

Running head: CLINIC-PLUS PROGRAM

Child and Family Clinic-Plus Program: How to Involve Children and Families in

Mental Health Screenings in a Clinic Setting

Yao-Szu Tsou

The College at Brockport

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Abstract

This study was aimed at using a survey to seek strategies to improve the mental health screening rate for the Child and Family Clinic-Plus program in a clinic setting. The Child and Family Clinic-Plus program is a package involving broad-based screening in natural environments, comprehensive assessment, and evidence-based treatment. A questionnaire was conducted to collect the Clinic-Plus practitioners' experiences and strategies regarding improvement of the screening rate and ways to better engage children and families in the Clinic-Plus Program in Western New York. Themes emerged from the results including participants utilizing multiple screening sites and personnel to conduct screenings, face to face encounter with families working well, learning collaborative meeting held by Office of Mental Health being helpful, and participants providing their challenges regarding screenings and strategies to engage families. Areas of future research developments were discussed. It concluded with the implications for practitioners to improve their practice of involving children and families in mental health screenings.

Child and Family Clinic-Plus Program: How to Involve Children and Families in
Mental Health Screenings in a Clinic Setting

Statement of the Problem

Child and Family Clinic-Plus Program is a new service model for the New York State Office of Mental Health (NYOMH) that was first implemented in 2007. This program is aimed at improving the mental health well-being of children. It recognizes the need for the transformation of clinic treatment. The underlying rationale and approach of this program is that childhood mental health is important for the social, emotional and behavioral well-being of children. Research shows that delayed access to mental health care not only puts children at risk for mental illness, but also renders them vulnerable to serious social, academic, and emotional difficulties (Kessler, Avenevoli, & Ries Merikangas, 2001). Early intervention and prevention start with early detection. This program works closely with families to help early identification of their children's emotional needs by providing screenings, comprehensive assessment, in-home treatment, expanded clinic-based treatment, and evidence-based treatment (NYOMH, 2008).

Existing data about the Clinic-Plus program was collected including cumulative services information, such as the number of children screened, the number of children receiving comprehensive assessments, those admitted to clinic treatment, and those receiving in-home treatment. It will be beneficial to analyze what models of screening strategies have been working to involve children and families in accessing mental health screenings. Since the program started operating, many service providers have faced practical challenges and problems, especially toward engaging more children and families in getting screenings. Minimal research attention has been directed towards these

concerns. It is important to solve practical problems for service providers who are currently conducting the Clinic-Plus program. The survey results can inform Clinic-Plus providers about strategies to involve more children and families in the mental health screenings and provide the following comprehensive assessments and evidence-based treatments to those children and families in need.

Purpose and Research Questions

The purpose of this study is to seek strategies to improve the mental health screening rate for the Child and Family Clinic-Plus program in a clinic setting. The objectives of this research are: (a) To conduct a survey (See Appendix A and B) by mailing out to the participants asking them about their problems regarding the conducting of screenings and eliciting strategies to improve screening rates of the Clinic-Plus program; (b) To analyze the survey results and make recommendations for Clinic-Plus program providers.

By examining the effective models of screening processes, the researcher will identify solutions and make suggestions to improve the screening rate for this clinic setting. With this understanding of involving more children and families in mental health screenings, families can proactively recognize and get treatments for their children's mental health issues to prevent later consequences. Mental health counselors and other providers can better engage children and families in identifying their needs and planning interventions that are scientifically proven to work. Researchers can better isolate variables and develop models for effective screening process.

Review of Literature

The Clinic-Plus program is aimed at providing early identification and intervention for children and adolescents as well as vulnerable populations who need mental health services. Current literature has investigated the prevalence (Kessler, Mcgonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen, & Kendler, 1994) and impact of childhood mental disorders (Kessler, Avenevoli, & Ries Merikangas, 2001) on these populations as well as the importance of screening (Bricker, Davis, & Squires, 2004) and the characteristics of the Clinic-Plus program screening tool (Jellinek, Murphy, Robinson, Felins, Lamb, & Fenton, 1988). This literature review will address the literature in the following way: (a) Background, rationale, and major components of the Clinic-Plus program; (b) The importance of the program in terms of the impact of childhood mental disorders; (c) Essential features of screening and the Clinic-Plus screening tool; (d) Utilization of clinic settings to conduct screening; (e) Action research and the role of self-reflection for practitioners to improve the quality of mental health services.

