellectual disabilities were present, or a developmental diagnosis was present (e.g., Autism, Asperger's, or Pervasive Developmental Disorder).

Recruitment of Subjects

Potential families were seeking outpatient mental-health treatment for their children between the ages of 6 to 17 years old. Upon initial intake, caregivers were asked to participate in the study by the intake coordinator. If caregivers agreed, a written informed consent was obtained. Youth were screened for eligibility upon completion of intake by clinicians via the use of a data checklist (see Appendix A). If youth exhibited any exclusionary criteria, data were not included in the analyses.

Measures

Beck Anxiety Inventory (BAI; Aaron T. Beck, 1990 & 1993). The BAI is a 21-item, self-report questionnaire that assesses for levels of anxiety in adults. Caregivers were asked to rate their levels of anxiety on a 4-point rating scale. The BAI requires 5 to 10 minutes to complete and is available in Spanish and English. The BAI exhibits good reliability and validity. Internal consistency reliability ranges from .85 to .94, and test-retest reliability is .75 (Beck & Steer, 1993). Content, concurrent, construct, discriminant, and factorial validity are also reported to be high (Beck & Steer, 1993).

Beck Depression Inventory, Second Edition (BDI-II; Aaron T. Beck, Robert A. Steer, & Gregory K. Brown, 1996). The BDI-II is a 21-item, self-report questionnaire that assesses for levels of depression in adults. Caregivers were asked to rate their levels of depression on a 4-point Likert scale. The BDI-II requires 5 to 10 minutes to complete and is available in Spanish and English. The BDI-II exhibits good reliability and validity (Beck, Steer, & Brown, 1996). Test-retest reliability of the BDI-II is .93 (Beck et al., 1996). Discriminant and convergent validity are also reported to be high (Beck et al., 1996).

Behavior Assessment System for Children, Second Edition (BASC-II; Cecil Reynolds & Randy Kamphaus, 2004). The BASC-II is a self-report questionnaire for caregivers (Parent-Rating Scale [PRS]) that measures adaptive and problem behaviors in the community and home setting. The PRS requires 10 to 20 minutes to complete and is available in both Spanish and English versions. Caregivers rate items on a 4-point Likert scale. The measure is comprised of 16 clinical and adaptive scales. Test-retest reliability and interrater reliability for the BASC-II are high at .80 to .90 (Reynolds & Kamphaus, 2004). Divergent, convergent, concurrent, and construct validity are also reported to be high (Reynolds & Kamphaus, 2004).

Demographic Questionnaire (DQ). The DQ was created by the coinvestigator for the purpose of this study. The DQ is a self-report questionnaire, completed by caregivers, that assesses for various demographic variables (see Appendix B). This form was available in both Spanish and English.

Agency Intake Form. The Agency Intake Form, a standard clinical interview conducted at the intake with the caregiver and youth together, was created by the

Cumberland County Guidance Center. The Agency Intake Form is a structured diagnostic interview aimed to assess psychopathology in youth (see Appendix C). This interview was conducted by Master's-level clinicians trained in counseling and social work.

Procedure

The study was completed over the course of 9 months (September 2011 to June 2012) after approval was obtained from the Philadelphia College of Osteopathic Medicine's Institutional Review Board (IRB). Clinicians and intake counselors from the clinic were asked to participate in collecting data. Staff members who agreed to participate in data collection were trained to administer and store the experimental materials during a 1-hour training seminar. During this training seminar, staff was provided with copies of consent forms, instructions, and questionnaires, which were available in both English and Spanish. Accurate Language Services (a translating agency) translated all consent forms, instructions, and the Demographic Questionnaire into Spanish to reflect the same content as that of the English versions. The BAI, BDI-II, and BASC-II were also available in Spanish.

Staff was instructed that families would be invited to participate in the 40-minute study when initially meeting with the intake counselor. If interested in participating, families were asked to sign consent forms. They were provided with packets (in English or Spanish) containing brief instructions (see Appendix D) and all the questionnaires. Caregivers completed all the forms while they sat in the lobby and then gave the completed forms to the treating clinician prior to intake. Clinicians were instructed to scan item number 9 on the BDI-II questionnaire and assess for suicidal ideation.

Master's-level clinicians also assessed families using the Agency Intake Form to confirm that a Primary Axis I diagnosis was present in the youth.

After completing the intake, all clinicians reviewed a brief checklist within the experimental packet listing all exclusionary criteria. Clinicians were asked to check off any exclusionary criteria that were present, thereby, precluding the data from being evaluated. All clinicians at the clinic placed completed questionnaires and consent forms (whether included or excluded) in the coinvestigator's designated locked file cabinet for storage.

The coinvestigator then created a spreadsheet to log youth identification numbers and corresponding numbers (increasing in count) for each packet completed in order to deidentify packet material. The coinvestigator also reviewed and recorded the total number of sessions attended by youth. The frequency of sessions attended for each youth and the raw data from the questionnaires were then entered into the Statistical Package for the Social Sciences (SPSS).

Results

Youth attended an average of 5.45 sessions at the CMHC. Based upon this mean, “non-adherence” was defined as remaining in treatment for fewer than or equal to five sessions, and “adherence” was defined as remaining in treatment for more than five sessions.

Caregiver/Youth Psychopathology and Travel Hypotheses, Logistic Regressions

A Binary Logistic Regression was calculated to identify if caregiver anxiety and depression, youth psychopathology, and the estimated time required for the caregiver to travel to the clinic in minutes predicted youth adherence to treatment. Results indicated no predictive effects on youth adherence to treatment. See Table 1.

Table 1

Contribution of Variables to the Prediction of Nonadherence/Adherence

Variable in the model	β	Standard Error	p
Constant	1.57	2.06	0.444
β BAI score	0.02	0.04	0.529
β BDI-II score	0.06	0.04	0.201
β BASC-II hyperactivity score	0.01	0.03	0.834
β BASC-II aggression score	0.05	0.04	0.169
β BASC-II anxiety score	0.03	0.03	0.245
β BASC-II depression score	0.02	0.03	0.577
β Estimated time to travel	0.03	0.05	0.601

Caregiver Relation and Mode of Transportation Hypotheses, Chi-Square Tests

A chi-square test for independence was calculated to assess differences in treatment adherence depending on the relation of caregiver (e.g., mother, grandparent) to the youth and the mode of transportation taken to the clinic. There were no significant differences between treatment adherence and the relation of caregiver to the youth, $\chi^2(5, N = 49) = 7.886, p = 0.163$, or mode of transportation taken to the clinic, $\chi^2(3, N = 49) = 4.764, p = 0.190$.

