Utilization of community-based services among families with children with a mental disorder

Dymika Machelle Lane

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UTILIZATION OF COMMUNITY-BASED SERVICES AMONG FAMILIES WITH CHILDREN WITH A MENTAL DISORDER

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Dymika Machelle Lane
June 2007
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Date 6/6/07
ABSTRACT

Families of children with a mental disorder typically have many stressors due to their children's behavioral functioning. These families do not always choose to receive community-based services that are intended to decrease the stressors within the families and prevent the children from being placed out of the families' homes. This study investigated the relationship between clients' functioning during their initial assessment provided by Victor Community Support Services (VCSS), compared to their functioning when they were discharged from VCSS based on the families' utilization of community-based services. This is a data analysis study. Data was extracted from 45 closed VCSS case files of families living in San Bernardino County from the period of July 1, 2005 until July 31, 2006.
ACKNOWLEDGMENTS

I acknowledge and thank Dr. Janet C. Chang my research advisor, for all of her assistance, support and guidance.

I would like to thank Victor Community Support Services staff, especially Paula Quijano for allowing me to collect data and being encouraging.

I would like to thank my family and friends for all of their encouragement, love and understanding during this milestone in my life.
DEDICATION

I dedicate this research project to my grandfather, Horace Smith, and to my uncle, Larry Smith. May they both continue to celebrate in heaven and watch over me.
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Families of children with mental disorders typically have many stressors due to their children behavioral functioning. According to U.S. Department of Health and Human Services (1999), studies show that at least one in five children and adolescents have a mental health disorder. The families of these children do not always choose to utilize community-based services that are intended to decrease the stressors within the family and prevent the children from being placed out of the families' home. Services that are provided in the client's home, school and community setting (i.e., church, store, recreational facility and park) are considered community-based services. When families miss appointments for community-based mental health services, there is a concern that there will be an increase in children being placed out of their families' homes, an increase in aggressive behaviors and an increase in these children not being able to function at school.
Problem Statement

There has been an increase of children being diagnosed with a mental disorder in the United States. The most common diagnoses given to children are Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), and Oppositional Defiance Disorder and Conduct Disorder. At least six million American children have difficulties that are diagnosed as serious mental disorders. This number has tripled since the early 1990’s. Most parents choose to treat their children with psychiatric medication. Due to the children’s behaviors, they sometimes attend special schools (Bulluck, 2006).

The utilization of community-based services could possibly increase the clients’ functioning, but many families choose not to utilize this service.

The mental disorders and resulting therapeutic treatments can cause discord within marriages, jobs and finances. The task of parents monitoring medications, navigating therapy sessions, arranging special school services are overwhelming. Some families must relocate from their homes and jobs in order to receive adequate services and support systems.
Bulluck (2006) told a realistic life story of a family who has a child with a mental disorder. This child’s name is Haley. Before Haley was ten years old, she started seeing things that were not there, such as bugs and mice crawling on her parents’ bed, imaginary friends sitting next to her on the couch and dead people at her church which was also the location of her school.

Like many parents who are in similar situations, Haley’s parents did not know what to think about Haley’s behaviors. Haley’s behaviors got worse as she got older. She developed tics in the following forms: dolphin squeaks, throat-clearing, and clenching her face and body as if moving her bowels. Haley began hearing voices and became very anxious over things that would be considered typical such as ambulance sirens and train rides. Her mood switched suddenly from being excited to mournfully panic-stricken. Haley’s fears, moods and obsessions disrupted into her family’s daily routines.

At the age of 10, Haley was diagnosed with a combination of bipolar disorder with psychotic features, obsessive-compulsive disorder, generalized anxiety disorder and Tourette’s syndrome. Risperdal was one of a dozen drugs Haley would try. Some helped initially, but
eventually the voices returned or side effects developed. Lithium caused weight gain which affected Haley fitting into her clothes. Huge pills and bad tasting liquid made Haley gag and have a tantrum. Haley's tantrums would last at least twenty minutes.

Her illness dominated every moment, every relationship, and every decision of her family's life. Haley's stream of symptoms, diagnoses, medications, and unrealized expectations were very stressful for her family. The intensity of Haley's behavior caused her parents to constantly worry.

Haley attended a typical school and tried her best not to show symptoms while she was at school. There were times when Haley could not function at school, which caused her to have a melt-down in the classroom. Haley was placed in a hospital when her behavior was extreme. Haley was not sociable with peers which caused her to be isolated.