Background of Child and Family Clinic-Plus Program

President's New Freedom Commission on Mental Health. In April 2002, President George W. Bush established the President's New Freedom Commission on Mental Health (NFC) to identify policies that could be implemented by Federal, State and local governments to increase the greatest utility of existing resources, advance coordination of treatments and services, and integrate community resources for adults with a serious mental illness and children with a serious emotional disturbance (NFC, 2002).

The final report of the Mental Health Commission entitled "Achieving the Promise: Transforming Mental Health Care in America" identified barriers which impede care for

people with mental illnesses. The Commission called for the need of transforming mental health care. The current fragmented mental health system, the result of disjointed reforms and policies, and poor access to the treatment all need improvement for children and their families to get quality care and services (Commission Reports, 2003).

In order to achieve the transformation of the children's mental health system, the New York State Office of Mental Health (NYOMH) acknowledges the importance of changing current clinic service structure to effective and flexible services. The Office of Mental Health conducts a Child and Family Clinic-Plus Program in 2007 aimed at systematically identifying childhood mental illness through screenings and providing evidence-based mental health services (NYOMH, 2008).

Overview of the Child and Family Clinic-Plus Program. The Office of Mental Health recognizes that the current mental health approaches needs to be more proactive and systematic in recognizing childhood emotional disturbance and engaging children and families to utilize the subsequent assessments and treatments. The Child and Family Clinic-Plus Program calls for more aggressive early recognition activities by providing community education, screening, and child and family engagement (NYOMH, 2008).

The major components of this Clinic-Plus program include the following: (a) Broad-based screening: The local mental health department collaborates with agencies to conduct systematic screenings for the identified priority populations who will benefit from a more comprehensive assessment; (b) Comprehensive assessment: All Clinic-Plus programs are required to conduct a comprehensive assessment including a comprehensive, diagnostic psychiatric formulation, evidenced-based psychometric scale assessments, and a thorough interview with the family to recognize their strengths, needs, and goals for the

treatment; (c) Evidence-Based Treatment: Clinic-Plus programs offer families clinical interventions that the outcomes are research proven to be effective (NYOMH, 2008).

The Process of the Clinic-Plus Program. Children and parents sign up for participation for the Clinic-Plus program. Children receive screenings by program screeners using Pediatric Symptom Checklist (PSC) (Jellinek et al., 1988) (See Appendix C) or Pediatric Symptom Checklist Youth Report (PSC-Y) (Jellinek, Murphy, & Burns, 1986) (See Appendix D). If the screening result shows positive in the screening, the screener will contact parents to get consent for a referral for comprehensive assessments. The counselor in the clinic will do the comprehensive assessments by interviewing and assessing the child and the family. By using DSM IV-TR, the counselor will provide a preliminary diagnosis and evaluate the need for treatment. If the parent and the child recognize the need for treatment, they can make the referral to the clinic and schedule an intake. After the intake and pre-admission sessions, children can continue the treatment depending on their situation.

Why Is the Clinic-Plus Program Important?

The Clinic-Plus Program recognizes the fact that mental disorders are relatively common among children and adolescents as well as vulnerable populations, such as children in foster care systems and those who are facing poverty. Because the onset of mental disorders often begins in childhood or adolescence, it has a great impact on social development and life course role transitions. However, children with emotional disturbance or behavioral disorders often go untreated or delay treatment. Therefore, the Clinic-Plus program stands out as a proactive role to help families early recognize

children's mental health needs and develop early intervention strategies to prevent adverse outcomes of childhood mental disorders.

The Prevalence of Mental Disorders among Children. Epidemiologic studies demonstrate that childhood emotional and behavioral disorders represent a relatively common and significant health burden in modern societies (Bayer & Sanson, 2003). A number of prevalence studies report that approximately 12-25% of all American school-age children and 13% of preschoolers have an emotional and/or behavioral disorder. (Brandenburg, Friedman, & Silver, 1990; Costello, Angold, Burns, Stangl, Tweed, Erkanlia, & Worthman, 1996; Costello, Costello, Edelbrock, Burns, Dulcan, Brent, & Janiszewski, 1988; Costello, Edelbrock, Costello, Dulcan, Burns, & Brent, 1988; Lavigne, Binns, Christoffel, Rosenbaum, Arend, Smith, Hayford, McGuire, & the Pediatric Practice Research Group, 1993). Some studies even found that there is an increasing prevalence of behavioral and emotional problems in children and adults. The results are not only being found in the U.S., but also in other countries (Kelleher, Childs, Wasserman, McInerney, Nutting, & Gardner, 1998; Ryan, Williamson, Inyegar, Orvaschel, Reich, Dahl, & Puig-Antich, 1992).