Primary Language Spoken, Chi-Square Tests

A chi-square test was also calculated to determine differences in treatment adherence and the primary language spoken within the home for both caregivers and youth, $\chi^2(1, N = 49) = 4.574, p = 0.032$ (caregivers) and $\chi^2(1, N = 49) = 4.574, p = 0.032$ (youth). Caregivers and youth whose primary language spoken was Spanish were more likely to adhere to treatment than caregivers and youth whose primary language spoken was English. See Table 2 and 3.

Table 2

Cross Tabulation: Primary Language Spoken and Nonadherence/Adherence

Language Spoken		Nonadherence/Adherence		
		Less than or equal to 5 sessions	More than 5 sessions	Total
Primary language spoken	English	27	16	43
	Spanish	1	5	6
Total		28	21	49

Table 3

Chi-Square Tests: Primary Language Spoken and Nonadherence/Adherence

	Value	df	Asym. Sig. (2-sided)
Pearson chi-square	4.574 ^a	1	.032
Likelihood ration	2.884	1	.089
Linear-by-linear association	4.481	1	.034
N of valid cases	49		

^a 2 cells (50.0%) have expected count less than 5. Minimum expected count is 2.57.

Sociodemographic Analyses, Chi-Square Tests

A chi square test for independence was calculated to assess differences in treatment adherence depending on sociodemographic characteristics. There were no significant differences between treatment adherence and youth gender, grade level, ethnicity, and diagnoses; caregiver’s level of education and ethnicity; or family constellation (e.g., mother, father, nuclear family, or other). See Table 4.

Table 4

Cross Tabulation: Sociodemographic Factors and Nonadherence/Adherence

Sociodemographic	χ^2	<i>p</i>
Youth gender	0.110	0.740
Youth grade level of education	5.794	0.926
Youth ethnicity	2.551	0.636
Youth diagnoses	0.776	0.855
Caregiver level of education	8.814	0.184
Caregiver ethnicity	4.397	0.355
Family constellation	2.749	0.432

Exploratory Analyses, Linear Regressions

Additional exploratory analyses were completed to examine the relationship of psychopathology variables and treatment adherence when using a “total treatment” operational definition, versus using the original operational definitions of nonadherence and adherence. Total treatment was defined as the total number of sessions attended by the youth. Since sample size was small, there was not enough power to run all youth and caregiver psychopathology variables in a complete regression, so psychopathology variables were run as separate multiple linear regression analyses.

Multiple linear regression analyses were completed to determine if child psychopathology predicted number of sessions attended. Hyperactivity, Aggression, Anxiety, and Depression subscale scores of the BASC-II were added as potential predictors. Youth Anxiety was found to be a predictor approaching significance, $F(4, 44) = 2.53, p = 0.055$, explaining 11.3% of the variance (adjusted $R^2 = 0.113$). See Table 5.

Table 5

Contribution of Youth Variables in the Prediction of Sessions Attended

Variable in the model	β	Standard Error	p
Constant	1.19	4.07	0.771
β BASC-II hyperactivity score	0.04	0.06	0.514
β BASC-II aggression score	0.32	0.07	0.628
β BASC-II anxiety score	0.11	0.05	0.055
β BASC-II depression score	0.04	0.06	0.481

Since the BASC-II Anxiety score was the only independent variable approaching significance, a bivariate linear regression was performed with the BASC-II Anxiety score as the independent variable and the number of sessions attended as the dependent variable. The BASC-II Anxiety score significantly predicted the number of sessions attended, $F(1, 47) = 8.47, p = 0.006$. This model explains 15.3% of the variance (adjusted $R^2 = 0.153$). See Table 6.

Multiple linear regression analyses were completed to determine if caregiver psychopathology predicted number of sessions attended. Caregiver Depression and Anxiety scores from the BDI-II and BAI were added as potential predictors. Results indicated there were no predictive effects on the number of sessions attended.

Table 6

Contribution of Caregiver Variables in the Prediction of Sessions Attended

Variable in the model	β	Standard Error	p
Constant	3.45	0.79	0.000
β BAI score	0.05	0.06	0.408
β BDI-II score	0.03	0.06	0.641

Discussion

Findings

This study examined the relationship between various clinical and sociodemographic factors and treatment adherence for youth receiving counseling services at a rural CMHC. Primary clinical and sociodemographic factors considered included caregiver internalizing symptoms, youth psychopathology, caregiver relation to youth, and transportation variables. Data analyzed from families yielded no significant results to support any of the proposed hypotheses. No significant results were found implicating that sociodemographic characteristics influenced treatment adherence with the exception that caregivers and youth who spoke Spanish in the home were more likely to adhere to treatment than caregivers and youth who spoke English.

One possible reason for the lack of significant findings may be the small sample size, low power, and subsequent effect size. Small sample sizes result in low power, which makes difficult detection of actual differences that may exist. Additionally, power is weaker when statistical analyses are completed between groups of unequal sizes (Kazdin, 2003). A 9-month period for data collection was approved by the CMHC. To ensure adequate power, the primary investigator anticipated that 100 families would be needed; however, during the set data collection period, only 67 families participated.

Proposed Hypotheses. In contrast to the hypotheses, no relationship was found between caregiver relation (e.g., mother, father, foster parent) to the youth and treatment adherence. These results differ from the findings of McKay and Bannon (2004), which suggested that nonbiological caregivers were less likely than biological caregivers to adhere to youth treatment. The differing results from this study may be attributed to the

very few youth displaced into alternate caregiver homes (approximately 14%), whereas approximately 86% of youth were residing with a biological caregiver. The significant difference between the number of participants residing in biological caregiver homes and alternate caregiver homes prohibited the ability to compare these groups statistically.

Results did not support the hypotheses that the mode of transportation and the time required to travel to the clinic would influence treatment adherence. Transportation may not have been a barrier to treatment for the participants in this study, as most families were able to transport themselves to their appointment using personal cars. Additionally, the length of time required to arrive to the clinic may not have affected treatment adherence because most families arrived to the clinic within 11 to 20 minutes. Possessing a personal car would allow families to arrive reliably to the clinic within a reasonable amount of time (11 to 20 minutes); therefore, the mileage traveled for a bimonthly appointment may not have been perceived as a strain. These results are in accordance with research suggesting that distance traveled to treatment was not a barrier for attending mental-health appointment (Fraps et al., 1982; Swan-Kremeier et al., 2005; Weisz et al., 1987; Werba et al., 2006).