With the increase in children having a mental disorder, more community-based mental health services have been developed. Many families, like Haley's, continue to refuse or are not consistent in receiving community-based services. There are several reasons why
families do not accept community-based services, such as they have kept their child's disorder a secret and community-based services would put that secret at risk. Thus they are too overwhelmed and do not have time for another form of treatment, or, they have decided their child's behavior is too severe for community-based services and would rather place the child in a group home.

Families who are refusing to seek community-based services because they want to keep the disorder a secret are preventing their children from functioning in their community which can lead to many other disorders due to children's isolation. If children are displaying behaviors that qualify them for placement in a county/state funded group home, this typically means the children's behavior is putting them at risk of harming themselves and/or others. Such children are sometimes placed in the foster care system. More than 500,000 children are in foster care in the United States (Sedlack, 1996).

In addition to foster care placement many children who are placed in a group home have been the victims of unstable environments during the early years of life. Such
crises are critical in the short- and long-term development of children's brains and the ability to subsequently participate fully in society (Garbarino, 1986).

Children in foster care have disproportionately high rates of physical, developmental, and mental health problems (Costello, 1995) and often have many unmet medical and mental health care needs (Rosenfeld, 1997). It is important for professionals (i.e., teachers, doctors and social workers) to assess children at risk in order to make sure these children are receiving appropriate support. Many social workers and mental health professionals continue to apply the old model of agency-based services that are clinic based instead of a system's theory approach in community-based services. The lack of collaboration between the children, guardians, schools, mental health providers, primary physician and other supporting individuals causes children to be inadequately assessed.

Research indicates that in-home therapy programs usually lessen the number of out-of-home placements of children (Hennegler, Melton, & Smith, 1992; Szykula & Fleashman, 1985; Walton, Fraser, Lewis, Pecora, & Walton,
1993), lowers the risk of hospitalization, and reduces symptoms associated with the presenting problems in the clients served (Frazer, Nelson, & Rivard, 1997).

**Purpose of the Study**

Many families continue to refuse community-based services even though it can possibly prevent the clients from being placed out of their homes, decrease their aggressive behaviors and improve their functioning at school. The purpose of this study was to investigate the relationship between clients initial Children Global Assessment Scale (CGAS) score and their closing CGAS score based on the type of community-based services (individual therapy, family therapy, family collateral, collateral, case management and medication services) the families utilized from Victor Community Support Services (VCSS).

According to Wikipedia Encyclopedia (2007) the CGAS is a numeric scale (1 through 100) used by mental health clinicians and doctors to rate the general functioning of children under the age of 18. Ratings on a CGAS scale should be independent of specific mental health diagnoses.
VCSS is a non-profit agency that provides therapeutic mental health services to families with children with mental disorders living in San Bernardino and Riverside counties. Clients are referred to VCSS due to their current behaviors putting them at risk of being removed from their homes and or school placement.

This is a data analysis study. Data was extracted from 45 closed VCSS case files. A data extraction tool was used to collect demographic information about the clients' ages, genders, ethnicities, mental disorders, types of services received, and CGAS scores. To avoid disrupting the treatment progress of families who are currently receiving services, utilization of closed files was appropriate.

This study included a multilevel, human/family ecological context. Buboltz and Sontag (1993) suggested that studies of family ecosystems should encompass properties of individuals, family units, their environments, and what is going on in and among them. The ecological approach is similar to the structure of the wraparound approach. The wraparound approach focuses on providing support to children in a practical environment. Wraparound services provide individualized,
comprehensive, in-home, community-based services and supports to children and adolescents with serious emotional and/or behavioral disturbances so they can be reunited and/or remain with their families and function in their communities.

This study asked the following question: is the type of community-based services (individual therapy, family therapy, family collateral, collateral, case management and medication services) families utilize parallel to an increase in the client’s CGAS score? This study will contribute to social workers being trained and socially competent on the impact utilization of community-based services has on the functioning of the families.

Significance of the Project for Social Work

Being aware of utilization of community-based services can help social workers, clinicians and other professionals in coordinating strategies for interventions that will result in an increase in service utilization. This awareness can provide insight into program effectiveness and lead to informed program development. Being aware of the utilization of community-based services can support decreasing the
number of children who are placed out of their families’ homes, have aggressive behaviors and are not functioning in their school setting.

This study can be used as training for social workers and other professionals in order to understand the importance of community-based services. This study will make professionals more knowledgeable about the clients they provide services to and reasons why the functioning of some families does not improve after receiving services.