One review (Egger & Angold, 2006) reported the prevalence of emotional and behavioral disorders in preschoolers range from 14%-26.4%. In another review (Roberts, Attkisson, & Rosenblatt, 1998), the prevalence of psychiatric disorders among preschool children is reported between 3.6% and 24% with a mean of 10.2%. The prevalence rates between school children age from 6-13 years are in the range of 5% to 30% with a mean of 13.2%. This review also indicated an increase of psychopathology in preschool to school children (Roberts et al., 1998).

Among specific psychiatric disorders, anxiety disorders are the most prevalent of all childhood mental disorders (Costello et al., 1996), which affecting 15% to 24% of youngsters before adulthood (Bosquet & Egeland, 2006; Kasen, Cohen, Skodol, Johnson, & Brook, 1999; Kessler, 1994). The prevalence rates of anxiety disorders in school-age children approximately range from 10% to 20% (Barrett & Dadds, 1997; Cole, Peeke, Martin, Truglio, & Seroczynski, 1998). For depression, the most frequently reported rates of major depressive disorder (MDD) is 1% of preschoolers, 2% of school-aged children, and 5-8% of adolescents (Birmaher, Brent, & AACAP, 1998; Jellinek & Snyder, 1998). The lifetime prevalence of broadly defined bipolar disorder (including bipolar I, bipolar II, and cyclothymia) among children and adolescents is nearly 1% (Lewinsohn & Klein, 1995). From the above mentioned studies, it is clear that mental health problems are comparatively common among children and adolescents in the general population.

Consequences of Childhood Mental Disorders. According to Costello, Egger, and Angold (2005), there is increasing evidence indicating that mental health disorders have the greatest societal costs than any other class of diseases (Murray & Lopez, 1996). In 1996, the World Health Organization (WHO) published *The Global Burden of Disease* (Murray & Lopez, 1996) that has revealed a drastically different picture of disease and has demonstrated the public health burden of psychiatric disorders. In the past, disease tended to be ranked in terms of the impact on mortality rates. This WHO project adopted a disability-adjusted life years (DALYs), which measure the number of expectable years of life lost (to death) or lived with disability. Among the 10 leading causes of DALYs in developed countries for the age range 15 to 44, nine out of 10 leading causes of DALYs is either a psychiatric disorder or strongly related to a psychiatric disorder (e.g., major

depression, alcohol use, schizophrenia, self-inflicted injuries, bipolar disorder, drug use, OCDs, and violence) (Costello et al., 2005; Murray & Lopez, 1996). According to Kessler, Avenevoli, and Ries Merikangas (2001), the reasons that psychiatric disorders cause the greatest suffering including the high prevalence rate, early ages of onset, strong patterns of chronicity, and substantial role impairments associate with many mental disorders. Among those reasons, early age at onset is remarkably the most distinctive characteristic because there are no other chronic illnesses that have onset as early as those of mental disorders (Kessler et al., 2001).

Because mental disorders often begin in childhood or adolescence, it has a much greater impact than other classes of illness on social development and life course role transitions (Kessler et al., 2001). For example, mental disorders in childhood are linked to a number of school and social impairments throughout development, including difficulties making friends and focusing on schoolwork (Birmaher, Bridge, Williamson, Brent, Dahl, Axelson, Dorn, & Ryan, 2004), school refusal, truancy (Egger, Costello, & Angold, 2003), lower academic achievement (Grover, Ginsburg, & Ialongo, 2007; Ialongo, Edelsohn, & Kellam, 2001; Shahar, Henrich, Winokur, & Blatt, 2006), and truncated educational attainment (Kessler, Foster, Saunders, & Stang, 1995). Psychiatric disorders also are associated with adverse effects on teenage childbearing (Kessler, Berglund, Foster, Saunders, Stang, & Walters, 1997) and marital stability (Kessler, Walters, & Forthofer, 1998). Therefore, the consequences of childhood mental disorders provide an underlying rationale why it is critical to early identify and intervene so that the subsequent adverse effects on social development and life role functioning can be minimized.