Furthermore, in the current study, caregivers and youth were given the option to have concurrent sessions. Consistent with Kazdin et al.'s (1997) barriers-to-treatment model, offering concurrent appointments to the caregiver and youth may mitigate the possibility of logistical and/or other practical barriers related to arriving to the appointments. By scheduling appointments at the same time for caregivers and youth, the CMHC afforded caregivers the opportunity to make one trip, arrange for a babysitter once a week, etc., thus making treatment attendance less of a burden.

It was also hypothesized that caregiver and youth psychopathology would predict youth treatment adherence; however, these hypotheses were not supported. These findings differ from the findings of Kazdin (1996) and Kazdin et al. (1997), which suggested discontinuation of youth mental-health treatment was associated with higher ratings of parental psychopathology and more severe ratings of youth psychopathology. Possibly, the current study did not find a significant relationship between caregiver and youth psychopathology and treatment adherence because of the study's small sample size. A small sample size reduces the power to detect statistically significant differences that may exist. Furthermore, a relationship may not have been found as a result of the operational definition for adherence. Adherence was defined as more than the average number of sessions attended for the total sample size; however, this definition may not have fully captured treatment adherence since individuals terminate treatment at different points in time, depending on variables such as diagnosis and symptom relief (Kazdin & Mazurick, 1994).

Caregiver/Youth Psychopathology and Continuous Sessions. To combat the possible problematic categorization of adherence, analyses were conducted to explore the relationship of caregiver and youth psychopathology and total treatment (the total number of sessions attended by the youth). No significant relationship was found between caregiver psychopathology and total treatment. This finding differs from research of Kazdin and Wassell (2000), which suggested that increased parental psychopathology and decreased quality of life predicted perception of barriers to treatment and participation in youth treatment. Because treatment was provided in an accessible environment with the option of scheduling several appointments at the same time,

bringing youth to treatment may not have been viewed as a barrier for these caregivers. Therefore, caregiver psychopathology may not have played a significant role in youth attendance.

However, concerning youth psychopathology and total treatment, results indicated that higher levels of anxiety (per BASC-II Anxiety scores) predicted more treatment sessions. Results are consistent with Kendall and Sugarman's (1997) research in which findings indicated that youth who endorsed more symptoms of anxiety were likely to attend treatment. A possible explanation for why those with heightened anxiety adhered to treatment may be attributed to the physiological experience and the associated negative emotions and cognitions that develop as a result of anxiety. In general, individuals experiencing anxiety tend to perceive heightened levels of danger and an inability to control outcomes, which can lead to the development of negative physiological reactions, feelings of anxiety, and negative thoughts (Lau, Chan, Li, & Au, 2010). Therefore, anxious youth are likely to perceive threat and danger in their environments and feel unable to cope effectively or manage emotions. Subsequent negative thoughts and avoidant behaviors can then develop (Lau, et al., 2010). As a result, anxious youth may be more likely to attend treatment in hopes of alleviating distressing symptoms of anxiety and avoidant behaviors, which can be functionally impairing in everyday life activities.

Sociodemographic Results. Sociodemographic characteristics were examined to assess whether these variables differentiated between families adhering or not adhering to treatment. Gender, youth grade level, youth ethnicity, youth diagnoses, caregiver level of education, caregiver ethnicity, or family constellation were not significantly different between families adhering or not adhering to treatment. However, significant differences

were found between those adhering and not adhering to treatment in regards to the primary languages spoken in the home. Specifically, caregivers and youth whose primary language spoken was Spanish were more likely than caregivers and youth whose primary language spoken was English to adhere to treatment; however, this finding is contrary to current research findings. Research has indicated that Latinos are more likely to underutilize mental-health treatment than are their European counterparts, and underutilization can be attributed to a lack of linguistically and culturally sensitive services. When clients speak a primary language different from that of the therapist, establishment of rapport leading to treatment nonadherence becomes difficult (Cabassa, Zayas, & Hansen, 2006; Kim et al., 2011; Rastogi, Massey-Hastings, & Wieling, 2012).

A possible factor explaining why Spanish-speaking Latinos were more likely than English-speaking families to adhere to treatment in this study may be associated with attempts taken by the CMHC to offer treatment within a linguistically and culturally sensitive environment. Offering treatment within a linguistically and culturally sensitive environment could have led to the development of a strong therapeutic alliance. According to Polo, Alegria, and Sirkin (2012); Cabassa and Zayas (2007); and Echeverry (1997), Latino use of mental-health services is largely accounted for by the patient's perception of his or her providers, which includes mutual respect rendered towards the patient, the participatory approach offered to engage in treatment, and positive rapport established with the clinician. Regarding this study, prior to beginning counseling services, Spanish-speaking families (if needed) were offered a variety of options through which they could receive counseling services for their youth. Options included receiving counseling services through a Spanish-speaking counselor, having a professional

translator present to facilitate communication exchange during sessions, or (if comfortable) receiving services through an English-speaking counselor. In all instances within this population, families elected to receive counseling services with an English-speaking counselor. Offering the choice of culturally sensitive communication styles to families may have created a relationship based upon cultural respect, as the effort was made to increase patient participation through linguistic sensitivity. As a result, linguistic and cultural sensitivity may have increased the families' levels of comfort and fostered the development of building and forming strong therapeutic alliances. In turn, the strong alliances between families and the clinician could have contributed to treatment adherence within this population.

Implications for CMHC

The current CMHC may wish to consider several practical implications related to language, transportation, appointments, and therapist variables when providing services to families at this rural location. Regarding the language-relevant results from this study, which indicated that Spanish-speaking Latinos were more likely than English-speaking families to adhere to treatment, the CMHC may wish to continue offering linguistically sensitive services. Linguistically sensitive services can be offered through the provision of a Spanish-speaking therapist or via the use of a professional translator. The CMHC may need to examine the budget and allocate a designated amount for the use of professional translators if a Spanish-speaking clinician is not available to render services. Regarding transportation, given that 77.6% of families arrived to the clinic using personal vehicles the CMHC may not need to contract a local taxi agency in order to provide transportation services to families. Instead, the CMHC can re-examine the budget and

allocate transportation funds to more appropriate and relevant needs. In relation to counseling appointments, the CMHC may also want to consider offering continued concurrent sessions to family members. Offering appointments at a joint time during this study could have reduced practical barriers to treatment, and thereby may have positively influence adherence. Lastly, the CMHC may want to consider and assess therapist variables (e.g., age, gender) and the interaction they have with families, as they may have also influenced treatment in this study. Generally, clinicians were younger and female, and those sociodemographic variables may have affected the development of therapeutic rapport between youth and their families within this setting. The CMHC may wish to make a match between the family and clinician if a clinician who possesses these sociodemographic variables is available to offer counseling services.