Providing services within the clients’ community setting, social workers can be aware of the norms in the household, assess the clients within their setting and plan on how supports will be provided within clients’ homes and communities. Within the service termination process, social workers will be able to encourage the families to follow-through with learned community-based interventions. This study should answer the following question: is the type of community-based service (individual therapy, family therapy, family collateral and collateral and medication services) a family utilizes parallel to an increase in the client’s CGAS?
CHAPTER TWO
LITERATURE REVIEW

Introduction

This chapter will examine literature on utilization of community-based services among families of children with a mental disorder. Community-based services consist of children receiving prevention and intervention services in their homes, school and community environment to avoid more intensive and restrictive placements. This approach to services empowers families, community resources and state agencies to work together to utilize all available resources. This approach is intended to treat the problems children and families face and reduce the need for out-of-home placements. Community-based services are sometimes referred to as wraparound services due to the similarities in both approaches. Wraparound services are therapeutic treatments that are provided in children homes, schools and communities.

Out-of-Home Placement

Thomas' (1999) project identified therapists who learned new home-based methods in order to connect with their clients. This project discusses ways in which
in-home family therapy can expand the ways that the therapist, family and other professionals can work together without crossing boundaries. This allowed all parties to be more flexible to meet the client's needs. It also allowed for everyone to work collaboratively with other social agencies.

According to Blader's (2004) study on predictors of children's psychiatric re-hospitalization findings showed that it is common for children to be re-hospitalized within one year of discharge due to the families presenting problems prior to admission. The results of this study showed there needs to be improvement within the initial period following inpatient care that addresses the needs of the family. If the children's treatment plans are not addressing community-based stressors prior to discharge then the children will not be prepared to adapt within their community following discharge. It is important for the treatment team to be proactive by coordinating resources and support systems that are realistic to the children's needs and environment in which the children live, address vigorously the complex treatment needs of those with
severe conduct problems, and aim to improve parents-children relations.

There is significant research on the benefits of individualized treatment service provided in the childrens' community associated with the reduction of the childrens' maladjustment behaviors. Clark (1996) examined a wraparound strategy for foster children between the age of six and sixteen years old with emotional and behavioral disturbance. A foster children's group who received Foster Individual Assistance Program (FIAP) services demonstrated improved change and a decrease in foster children running away. The children who received FIAP will more likely have a stable placement than the children who did not receive FIAP.

Brown (1996) has identified placement for children with moderate to severe emotional difficulties. The treatment facility used wraparound services as an alternative to residential care. The treatment facility used a person-centered approach to provide children with services they requested. The parents of these children stated in-home help, stress reduction, and individual one-on-one services as major contributors to the children's success.
School Functioning

According to Eastfield Ming Quong's (2003) agency statistics, fewer than 10% of public schools have mental health services. Eber (1996) followed a school-based wraparound approach for three years. Participants in this study were students who were diagnosed to be emotionally disturbed. Nineteen students were identified who were in self-contained special education classrooms and were compared to twenty-five students who were identified from various other school and mental health settings. Students from the school-based program were less clinically involved. The use of wraparound approaches throughout the various educational programs to prevent out-of-school and out-of-home care was discussed.

Many children have learning disabilities in conjunction with their mental disorders. An article by Morrison (2006) recommends utilization of an ecological treatment intervention that is specifically tailored to the needs of the children based on a formulation of the children's experience and developmental deficits. This article discussed the importance of providing interventions within children's school settings in order to improve developmental deficits.
Problematic Behaviors

Northey (1997) identified interventions with chronic juvenile delinquents and their families. Interventions with this population are typically unsuccessful in reducing crime, because they fail to account for the system in which the delinquents operate. In this study, the wraparound model is based on four premises. These premises include: the quality of attachment to others affects the juvenile's behavior; an intervention must take the juvenile's interpersonal interactions into account; interventions should focus on intrapsychic, international experiences of the juvenile, family, extended family, and active kin networks; and the integration of these in an ecosystem perspective will decrease conflicts in the network of a collaborative team. The key to the model is impacting family interactions at different levels, building on family strengths and clarifying meanings associated with problematic behaviors.

There are unique relationships between symptoms of depression, conduct disorder and inattention hyperactivity disorder and characteristics of the family environment. George (2006) studied these relationships
and found remarkable similarity in the family characteristics across a wide range of child psychopathologies. The participants of this study included parents and teachers. The participants completed surveys that questioned multiple behavioral, emotional, and family measures that described the characteristics of the community sample of 362 children. The results of this study indicated that depression and conduct problems/aggression symptoms were uniquely associated with specific family environments. Both symptom clusters predicted family environments marked by less cohesiveness and intellectual/cultural pursuits and greater conflict.