Children with Mental Disorders Often Go Untreated or Delay Treatment. With the high prevalence rates and associated functional impairment, it might be expected that childhood mental disorders will be early identified and intervened. However, research shows that up to 75% of youth with anxiety and depressive disorders do not receive treatment (Essau, 2005; Keller, Lavori, Wunder, Beardslee, Schwartz, & Roth, 1992; Wu, Hoven, Cohen, Liu, Moore, Tiet, Okezie, Wicks, & Bird, 2001). Kessler, Olfson, and Berglund (1998) found that most people with DSM-III-R mood, anxiety, and addictive disorders eventually make treatment contacts, but treatments are usually delayed for six to 14 years across these disorders. Delays and low overall probabilities of lifetime treatment contact were found most likely among people with childhood-onset mood and anxiety disorders (Kessler et al., 1998).

There are several reasons that explain why children with mental disorders delay treatment or remain untreated. For instance, parents may be unable to recognize signs of mental disorders and the need for treatment (Fox, Halpern, & Forsyth, 2008). In addition, children usually need to depend on the adults around them to initiate the referral process (Costello & Janiszewski, 1990; Dulcan, Costello, Costello, Edelbrock, Brent, & Janiszewski, 1990). Delayed access to care for youths in the 14-20 year-old range not only exposes them to the consequences of psychiatric disorders, but also results in developmental impairment and rendering them vulnerable to serious social, academic, and emotional dysfunctions during the most fundamental period of life (Kessler et al., 2001). These findings call for a proactive mental health approach to identify those in need and to intervene at the earliest possible opportunity (NYOMH, 2008).

The Need of Mental Health Services for Vulnerable Populations. The Clinic-Plus program acknowledges the necessity to put targeted efforts in recognizing vulnerable children's mental health needs (NYOMH, 2008). For example, children in foster care replacements are at high risk of developing mental health problems. Poverty is one of the barriers for children and adolescents accessing to care, especially for urban minority populations. Parent with mental health issues is also a risk factor that renders youths vulnerable to mental illness.

Studies conducted in the 1970s and early 1980s estimated that the prevalence of foster children's emotional and behavioral problems was 30% to 40% (Moffat, Peddie, Stulginskas, Pless, & Steinmetz, 1985; Schor, 1982; Shah, 1972; Wolkind & Rutter, 1977). More recent studies have yielded even higher rates. Thirty-five percent to 85% of children entering foster care exhibit mental health problems (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Hochstadt, Jaudes, Zimo, & Schachter, 1987; Pilowsky, 1995; Stein, Rae-Grant, Ackland & Avison, 1994; Thompson & Fuhr, 1992).

A survey conducted by Clausen et al. (1998) indicated that children in foster care manifested high levels of mental health and behavior problems as well as difficulties in the social competence domain. The Northwest Foster Care Alumni Study found that 54.4% of foster children had significant mental health issues including depression, social problem, anxiety, and posttraumatic stress disorders (PTSD) (Casey Family Program, 2005). In a study, Burns, Phillips, Wagner, Barth, Kolko, Campbell, & Landsverk (2004) found that almost half of the children in foster care showed clinical signs of mental health problems. Among those children who had the worst symptoms, only 4% received mental health care and 84% did not have any mental health services provided (Burns et al., 2004).

Therefore, it is critical to acknowledge and address mental health needs for children in foster care.

Ellermann (2007) explored various influences on foster children's mental health. Major themes emerging from children in care included difficulties associated with perceiving oneself as being different, the children's need for coping strategies, problems encountered with the foster care system, transitions between foster homes, and the need for medical homes. The result also revealed that it is common for foster children to experience anxiety, depression, negative self-esteem, and feelings of mistrust.

Poverty has adverse effects on childhood development and is one of the risk factors associated with the occurrence of mental health problems for youngsters (U. S. Public Health Services, 2000). Research studies (Duncan, Brooks-Gunn, & Klebanov, 1994; Garrett, Ng'andu, & Ferron, 1994; McLeod & Shanahan, 1997) showed that economic deprivation has an impact on children's physical and emotional development. For example, children facing economic disadvantages are likely to experience poor health and to die young during childhood as compared to rich or middle class children (Lewit, Terman, & Behrman, 1997). Children exposed to persistent poverty are more likely to appear higher levels of depression, anxiety, social withdrawal, peer conflict, and aggression (McLeod & Shanahan, 1997). Duncan et al. (1994) identified that family income is strongly related to child IQ and behavior problems even after controlling for a number of other parental characteristics. They found that persistent and extreme poverty has negative effects on children's cognitive development and externalizing behaviors (Duncan et al., 1994). Children who are in families experiencing persistent economic hardship also have greater difficulties with peer relationships, more conduct problems at

school, and lower self-esteem than children who experienced poverty intermittently (Bolger, Patterson, Thompson, & Kupersmidt, 1995).