Benefits of the Study

According to Lee, Rosen, and Burns (2013) and the American Psychological Association (APA; 2003), current research should examine multiple and intersecting dimensions of identity (e.g., race, ethnicity, social class) to understand the multicultural experiences of distinct populations and the implications of cultural identity on treatment. A specific strength of the current study is the diverse population of participants. Families who spoke either English or Spanish were able to participate. Additionally, families were primarily of lower socioeconomic status and were typically receiving public-funded treatment for comorbid diagnoses. Therefore, through the course of examining different dimensions of multicultural identity within this study, the current research found that Spanish-speaking families were more likely to adhere to treatment than English-speaking families. As a result, CMHCs may wish to offer options of linguistic services (as needed),

which thereby may increase therapeutic alliance, increase treatment adherence, and possibly improve youth symptomatology and functioning.

Limitations

Despite this benefit, several limitations should be considered. First, one should note that the operational definitions used for nonadherence and adherence might not be indicative of actual treatment adherence, thus reducing construct validity. This study defined nonadherence/adherence based on less than or equal to, or more than, the average number of sessions attended for the total sample size. Kazdin and Mazurick (1994) stated that, individuals can discontinue treatment at different times (e.g., prior to intake, after intake, after a number of sessions, or as sessions continue), which is not necessarily defined as the average number of sessions attended. Additionally, the delivery of counseling services varies and often depends on the presenting problem and the severity of the presenting problem. More specifically, the progression of treatment may be dependent on the presenting problem. Therefore, the approach and length of treatment can vary, ultimately affecting adherence.

Second, this study demonstrated threats to statistical conclusion validity. The limited sample size ($N = 67$) reduced the overall power and effect size.

Therefore, detecting actual differences that may have existed was less likely.

Third, these findings may not be representative of the population at large, thus reducing external validity. Specifically, adherence was examined in a rural population composed of individuals who were of lower socioeconomic status. This population is rather distinct, and results may not be generalizable to other populations, such as individuals in an urban setting seeking treatment at psychiatric hospitals. In addition,

Latino minority youth were included in this study; however, only data about the primary language spoken in the home by caregivers and youths were obtained. Additional cultural information (e.g., ethnic group, immigration status, generational status, and language proficiency) was not obtained. Therefore, it is difficult to identify if and to what degree any of the cultural variables influenced adherence in this population, and if that influence would carry over to other Latino populations in other settings (e.g., urban settings).

Fourth, this study examined limited psychopathology for the sample of caregivers and youth, also reducing construct validity resulting from narrow stimulus sampling. Internalizing psychopathology, specifically symptoms of anxiety and depression, was examined for caregivers. Symptoms of anxiety, depression, hyperactivity, and aggression were examined in youth. This limited examination of psychopathology provided information about some clusters of psychopathology, but not about the entire range of psychopathology clusters that could exist for both caregivers and youth. Additional relationships may exist between a broader range of diagnoses and treatment adherence, which still need to be examined. Therefore, based upon the narrow stimulus sampling of psychopathology in this specific CMHC, only conclusions about these psychopathologies and treatment adherence can be made, again reducing the construct validity, as well as the generalizability of findings.

Future Direction

Future research should replicate this study with a larger sample in order to increase data collected for all the variables analyzed (e.g., youth clinical variables, adult clinical variables) given that results indicated Spanish-speaking Latinos and youth with high levels of anxiety were more likely than youth English-speaking families and youth

with low levels of anxiety to adhere to treatment. A larger sample size would increase the power and perhaps provide a better understanding of why families adhere to treatment.

Results of this study suggested that when Spanish is the primary language spoken in the home, treatment adherence increases. Research should continue to assess additional linguistic and cultural characteristics not examined within this study to determine if and how they could influence treatment adherence. Examples include assessing the degree of rapport and therapeutic alliance established between Latino families and clinicians, ethnic group, immigration status, generational status, and language proficiency.

Future studies may also consider exploring youth anxiety, since the current study found that increased levels of anxiety were related to treatment adherence. These findings emerged from a small sample size; hence, conducting a study with a larger sample size would help increase the understanding of youth anxiety. Anxiety can also be experienced as somatization and can be exacerbated when one experiences an inability to control or eliminate physical/somatic sensations. As a result, heightened fear and physical sensations are often maintained in a reciprocating cycle until autonomic responses abate or an individual perceives a sense of safety (Barlow, 2008). Therefore, if parental report from the BASC-II does not indicate significant elevations on the anxiety subscale, significant elevations on the somatization subscale may exist (with anxiety precipitating the somatic complaints), and those youth may also be more likely to adhere to treatment.

Lastly, understanding the level of comfort and trust a family has with the clinician is key in the establishment of therapeutic rapport. Questions could include analyzing the quality of the therapeutic relationship families had with the clinician (e.g., patient's perception of rapport, provider's competence, level of trust, ability to disclose personal

information), which may provide supplemental information about therapeutic alliance and subsequent treatment adherence.

Overall, additional research about Latino linguistic and cultural characteristics, youth psychopathology, and the influence of the therapeutic alliance on treatment could provide information regarding the factors that contributed to treatment adherence in this population. Multicultural sensitivity and clinically appropriate services then can be incorporated into treatment, as there would be an understanding of the relationship between these variables and treatment adherence. As a result, the course and outcome of clinical services for youth seeking treatment might result in the delivery of culturally sensitive therapeutic services to families, reduction of youth symptoms and functional impairment, improved quality/delivery of therapeutic services, and subsequent cost savings to CMHCs.