McDonald (1995) describes individualized wraparound strategies for foster children with emotional/behavioral disturbance and their families. Recommendations are based on positive results of a controlled evaluation and qualitative modifications to the FIAP. FIAP family specialists served as clinical case managers, providing strength-based assessment, “life-domain planning, home-based services, brokered services, and follow along monitoring and supports” (McDonald, 1995, p. 156).

It is important to do a family’s need assessment during the assessment phase of mental health services.
Based on the occurrences of specific need, the mental health agency can develop specific community-based services. Quinn (1995) brought attention to a community's attempt to merge community and individual-based services. One hundred and eighty direct service providers were surveyed as to how such services could best be developed and implemented. The survey focused on existing barriers to providing services and specific service priorities for system development.

An agency can gather information on a communities' need from telephone survey a well. Rosen (1994) presented bimonthly telephone survey data from 20 youths, who received community-based, wraparound services in Vermont, about their satisfaction, sense of involvement, and feelings of unconditional care; each of these variables was, in turn, related to behavioral adjustment. The analysis indicated that the youth's sense of involvement and their perceptions that their care was unconditional were strongly associated with satisfaction with services. Although, satisfaction or involvement was correlated with the severity of acting-out behaviors; perceptions that care was unconditional were strongly and negatively correlated. While the relationship between
satisfaction and behavior remains unclear, it is clear that youths' perceptions of the stability of their services play a role in there acting out.

Clarke (1992) identified how the adjustment of home and school environment is for children with severe emotional and behavioral problems. Project Wraparound - a community-based treatment program in rural New England - was described. The Child Behavior Checklist and the Teacher Report Form provided standardized information on the severity of child problem behavior from the perspective of parents and classroom teachers, and then intensive home and school-based services were applied. Results show that of nineteen families observed, a substantial improvement occurred in child functioning in the home, but not in the school.

Quinn (1995) followed one-hundred and eighty direct service providers about barriers to providing services, specific service priorities for system development, and how services could best be developed and implemented, and found support for a wraparound model. Empirical evidence of the effectiveness of wraparound for children and adolescents with severe behavioral and emotional disorders, who may have co-occurring substance abuse
issues, for strong support is also found among service providers and consumer families. Support among providers and consumers have been found by Quinn.

Theories Guiding Conceptualization

Zastro (2004) states systems theories make up a broad category of such symbolic representations. They involve concepts that emphasize interactions and relationships among various systems, including individuals, families, groups, organizations, or communities. Community-based mental health services support the children’s interactions within the system which helps the whole system (family) function better. Parad (1965) and Bloom (1979) suggest system theory approach emphasizes concern for precipitating factors and the linking of interventions with stressful life events. If children experience a crisis such as being sexually abused, it typically causes them to regress in their daily functioning in the forms of isolating themselves, decreasing school performance, bed wetting and other symptoms. Such symptoms affect other parts and systems as a whole.
According to Malysiak (1998), results suggest that wraparound is an emerging collaborative model based in critical and constructivist thought and in ecological systems theory. The ecological systems theory guided this study in examining the utilization of services as it related to the wraparound approach. Dunkle and Norgard (1995) recommended using the person-in-environment (PIE) approach, developed by Lawton and Nahemow (1973) to examine children's environment, families, and needs. The PIE approach emphasizes focusing on children's strengths and adaptation skills in relation to their environment. The PIE theory supported this researcher's study in determining if the type of services utilized in children's community is parallel to an increase in the children's CGAS score. Variables such as history of substance abuse, type of school placement and mental disorder were analyzed as factors in the families' utilization of services and closing CGAS score.

Role theory analyzes the various roles each family member experiences when one family member is utilizing mental health services. The roles of each family member changes the longer the children utilize services, the family involvement in services and the severity of the
children behaviors. Delton and Wenston (1989) suggest that intervention strategies for new role formation can increase the likelihood of a more positive self-perception while minimizing the family's weakness.

Summary

The literature review examined studies of the public's understanding of children who display severe behaviors that put them at risk of being placed out of their families' homes, assigned to restricted school placement and put them at risk of harming themselves or others. Several theories were used to conceptualize the proposed study. Issues relating to the outcomes of families who do not utilize services were discussed. Little research has been done that focuses on the utilization of mental health services by families of children with mental disorders and these children's outcomes.
CHAPTER THREE

METHODS

Introduction

Chapter Three documents the steps used in developing this study. This chapter will describe the methods used in obtaining and analyzing the data for this study, specifically, the study design, sampling, data collection and instruments, procedures, protection of human subjects, and data analysis. The chapter concludes with an overall summary.