According to Tuma (1989), children have been identified as the forgotten population in the care of mental health. Among this forgotten population, urban children who are poor and of minority status have been shown to have great risks of psychiatric disorders (Tuma, 1989). Gonzalez (2005) pointed out that the association of poverty, being an ethnic minority, and the use of mental health services are interrelated. Chow, Jaffee, and Snowden (2003) also noted that the relationship between race/ethnicity, poverty, and mental health services utilization is complex. Ecological studies (Dear & Wolch, 1987; Wolch & Dear, 1994) revealed that people with mental illness and members of racial/ethnic minority are excessively concentrated in high-poverty areas. Research (Bui & Takeuchi, 1992; Cohen & Hesselbart, 1993; Kazdin, 1993; McKay, McCadam, & Gonzales, 1996) also reported that children who are facing poverty are at risk of developing mental health problems, are less likely to engage with mental health treatment, and are more likely to both drop out of services and shorter lengths of treatment. Griffin, Cicchetti, and Leaf (1993) found that urban children, and in particular low-income minority children, are at higher risk for psychopathology, and are less likely to receive child mental health services. Utilization rates of mental health service are lower for urban, low-income minority children than those of middle-class children living in suburban environments (Armbruster & Fallon, 1994; Garland & Zigler, 1994; Kazdin, 1993). Kazdin (1993) reported 50-75% of urban children that are in need of mental health treatment do not receive care, and of those who do receive some level of care many end treatment prematurely.

Considering the use of mental health services is underutilized by poor minority children and their families, it is critical to examine the reasons why they do not receive treatment. Many barriers to the mental health care by low-income minority children and their families have been documented in the literature, such as transportation problems, inconvenient location, cost of the service, lack of health insurance (Anderson, 1995; Lewit et al., 1997; U.S. DHHS, 1999, 2001), stigma associated with counseling services (Gary, 2005), and lack of information regarding available services (Caldwell, 1996; Cauce, Domenech-Rodriguez, Paradixe, Cochran, Shea, Srebnik, & Baydar, 2002; Taylor, Jackson, & Chatters, 1997).

Parental mental illness also places children at a significant risk for psychiatric disorders (Maybery, Ling, & Szakacs, 2003). Critical familial factors including parental mental illness and parenting behavior have a great impact on child and adolescent well-being (Conger, Ge, Elder, Lorenz, & Simons, 1994; McLoyd, 1990; 1998). According to Maybery, Ling, Szakacs, and Reupert (2005), children whose parents have a mental illness may face inconsistency, neglect, trauma of family disruption, and out-of-home placement due to the parent's hospitalization or inability to care for them on a daily basis.

Family disturbances such as marital discord, social adversity, multiple caretakers (Oates, 1997), unemployment, and separations due to hospital admissions as a result of the illness also add to the risk for children developing mental illness (Hall, 1996). Hall (1996) suggested that a high rate of disturbance in children of mental illness can be attributed to hostility, aggression, and disruption in the family.

Parental mental illness can have an impact on child's social, emotional, and physical development (Singleton, 2007). Children learn how to socialize, communicate and relate

to others primarily through the parent-child relationship (Berk, 2005). If a parent has mental health problems, then their ability to relate to their child may be interfered (Singleton, 2007). Parental mental illness is thought to impact negatively on parent-child attachment, which in turn, has been linked to a variety of adverse outcomes (Erwin, 1998; Rutter, 1986). For example, the parent's chronic disability and symptomatology may affect their ability to parent or nurture adequately his or her child (Tussing & Valentine, 2001). The parent may not be responsive to the child's needs, nutrition, and other aspects of basic physical care (Oates, 1997). Such insensitive and unresponsive cues often lead to what has been referred to as avoidant, anxious or insecure/disorganized attachment, which have a negative impact on children's interpersonal relationships (Erwin, 1998; Rutter, 1986). Studies (Jacob & Johnson, 1997) have shown that parents with depression can have communication impairments with their child and may be unconsciously less positive or responsive in their speech toward their child. In addition, Schizophrenia or bipolar affective disorder can also affect parent's abilities to recognize and respond to their child's no-verbal communications (Riordan, Appleby, & Faragher, 1999). Thus, in turn, these impacts can lead to children's impaired relationships (Barnes, 1996).