References

- American Psychological Association. (2003). Guidelines on multicultural education and training, research, practice, and organizational change for psychologists. *American Psychologist*, 58(5), 377-402.
- Armbruster, P., & Schwab-Stone, M. E. (1994). Sociodemographic characteristics of dropouts from a child guidance clinic. *Hospital and Community Psychiatry*, 45, 804-808.
- Barlow, D. H. (2008). *Clinical handbook of psychological disorders: A step-by-step treatment manual* (4th ed.). New York, NY: Guilford Press.
- Barrett, M. S., Chua, W., Crits-Christoph, P., Gibbons, M. B., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy: Theory, Research, Practice, Training*, 45(2), 247-267.
- Beardslee, W. R., Gladstone, T. R. G., Wright, E. J., & Cooper, A. B. (2003). A family-based approach to the prevention of depressive symptoms in children at risk: Evidence of parental child change. *Pediatrics*, 112(2), 119-131.
- Beck, A. T., & Steer, R. A. *Beck anxiety inventory [1993 edition]* Pearson, 19500 Bulverde Road, San Antonio, TX 78259; Telephone: 800-627-7271; FAX: 800-632-9011; E-mail: pearsonassessments@pearson.com; Web: www.pearsonassessments.com.
- Beck, A. T., Steer, R. A., & Brown, G. K. *Beck depression inventory-II* Pearson, 19500 Bulverde Road, San Antonio, TX 78259; Telephone: 800-627-7271; FAX: 800-632-9011; E-mail: pearsonassessments@pearson.com; Web: www.pearsonassessments.com.

- Boggs, S. R., Eyberg, S. M., Edwards, D. L., Rayfield, A., Jacobs, J., Bagner, D., & Hood, K. K. (2004). Outcomes of parent-child interaction therapy: A comparison of treatment completers and study dropouts one to three years later. *Child and Family Behavior Therapy, 26*(4), 1-22.
- Brannan, A. M., & Heflinger, C. A. (2006). Caregiver, child, family, and service system contributors to caregiver strain in two child mental health service systems. *Journal of Behavioral Health Services and Research, 33*(4), 408-422.
- Bui, K. T., & Takeuchi, D. T. (1992). Ethnic minority adolescents and the use of community mental health care services. *American Journal of Community Psychology, 20*(4), 403-417.
- Cabassa, L. J., & Zayas, L. H. (2007). Latino immigrants' intentions to seek depression care. *American Journal of Orthopsychiatry, 77*(2), 231-242.
- Cabassa, L. J., Zayas, L. H., & Hansen, M. C. (2006). Latino adults' access to mental health care: A review of epidemiological studies. *Administration and Policy in Mental Health Services Research, 33*(3), 316-330.
- Cheung, F. K., & Snowden, L. R. (1990). Community mental health and ethnic minority populations. *Community Mental Health Journal, 26*(3), 277-291.
- Echeverry, J. (1997). Treatment barriers: Accessing and accepting professional help. In J. G. García & M. C. Zea (Eds.), *Psychological interventions and research with Latino populations* (pp. 94-107). Boston, MA: Allyn & Bacon.
- Evans, G. D., Radunovich, H. L., Cornette, M. M., Wiens, B. A., & Roy, A. (2008). Implementation and utilization characteristics of a rural, school-linked mental health program. *Journal of Child and Family Studies, 17*, 84-97.

- Fraps, C. L., McReynolds, W. T., Beck, N. C., & Heisler, G. H. (1982). Predicting client non-adherence from psychotherapy through behavioral assessment procedures and a critical response approach. *Journal of Clinical Psychology, 38*(4), 759-764.
- Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice, 9*(3), 329-343.
- Issakidis, C., & Andrews, G. (2004). Pretreatment non-adherence and dropout in an outpatient clinic for anxiety disorders. *ACTA Psychiatric Scandinavia, 109*, 426-433.
- Kazdin, A. E. (1996). Dropping out of child psychotherapy: Issues for research and implications for practice. *Clinical Child Psychology and Psychiatry, 1*(1), 133-156.
- Kazdin, A. E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology, 65*(3), 453-463.
- Kazdin, A. E. & Mazurick, J. L. (1994). Dropping out of child psychotherapy: Distinguishing early and late childhood dropouts over the course of treatment. *Journal of Consulting and Clinical Psychology, 62*, 1069-1074.
- Kazdin, A. E., & Wassell, G. (1999). Barriers to treatment participation and therapeutic change among children referred for conduct disorder. *Journal of Clinical Child Psychology, 28*(2), 160-172.
- Kazdin, A. E., & Wassell, G. (2000). Predictors of barriers to treatment and therapeutic change in outpatient therapy for antisocial children and their families. *Mental Health Services Research, 2*(1), 27-40.

- Kazdin, A. E. (2003). *Research design in clinical psychology* (4th ed.). Boston, MA: Allyn & Bacon.
- Kendall, P. C., & Sugarman, A. (1997). Non-adherence in the treatment of childhood anxiety disorders. *Journal of Consulting and Clinical Psychology, 65*(5), 883-888.
- Kim, G., Aguado Loi, C. X., Chiriboga, D. A., Jang, Y., Parmelee, P., & Allen, R. S. (2011). Limited English proficiency as a barrier to mental health service use: A study of Latino and Asian immigrants with psychiatric disorders. *Journal of Psychiatric Research, 45*, 104-110.
- Lau, W., Chan, C. K., Li, J. C., & Au, T. K. (2010). Effectiveness of group cognitive-behavioral treatment for childhood anxiety in community clinics. *Behavior Research and Therapy, 48*, 1067-1077.
- Lee, D. L., Rosen, A. D., & Burns, V. (2013). Over a half-century encapsulated: A multicultural content analysis of the *Journal of Counseling Psychology, 1954-2009*. *Journal of Counseling Psychology, 60*(1), 154-161.
- Maybery, D., & Reupert, A. (2009). Parental mental illness: A review of barriers and issues for working with families and children. *Journal of Psychiatric Mental Health Nursing, 16*, 784-791.
- McKay, M. M., & Bannon, W. M., Jr. (2004). Engaging families in child mental health services. *Child Adolescent Psychiatric Clinic North America, 13*, 905-921.
- McMiller, W. P., & Weisz, J. R. (1996). Help-seeking preceding mental health clinic intake among African American, Latino, and Caucasian youth. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 1086-1094.

- Miller, L. M., Southam-Gerow, M. A., & Allin, R. B. Jr. (2008). Who stays in treatment? Child and family predictors of youth client retention in a public mental health agency. *Child Youth Care Forum, 37*, 153-170.
- Nock, M. K., Phil, M., & Kazdin, A. E. (2001). Parent expectancies for child therapy: Assessment and relation to participation in treatment. *Journal of Child and Family Studies, 10*(2), 155-180.
- Nock, M. K., & Kazdin, A. E. (2005). Randomized controlled trial of a brief intervention for increasing participation in parent management training. *Journal of Consulting and Clinical Psychology, 73*(5), 872-879.
- Nock, M. K., & Photos, V. (2006). Parent motivation to participate in treatment: Assessment and prediction of subsequent participation. *Journal of Child and Family Studies, 15*(3), 345-358.
- Pina, A. A., Silverman, W. K., Weems, C. F., Kurtines, W. M., & Goldman, M. L. (2003). A comparison of completers and noncompleters of exposure-based cognitive and behavioral treatment for phobic and anxiety disorders in youth. *Journal of Consulting and Clinical Psychology, 71*(4), 701-705.
- Polo, A. J., Alegria, M., & Sirkin, J. T. (2012). Increasing the engagement of Latinos in services through community-derived programs: The right question project-mental health. *Professional Psychology: Research and Practice, 43*(3), 208-216.
- Rastogi, M., Massey-Hastings, N., & Wieling, E. (2012). Barriers to seeking mental health services in the Latino/a community: A qualitative analysis. *Journal of Systemic Therapies, 31*(4), 1-17.