Study Design

The purpose of this study was to investigate the relationship between a children’s initial Children Global Assessment Scale (CGAS) score and their closing CGAS score based on the type of community-based services (individual therapy, family therapy, family collateral, collateral, case management and medication services) the families utilized from Victor Community Support Services (VCSS).

The design of this study is data analysis. A data extraction tool was used to collect demographic information about the childrens’ ages, genders,
ethnicity, mental disorders, types of services received, and CGAS scores. According to Wikipedia Encyclopedia (2007) the CGAS is a numeric scale (1 through 100) used by mental health clinicians and doctors to rate the general functioning of children under the age of 18. Ratings on a CGAS scale should be independent of specific mental health diagnoses.

Data was extracted from closed case files from VCSS office. The files were used to gather standard demographic information which included age, gender, ethnicity, mental disorder, types of services utilized and CGAS score. The CGAS scores are on a Lakert-scale. The lower the score, the more severe are the children’s behaviors.

The utilization of a particular service (individual therapy, family therapy, collateral, family collateral, case management and medical services) among families of children with a mental disorder might have a reflection of the closing CGAS score. The hypothesis of this study is if a family utilized services that involved family and community involvement (family therapy, family collateral, collateral, case management), the child’s closing CGAS score will be higher than a family who only utilize
individualized therapy (individual therapy, medical services) services.

The variables that were analyzed in this study provide insight into the effectiveness of services provided by VCSS, help to identify training needs, and can identify areas that VCSS can improve in. The limitations of this study are that the case files documented the frequency of the types of services that were utilized but did not reflect if the families were informed of the services that they were eligible to receive. The CGAS scores were given by the clinicians based on their judgment, which may not be reliable. In addition the study size was a small sample that was selected from one geographic area in San Bernardino.

Sampling

The sample for this study was taken from closed case files at VCSS. Data was extracted from 45 closed VCSS case files of families who lived in San Bernardino County and received services from the period of July 1, 2005 until June 30, 2006. These dates were selected because they coincide with the most current State of California fiscal year. The 45 case files were drawn from the VCSS
data base which had a list of case files that were opened and closed during the period identified above. The data collection occurred over the period of two days and took a total of 18 hours.

Data Collection and Instruments

A data extraction tool was developed to collect the needed information, and can be found in Appendix A. This study collected data on the following variables: gender, age, ethnicity, types of services utilized, school placement, history of substance abuse, initial CGAS score, closing CGAS score, and diagnoses. The types of services families utilized were cross tabulated with the child's closing CGAS score.

The data extraction tool provided a structure in collecting the same information from all of the charts. The limitation of the tool was that it had not been tested in another study to prove reliability. It is not certain if the clinician updated the child's CGAS score accurately based on evidence of the child's functioning during the closing phase of the case. The data extraction tool was given to VCSS Director for her review.
This study focused on independent variables of age, gender, ethnicity, types of services received, disorder, initial GAS score, history of substance abuse and school placement. The dependent variable was the outcome of the case which was the closing CGAS score.

The following variables were interval: assessment date, last service provided date, initial CGAS score, and closing CGAS score. The following variables were nominal: ethnicity, gender, mental disorder, school placement, history of school suspensions and referrals, history of substance abuse and services on treatment plan.

Procedures

A consent form from the Director of VCSS was obtained to have access to the charts. Once the Director provided consent, the days and time range the charts could be reviewed was established. A chart was developed in order to organize which charts were opened during the fiscal year of July 1, 2005 through June 30, 2006. The data was collected in the winter of 2007. The data was gathered by reviewing gender, age, ethnicity, types of services utilized, school placement, history of substance abuse, initial CGAS score, closing CGAS score, and
diagnoses from children’s charts in a locked chart room at VCSS in San Bernardino. The data collection occurred over the period of two days and took a total of 18 hours. It took an additional five hours to enter the data into Statistical Package for the Social Sciences (SPSS) computer software program for analysis. The data collected was kept in a locked box stored in the researcher’s car.

Protection of Human Subjects

The human subjects in this research project were case files of children, between the ages of 4 and 17, who were clients that received mental health services from VCSS. In order to keep all records confidential, the data that the researcher collected did not include identifying information. Identifying information includes the names, addresses, social security numbers, telephone numbers or Medi-Cal numbers of the children. Each data form was assigned a case number for tracking purposes.

Data Analysis

The data retrieved was analyzed using the Statistical Package for the Social Sciences (SPSS). Descriptive statistical analyses included frequency,
correlations and t-tests. Patterns in the data were observed and noted.