- Reynolds, C. R., & Kamphaus, R. W. *Behavior assessment system for children [second edition]* Pearson, 19500 Bulverde Road, San Antonio, TX 78259; Telephone: 800-627-7271; FAX: 800-632-9011; E-mail: pearsonassessments@pearson.com; Web: www.pearsonassessments.com.
- Shelton, D. (2004). Experiences of detained young offenders in need of mental health care. *Journal of Nursing Scholarship, 36*(2), 129-133.
- Sherman, M. L., Barnum, D. D., Nyberg, E., & Buhman-Wiggs, A. (2008). *Predictors of preintake non-adherence in rural community mental health centers*. Washington, DC: American Psychological Association.
- Southam-Gerow, M. A., Chorpita, B. F., Miller, L. M., & Gleacher, A. A. (2008). Are children with anxiety disorders privately referred to a university clinic like those referred from a public mental health system? *Administration Policy Mental Health, 35*, 168-180.
- Swan-Kremeier, L. A., Mitchell, J., Twardowski, T., Lancaster, K., & Crosby, R. D. (2005). Travel distance and non-adherence in outpatient eating disorders treatment. *International Journal Eating Disorders, 38*(4), 367-370.
- Weissman, M. M., Pilowsky, D. J., Wickramaratne, P. J., Talati, A., Wisniewski, S. R., Fava, M.,...Rush, A. J. (2006). Remissions in maternal depression and child psychopathology: A STAR*D-child report. *JAMA: The Journal of the American Medical Association, 295*, 1389-1398.
- Werba, B. E., Eyberg, S. M., Boggs, S. R., & Algina, J. (2006). Predicting outcome in parent-child interaction therapy. *Behavior Modification, 30*(5), 618-646.

Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout.

Professional Psychology: Research and Practice, 24(2), 190-195.

Weisz, J. R., Weiss, B., & Langmeyer, D. B. (1987). Giving up on child psychotherapy:

Who drops out? *Journal of Consulting and Clinical Psychology, 55*, 916-918.

Zhang, P., Tao, G., & Anderson, L. A. (2003). Differences in access to health care services among adults in rural America by rural classification categories and age.

Australian Journal Rural Health, 11, 64-72.

Appendix A

Data Checklist

DATE OF INTAKE: _____

Client ID Number: _____

<u>Questions</u>	<u>Yes</u>	<u>No</u>
1. Is the youth seeking medication monitoring services only?		
2. Was a referral for a higher level of care provided upon completion of the intake (e.g., in-home therapy, partial care, etc.)		
3. Is the youth already receiving counseling services at another agency?		
4. Does the youth have a drug or alcohol primary diagnosis?		
5. Does the youth have a diagnosis of Autism, Asperger's or Pervasive Developmental Disorder?		
6. Does the youth have an intellectual disability?		
7. Was a referral for a higher level of care provided while the youth was seeking counseling services at the agency?		
8. What was the DSM-IV Axis I diagnosis?	1. _____ 2. _____ 3. _____	
9. What was the DSM-IV Axis II diagnosis?	1. _____ 2. _____ 3. _____	

Appendix B

Demographic Questionnaire

1. What is the age of your child? _____
2. How many people live in your home? _____
3. Please provide the following information about people residing in your home:

<u>Age of Individuals Residing in the Home</u>	<u>Relation of Individuals Residing in the Home to the Child</u>	<u>Gender of Individuals Residing in the Home</u>
Example: 32	Example: Mother	Example: Male or Female
		Male or Female
		Male or Female
		Male or Female
		Male or Female
		Male or Female
		Male or Female
		Male or Female
		Male or Female
		Male or Female
		Male or Female
		Male or Female
		Male or Female
		Male or Female
		Male or Female

4. What is the highest level of education you completed? _____
5. What grade is your child in? _____

6. What language do you personally primarily speak in your home? _____
7. What language does your child primarily speak in your home? _____
8. What is your ethnicity? _____
9. What is your child's ethnicity? _____
10. How are you related to your child?
 - a. Mother
 - b. Father
 - c. Grandmother
 - d. Grandfather
 - e. Aunt
 - f. Uncle
 - g. Adoptive mother
 - h. Adoptive father
 - i. Foster mother
 - j. Foster father
 - k. Other (please specify) _____
11. How did you and your child get to the appointment today?
 - a. Personal vehicle
 - b. Medical transportation services
 - c. Taxi
 - d. Driver by family/friend
 - e. Other (please specify) _____
12. Please estimate how many minutes it took to travel to your child's appointment today. _____minutes

Cuestionario demográfico

1. ¿Cuántos años tiene su hijo? _____
2. ¿Cuántas personas viven en su casa? _____
3. Por favor, suministre la siguiente información acerca de las personas que viven en su casa:

<u>Edad de las personas que viven en la casa</u>	<u>Relación que las personas que viven en la casa tienen con el niño</u>	<u>Sexo de las personas que viven en la casa</u>
Ejemplo: 32	Ejemplo: Madre	Ejemplo: Masculino o Femenino
		Masculino o Femenino
		Masculino o Femenino
		Masculino o Femenino
		Masculino o Femenino
		Masculino o Femenino
		Masculino o Femenino
		Masculino o Femenino
		Masculino o Femenino
		Masculino o Femenino
		Masculino o Femenino
		Masculino o Femenino
		Masculino o Femenino
		Masculino o Femenino
		Masculino o Femenino

4. ¿Cuál es el nivel de educación más alto que ha completado? _____
5. ¿En qué grado se encuentra su hijo? _____

6. ¿Cuál es el idioma que más habla usted en su casa? _____
7. ¿Cuál es el idioma que más habla su hijo en su casa? _____
8. ¿Cuál es su origen étnico? _____
9. ¿Cuál es el origen étnico de su hijo? _____
10. ¿Cuál es el parentesco con su niño?
 - a. Madre
 - b. Padre
 - c. Abuela
 - d. Abuelo
 - e. Tía
 - f. Tío
 - g. Madre adoptiva
 - h. Padre adoptivo
 - i. Madre de acogida
 - j. Padre de acogida
 - k. Otro (por favor, especifique) _____
11. ¿Cómo llegaron Ud. y su hijo hasta la cita del día de hoy?
 - a. Vehículo personal
 - b. Servicios de transporte médico
 - c. Taxi
 - d. Un familiar / amigo los trasladó hasta el lugar
 - e. Otro (por favor, especifique) _____
12. Por favor, indique la cantidad aproximada de tiempo que le llevó viajar hasta la cita de su hijo hoy. _____ minutos

Appendix C

Agency Intake Form

CUMBERLAND COUNTY GUIDANCE CENTER
OUTPATIENT COMPREHENSIVE ASSESSMENT

Client's Name: _____	DOB: _____	Case #: _____
Date of Intake: _____		Name of Clinician(Print): _____
Presenting Problem/Chief Complaint: _____ _____		
Diagnostic Impressions—DSM-IV		
Axis I _____	Diagnostic Code	____ ____ ____ ____
_____	Diagnostic Code	____ ____ ____ ____
Axis II _____	Diagnostic Code	____ ____ ____ ____
_____	Diagnostic Code	____ ____ ____ ____
Axis III Current Medical Conditions: <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Other: _____		
Axis IV Psychosocial and Environmental Problems <i>Indicate All That Apply:</i>		
<input type="checkbox"/> Problems with primary support group: _____ <input type="checkbox"/> Educational problems: _____		
<input type="checkbox"/> Problems related to social environment: _____ <input type="checkbox"/> Housing problems: _____		
<input type="checkbox"/> Problems with access to health care services: _____ <input type="checkbox"/> Occupational problems: _____		
<input type="checkbox"/> Problems with legal system/crime: _____ <input type="checkbox"/> Economic problems: _____		
<input type="checkbox"/> Other psychosocial and environmental problems: _____		
Rate Severity of Current Psychosocial and Environmental Problems: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Axis V Current Global Assessment of Functioning (GAF) ____ Highest GAF during past year ____		
Medications: <input type="checkbox"/> No <input type="checkbox"/> Yes (specify) <input type="checkbox"/> Psychotropic <input type="checkbox"/> Non-psychotropic (General Medical)		
Medication(s) at the time of admission and name of prescriber		
ALLERGIES medication and/or environmental <input type="checkbox"/> no <input type="checkbox"/> yes Describe: _____		
MULTI-AXIAL DIAGNOSIS, MEDICATIONS & ALLERGIES		

CUMBERLAND COUNTY GUIDANCE CENTER
OUTPATIENT COMPREHENSIVE ASSESSMENT

Client's Name:	DOB:	Case #:
HISTORY OF PRESENT ILLNESS include onset of current symptoms and recent contributing factors leading to admission		
SIGNIFICANT HISTORY Consider the following:		
A. Mental Health include treatment(s), inpatient/outpatient, medications and response:		
B. Physical/Sexual Abuse, Neglect and Domestic Violence as victim or abuser <input type="checkbox"/> no <input type="checkbox"/> yes Describe:		
C. Alcohol and Drug Use/Abuse substance(s) of choice, frequency of use, extent of use, current or prior treatments:		
D. Physical Health include medical conditions, medications, operations, and high-risk behaviors:		
E. Family History mental illness, drug/alcohol problems, etc. – indicate relationship		
HISTORY OF PRESENTING PROBLEM - HEALTH HISTORY		

**CUMBERLAND COUNTY GUIDANCE CENTER
OUTPATIENT COMPREHENSIVE ASSESSMENT**

Client's Name:	DOB:	Case #:
A. Family Information family background, constellation of the family group, relationship with parents & siblings:		
B. Education highest grade completed, school disruptions & classifications, special training(s):		
C. Occupational History current job, past employment, military history, financial status:		
D. Legal Status current legal involvement, history of legal problems, dates, legal charges/outcomes:		
E. Marital History include current relationship and any children:		
F. Strengths & Liabilities resources of client/family, support system (family/social), special needs, barriers to service:		
G. Community Resources Currently Utilized by the Client		
H. Recreational Interests/Involvement hobbies, social groups, leisure/spiritual activities:		
PERTINENT PERSONAL/FAMILY/LEGAL HISTORY—STRENGTHS & LIABILITIES		

**CUMBERLAND COUNTY GUIDANCE CENTER
OUTPATIENT COMPREHENSIVE ASSESSMENT**

Client's Name:	DOB:	Case #:
DEVELOPMENTAL HISTORY (REQUIRED FOR ALL CHILDREN) <small>Indicate significant developmental issues:</small>		
Place of Birth:	Birth Order:	
A. Prenatal and Birth Issues <small>(include birth weight, length of gestation, medical problems of mother, parental substance abuse during pregnancy, etc.)</small>		
B. Infancy and Early Childhood Development <small>(crawling, walking, toilet training, speech, responses to affection and distress, etc)</small>		
C. Middle and Late Childhood Issues <small>(play skills, socialization skills, adjustment to school classroom routines, visual-motor problems, math, spelling, or reading difficulties, etc).</small>		
D. Adolescence <small>(academic and career interests, achievements, taking responsibility for chores and schoolwork, peer relationships, dating, sexual issues, interactions with family members and adults, etc.)</small>		
ADDITIONAL CLINICAL INFORMATION <small>Use this space to record any other pertinent information:</small>		
DEVELOPMENTAL HISTORY AND ADDITIONAL INFORMATION		