Summary

The purpose of this study was to investigate the relationship between a client's initial CGAS score and their closing CGAS score based on the type of community-based services (individual therapy, family therapy, family collateral, collateral, case management and medication services) the families utilized from VCSS. A data extraction tool was used to collect demographic information about the clients' ages, genders, ethnicity, mental disorders, types of services received, and CGAS score. The methods used to insure the protection of human subjects was described. There was a description of the instruments used and data analysis methods employed were also reported.
CHAPTER FOUR

RESULTS

Introduction

This chapter looks at the results gathered from the study. The chapter describes demographics of VCSS clients. Reported in this chapter are significant findings of frequencies, percentages and paired-sample t-test statistical analysis.

Presentation of the Findings

Data were extracted from a total of 45 closed case files. Table 1 shows the demographic characteristics of the clients utilizing mental health services. The majority of the clients were males (60%) and 40% were females. The age range of the clients was from 4 years of age to 17 years of age. The mean age was 12 years old. Forty-eight percent of the clients were in the 13 to 17 old age range. There were 31% of clients who were in the 9 to 12 years old age range and 20% of clients who were in the 4 to 8 years old age range. The majority of the clients were Hispanic (42%); 29% of the clients were African-American; 24% of the clients were Caucasian and 2% of the clients were Asian or in the Other category.
Table 1. Demographic Characteristics of Respondents

<table>
<thead>
<tr>
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<th>Percentage</th>
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</tr>
<tr>
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<td>Female</td>
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<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-8</td>
<td>9</td>
<td>20%</td>
</tr>
<tr>
<td>9-12</td>
<td>14</td>
<td>31%</td>
</tr>
<tr>
<td>13-17</td>
<td>22</td>
<td>48%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>11</td>
<td>24%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>19</td>
<td>42%</td>
</tr>
<tr>
<td>African-American</td>
<td>13</td>
<td>29%</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2%</td>
</tr>
</tbody>
</table>

Table 2 shows the diagnosis of the participants, their initial CGAS scores and closing CGAS scores. Majority of the clients were diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) (40%). There were 22% clients who were diagnosed with depression. Eight clients were diagnosed with Oppositional Defiant Disorder. Twenty percent of the clients had a diagnosis other than the above diagnosis.
The majority of the clients had an initial CGAS score between 37-50 (64%). There were fourteen clients who had a CGAS score between 51-60 was 32%. The highest ranking assessment scores were between 61-63 (4%). The majority of the clients had a closing CGAS score between 35-50 (58%). There were 29% of clients who had a closing CGAS score between 51-60. There were 13% of clients who had a CGAS score between 61-70 compared to the initial CGAS score.

The increase in clients who ranked between 61-70 reflects there was an increase in their progress from entry into the program until they were discharged. A paired t-test was conducted to see whether there was a significant difference between initial and closing CGAS scores. The findings of the t-test were significant \( t = -3.004, \) \( df = 44, \) \( p = .004 \). The respondents significantly improved their CGAS score at closing compared to their initial score.
Table 2. Diagnosis, Closing Children Global Assessment Scale Score and Initial Children Global Assessment Scale Score

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADHD</td>
<td>18</td>
<td>40%</td>
</tr>
<tr>
<td>Depression</td>
<td>10</td>
<td>22%</td>
</tr>
<tr>
<td>Oppositional</td>
<td>8</td>
<td>18%</td>
</tr>
<tr>
<td>Defiant Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>20%</td>
</tr>
<tr>
<td>Initial CGAS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37-50</td>
<td>29</td>
<td>64%</td>
</tr>
<tr>
<td>51-60</td>
<td>14</td>
<td>32%</td>
</tr>
<tr>
<td>61-63</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Closing CGAS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35-50</td>
<td>26</td>
<td>58%</td>
</tr>
<tr>
<td>51-60</td>
<td>12</td>
<td>29%</td>
</tr>
<tr>
<td>61-70</td>
<td>7</td>
<td>13%</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2%</td>
</tr>
</tbody>
</table>

Table 3 reflects the types of school placements the clients were in. The majority of the clients were in typical school placement (71%) and 29% of the clients were in placements other than typical. The great majority of the clients (82%) had a history of school suspensions.
This high percentage reflects how the clients' behaviors were affecting their school placement and the importance of community based interventions in stabilizing the clients functioning. There were 10% of the clients who had a history of substance abuse.