**CUMBERLAND COUNTY GUIDANCE CENTER
OUTPATIENT COMPREHENSIVE ASSESSMENT**

Client's Name:	DOB:	Case #:
MENTAL STATUS EXAM	•Make assessment comments	•Describe abnormal findings
Attitude and General Behavior (Describe general appearance, manner of dress, eye contact, demeanor, attitude toward interview, etc.)		
Motor Behavior <input type="checkbox"/> U <input type="checkbox"/> R (ex., restless, agitated, hyperactive, hypoactive, tremulous, psychomotor retardation, etc.)		
Speech: Tone/Quality <input type="checkbox"/> U <input type="checkbox"/> R (ex., loud, soft, slurred, crying, abrupt, accent, expressive aphasia, neologisms, etc.), Pace <input type="checkbox"/> U <input type="checkbox"/> R (ex., slow, rapid, latency of response, poverty of speech, pressured, blocking, etc.)		
Mood <input type="checkbox"/> U <input type="checkbox"/> R (ex., elevated, elated, euphoric, irritable, constantly depressed, intermittently depressed, worried, angry, hopeless, distraught, etc.)		
Affect: Feeling Tone <input type="checkbox"/> U <input type="checkbox"/> R (ex., anxious, sad, worried, ashamed, disinterested, apprehensive, silly, hostile, etc.), Range <input type="checkbox"/> U <input type="checkbox"/> R (ex., limited, labile, etc.), Intensity <input type="checkbox"/> U <input type="checkbox"/> R (ex., constricted, blunted, flat, etc.)		
Associative Process: Connectedness <input type="checkbox"/> WNL <input type="checkbox"/> IMP (ex., circumstantial, tangential, loosened associations, flight of ideas, perseveration, incoherence, poverty of content, etc.), Quality of Reasoning <input type="checkbox"/> U <input type="checkbox"/> R		
Thought Content—Describe: (include any relevant information pertaining to depression, mood disturbances, obsessions, compulsions, preoccupations, anxiety, panic, phobias, persecutory worries, victimization, overvalued ideas, ideas of reference, etc.)		
Hallucinations <input type="checkbox"/> A <input type="checkbox"/> P, Delusions <input type="checkbox"/> A <input type="checkbox"/> P, Suicidal/Violent Ideation <input type="checkbox"/> A <input type="checkbox"/> P		
Sleep/Appetite <input type="checkbox"/> WNL <input type="checkbox"/> IMP		
Cognitive Functioning: Attention Span <input type="checkbox"/> WNL <input type="checkbox"/> IMP, Oriented to Time, Place, and Person <input type="checkbox"/> Y <input type="checkbox"/> N, Recent Memory <input type="checkbox"/> WNL <input type="checkbox"/> IMP, Remote Memory <input type="checkbox"/> WNL <input type="checkbox"/> IMP		
Insight <input type="checkbox"/> WNL <input type="checkbox"/> IMP, Judgment <input type="checkbox"/> WNL <input type="checkbox"/> IMP		
Estimate of Intelligence <input type="checkbox"/> Average <input type="checkbox"/> Below Average <input type="checkbox"/> Above Average		
INSTRUCTIONS: Check and circle appropriate designations		
U=Unremarkable	WNL=Within Normal Limits	A=Absent
R=Remarkable	IMP=Impaired	P=Present
		Y=Yes
		N=No
MENTAL STATUS EXAM		

**CUMBERLAND COUNTY GUIDANCE CENTER
OUTPATIENT COMPREHENSIVE ASSESSMENT**

Client's Name:	DOB:	Case #:
CASE FORMULATION AND CONCLUSIONS (Based on information from pages 1, 2, 3, 4, 5)		
Relevant Factors: <input type="checkbox"/> Age Related <input type="checkbox"/> Interpersonal <input type="checkbox"/> Family <input type="checkbox"/> Educational <input type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Victim of Assault/Abuse <input type="checkbox"/> Limited Support System <input type="checkbox"/> Lacks Support System <input type="checkbox"/> Other:		
Severity of Psychiatric Illness: <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild <input type="checkbox"/> Persistent <input type="checkbox"/> History of Assaultiveness <input type="checkbox"/> History of Suicidal Behavior <input type="checkbox"/> History of Self-Injurious Behavior		
Comorbid Conditions: <input type="checkbox"/> Medical <input type="checkbox"/> Behavioral/Personality Disordered <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Alcohol/Substance Abuse or Dependence		
Severity of Symptoms: <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild <input type="checkbox"/> Delusions/Hallucinations <input type="checkbox"/> Disorganized Thinking <input type="checkbox"/> Depressive <input type="checkbox"/> Anxiety/Phobia <input type="checkbox"/> Behavioral <input type="checkbox"/> Other		
Severity of Impairment: <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild <input type="checkbox"/> Work <input type="checkbox"/> Family/Relational <input type="checkbox"/> Social <input type="checkbox"/> Academic <input type="checkbox"/> Self-Care/Basic Functions		
Treatment History: Prior Psychiatric Treatment-- <input type="checkbox"/> Outpatient Therapy <input type="checkbox"/> Medication Monitoring <input type="checkbox"/> Residential <input type="checkbox"/> Group Home/Therapeutic Foster Home <input type="checkbox"/> Inpatient <input type="checkbox"/> Social <input type="checkbox"/> Partial Care <input type="checkbox"/> MICA <input type="checkbox"/> Other: Prior Substance Abuse Treatment-- <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient		
History of Adherence To Treatment (describe):		
Assessment of Risk Management Status: <input type="checkbox"/> Emergent <input type="checkbox"/> Urgent <input type="checkbox"/> Routine		
Phase of Treatment: <input type="checkbox"/> Acute <input type="checkbox"/> Stabilization <input type="checkbox"/> Stable		
TREATMENT RECOMMENDATIONS		
Considerations: Optimal therapeutic approach, client's interest and capabilities, availability of resources, additional information needed, frequency and duration of treatment.		
Comments (indicate client's responses, preferences, family participation, etc)		
Clinician's Signature:		Date:
CASE FORMULATION/CONCLUSIONS AND TREATMENT RECOMMENDATIONS		

Appendix D

Instructions

You will be asked to complete the following forms/questionnaires. Please read the instructions on each form/questionnaire carefully before filling them out. If you have any questions, please ask the clinician, who will be completing your child's intake, for further clarification on those forms/questionnaires.

There are four forms for you, the parent, to complete. The BAI and the BDI-II are questionnaires about how **YOU** feel. The BASC-2 is a questionnaire about your **CHILD'S** feelings and behaviors. The demographic questionnaire asks about general family information.

Please provide all completed forms to your clinician when called back to complete your child's intake.

Instrucciones

Se le pedirá que complete los siguientes formularios / cuestionarios. Por favor, lea las instrucciones atentamente con anterioridad. Si tiene preguntas, hable con el médico a cargo del proceso de admisión de su hijo para que despeje las dudas que puedan surgir.

Como padre, deberá completar cuatro formularios. El BAI y el BDI-II son cuestionarios acerca de cómo se siente **USTED**. El BASC-2 es un cuestionario sobre los sentimientos y comportamientos de su **HIJO**. El cuestionario demográfico hace referencia a la información familiar general.

Por favor, entregue todos los formularios completos a su médico clínico en el momento en que se lo llame para completar el procedimiento de admisión de su hijo.