Table 3. School Placement, History of School Suspensions, and Referrals and History of Substance Abuse

<table>
<thead>
<tr>
<th>School Placement</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typical</td>
<td>32</td>
<td>71%</td>
</tr>
<tr>
<td>Special-Education</td>
<td>6</td>
<td>13%</td>
</tr>
<tr>
<td>Continuation/ Adult School</td>
<td>4</td>
<td>9%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>History of School Suspension/ Referral Ethnicity</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>37</td>
<td>82%</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>18%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>History of Substance Abuse</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>10</td>
<td>22%</td>
</tr>
<tr>
<td>No</td>
<td>35</td>
<td>78%</td>
</tr>
</tbody>
</table>

Table 4 reflects the frequency distribution of various types of services clients received: family therapy, case management, individual therapy, collateral
and medical services. The great majority of the clients did not receive family therapy (71%). This is a high percentage which is alarming since the clients are minors and legally cannot make life changing decisions without the consent and involvement of their guardians. Almost every client did not receive case management services (96%). This high percentage reflects that families are not being referred to community resources which can support them when they no longer qualify for VCSS services. The majority of the clients received individual therapy (98%). The majority of the clients received collateral services (73%) which mean the clinicians had contact with individuals involved in the clients’ lives such as family members, teachers and doctors. There were 73% of the clients that did not receive medical services. Medical services include psychiatric evaluations, medication support and other psychiatric consultation which is provided at VCSS clinic. The high percentage of clients who do not seek medical services might be due to inconvenience because these services not being offered by VCSS in the clients’ community.
Table 4. Types of Services

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13</td>
<td>29%</td>
</tr>
<tr>
<td>No</td>
<td>32</td>
<td>71%</td>
</tr>
<tr>
<td>Case Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>No</td>
<td>43</td>
<td>96%</td>
</tr>
<tr>
<td>Individual Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>44</td>
<td>98%</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Collateral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>33</td>
<td>73%</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
<td>27%</td>
</tr>
<tr>
<td>Medical Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12</td>
<td>27%</td>
</tr>
<tr>
<td>No</td>
<td>33</td>
<td>73%</td>
</tr>
<tr>
<td>No</td>
<td>35</td>
<td>78%</td>
</tr>
</tbody>
</table>

A series of independent sample t-tests were conducted to assess whether types of treatment made a difference in the improvement of CGAS scores. The improvement in CGAS scores were not related to the types of treatment the clients received.
Summary

The details related to the frequency of the variables and percentages were presented. This study looked at the relationships among and between variables, and specifically at the initial and closing CGAS scores to determine if relationships existed with the independent variables. The client significantly improved their closing CGAS score compared to their initial CGAS score.
CHAPTER FIVE

DISCUSSION

Introduction

This chapter discusses the findings of this study. The limitations of this study, recommendations for further research, policy and procedure changes for VCC, and areas where additional training are needed for VCSS workers are discussed. Last, this chapter concludes with a summary of the implications for social work practice.

Discussion

This study answered the following question: Does the type of community-based service (individual therapy, family therapy, family collateral and collateral and medication services) a family utilizes contribute to an increase in the client’s CGAS score? My hypothesis was not supported because only a few clients utilized family or case management services. However the clients CGAS scores increased which reflects their progress.

Hispanic families represented the majority of clients who utilized VCSS services. This ethnicity outcome is consistent with the San Bernardino population. In Garland’s study (2005), racial/ethnic disparities in
the use of a variety of outpatient, inpatient, and informal mental health services among high-risk youths were examined. The outcome of racial/ethnic disparities of Garland's study was similar to this study's outcome in service utilization and how the lack of utilization remains a public health problem.

In this study, Attention Deficit Hyperactivity Disorder (ADHD) was the most common disorder of the clients. ADHD is one of the most common mental health disorders in children within the United States. The majority of the clients were in typical school placement, although there were 82% of clients who had a history of school suspensions. This high percentage reflects how the clients' behaviors affected their school placement and that community based interventions are important in stabilizing the clients' functioning. These children may need adaptation and/or school based mental health services to function in typical class placements.

If there is a high rate of school suspensions, then there should be a high rate of case management services in order to coordinate additional support for these children. In this study, there was a low amount of case management services which could reflect why school
suspensions are high. The low percentage of case management services also indicates that the families were not being referred to community resources, while their cases were opened, in order to prepare them with enough support when they no longer qualified for VCSS services. There were 73% of the clients that had not received medical services. Medical services include psychiatric evaluations, medication support and other psychiatric consultation which are provided at VCSS clinic. The families might have cultural biases toward psychiatric services. The clinicians might not be informing the families of the health benefits from psychiatric consultations. The high percentage of clients who do not seek medical services might be due to inconvenience because these services not being offered by VCSS in the clients' community.

The majority of the clients’ scores increased with limited utilization of specific services such as family therapy and case management. The increase was based on the closing CGAS score. This score is given by the client’s clinician based on the clinician’s observations. It is not clear if the client’s improvement was due to a
subjective assessment from the clinicians who provided the services.

Limitations

One limitation of this study was that case files documented the frequency of the types of services that were utilized but it did not reflect if the families were informed of the services that they were eligible to receive. The CGAS scores were given by the clinicians based on their judgment which may not be reliable. The method of giving children CGAS scores was subjective. VCSS is a managed care mental health agency that follows state and county regulations when documenting if clients qualify for services and when they have met their treatment goals. The CGAS score has to be at a certain score to make it evident that a client meets medical necessity for out-patient services and in order to open the case. Whether the clinician reassessed the clients CGAS score from initial assessment to closing assessment is unknown. Another limitation of this study was a small sample size that was selected from one geographic area in San Bernardino.
Recommendations for Social Work Practice, Policy and Research

As demonstrated in the results, many children diagnosed with a mental disorder have a history of school suspensions/referrals which leads to their being placed in restrictive school settings. It should be standard practice for social workers to provide case management linkage to community resources that will be a diversion from students being placed in restrictive school settings. It is important for agencies to provide trainings to social workers that emphasize the importance of involving family members and other support systems in treatment.

An increase in community-based training will increase the social workers' knowledge on how to coordinate interventions that involve the clients' community support systems. This training will provide insight into program effectiveness and lead to informed program development. Being aware of the utilization of community-based services can support decreasing the number of children with aggressive behaviors and inadequate functioning who are placed out of their families' home and in a restrictive school setting.
A change in policies that assess social workers' knowledge of community resources and the amount of case management they are providing to their clients will increase the quality of services. Social workers should be aware of the types of services they are providing their clients and the importance of involving the children's families and other community agencies who are a part of the clients' support systems. Providing services within the clients' community setting, social workers can be aware of the norms in the household, assess the clients within their settings and plan on how supports will be provided within clients' homes and communities. Within the service termination process, social workers will be able to encourage the families to follow-through with learned community-based interventions.

A recommendation for change in social policy would be to promote community based services as a diversion to children being placed in restrictive home and school environments. If mental health providers had policies that mandate and regulate community involvement in the delivery of services then more families would have
support within their communities following out patient services.

A recommendation for more coursework on community-based treatment approaches in the social work curriculum would improve social workers' knowledge on this form of treatment. The utilization of community based services and the outcomes of this utilization are often neglected. Due to this neglect, many families are not receiving services that will support them in sustaining progress when therapeutic services terminate.

It is important for social workers and other professionals to be aware of their clients' communities and provide services within the clients' communities in order for services to be person centered.

This study can be used as a guide for training for social workers and other professionals in order to understand the importance of community-based services. This study helps professionals become more knowledgeable about the clients they provide services to and reasons why some families do not improve after receiving services. More research is needed on the utilization of mental health services by families of children diagnosed with a mental disorder.
Conclusions

This study investigated the relationship between clients' functioning during their initial assessment provided by VCSS compared to their functioning when they were discharged from VCSS based on the families' utilization of community-based services. The majority of the clients had an increase in CGAS scores at their closing assessment. Most clients utilized individual therapy. A few clients utilized family therapy and case management services. While the majority of the clients had a history of school suspensions and referrals, limited case management and family services were provided.

It is hoped this study will help social workers to increase their knowledge on the importance of community-based services and provide more case management and family services. Increasing social work knowledge on community-based services will encourage further research which will result in an improvement in services to families of children with a mental disorder.
APPENDIX

DATA EXTRACTION TOOL
1. Case Number:

2. Assessment Date:

3. Last Service Provided Date:

4. Age:

5. Ethnicity:
   1  Caucasian       2  Hispanic
   3  African-American 4  Asian
   5  Other

6. Gender:
   1  Male       2  Female

7. Mental Disorder:
   1  ADHD       2  Bipolar
   3  Depression 4  Conduct Disorder
   5  Oppositional Defiant Disorder 6  Other

8. Initial CGAS score:

9. Closing CGAS score:

10. School Placement:
    1. Typical       2. Special Ed.
    3. NPS           4. Home
    5. Continuation / Adult 6. Other

11. History of school suspensions and referrals:
    1. Yes       2. No

    1. Yes       2. No

13. Services on Treatment Plan:
    1. Individual Therapy       2. Family Therapy
    5. Collateral               6. Medical Service
    7. Family Collateral

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REFERENCES