Adolescents whose parent with a mental illness may be at a vulnerable state to establish their developmental tasks, such as developing independence, identities, value systems, and differentiation of self (Tussing & Valentine, 2001). For instance, their parent's mental illness can jeopardize adolescents' differentiation of self, leaving them feeling guilt and confusion that the ill parent is being left behind (Tussing & Valentine, 2001). Furthermore, many adolescents experience the crisis of identity formation (Tussing & Valentine, 2001). They may experience shamed feelings about a parent's

illness and strive to keep their family life entirely separate from relationships outside the home (Barnes, 1996). As a result of vulnerabilities for children and adolescents with parental mental illness, they need resources to help them cope with a mental illness in the family and to decrease the risks for emotional and behavioral difficulties (Tussing & Valentine, 2001).

Essential Features of Screening

The most essential part of the Clinic-Plus program is to engage children and families to mental health screenings. Bricker, Davis, and Squires (2004) indicated that without screening, clinicians would not recognize who needs further assessments and provide subsequent interventions for them. The following will discuss the rationale and characteristics of screening tools; while reviewing screening programs in the worldwide literature and the psychometric properties of the Clinic-Plus program screening tool.

Early Identification Is the Key. Given the fact that large numbers of children have potential mental health problems, early identification or screening becomes urgent for the subsequent preventions and interventions. According to Bricker et al. (2004), screening refers to “a relatively quick and low-cost procedure for classifying large groups of individuals into two basic categories” (p. 140). The two categories can be considered as those who appear to be developing without problems (ie, OK) and those who appear to be inappropriate (ie, not OK) to the concern. Screening involves brief lists of questions or questionnaires and is completed by the child, teacher, parent, and/or clinician (Costello et al., 2005). Screening is widely used for clinicians to assess mental health problems in schools, primary care pediatric offices, and with high risk populations, such as children in juvenile justice settings (Costello et al., 2005).

Bricker et al. (2004) indicated that the purpose of screening is to allow clinicians to have a more comprehensive understanding of the child's social-emotional development, identifying challenges and capacities so that they can plan developmentally appropriate interventions for the child and family. Costello et al. (2005) also mentioned that screening serves as a tool to identify high- risk children so that they can be selected for further evaluation, clinical services, or preventive interventions. Bricker et al. (2004) believed that early detection is essential to the subsequent interventions that are to be effective. Screening should be seen as the first step or an essential service component in a system approach of early identification and treatment of mental health problems (Bricker et al., 2004).

Characteristics of Accurate Screening Tools. Given the fact that screening is essential for further assessments and treatments (Bricker et al., 2004), the accuracy of screening indices needs to be addressed. Glascoe (2005) indicated that the accuracy of a screening tool is defined by its sensitivity, specificity, and positive predictive value. According to Glascoe (2005), sensitivity indicates “the percentage of children with true problems correctly identified by a screening test” (p. 174). Specificity refers to “the percentage of children without disabilities correctly identified by passing typical or negative findings on screening” (Glascoe, 2005, p. 174). Positive predictive value is “the percentage of children with failing scores on screening tests who are later found to have a disability (Glascoe, 2005, p. 174). Negative predictive value refers to “the proportion classified as not at-risk in whom the outcome is absent” (Hill et al., 2004, p. 810). Similarly, Hill, Coie, Lochman, Greenberg, and the Conduct Problems Prevention Research Group (2004) also noted that the function of a screen is to categorize

individuals into two binary outcomes: those who are at risk and those who are not. A screen's accuracy are derived from the matrix of these two binary outcomes and sensitivity (the proportion of true positives correctly identified), specificity (the proportion of true negatives correctly identified), positive predictive value, or PPV (the proportion of those classified as at risk), and negative predictive value, or NPV (the proportion classified as not at risk).

Glascoe (2005) believed that standards for sensitivity are at the range of 70-80%, meaning 70-80% of children with disabilities will be identified at a single test administration. Specificity should be closer to 80%, which means 80% of children with typical development and only 20% of children with disabilities, so that the referrals for services will be minimized. In reality, positive predictive value is rarely high and values of 30-50% are common (meaning that for every two to three children referred to screening, only one would result in a diagnosis) (Glascoe, 2005).

The psychometric properties of a screening tool need to be considered as in all other tests (Glascoe, 2005). According to Glascoe (2005), screening tools should incorporate standardized and representative norms based on a large national and current sample. That is because the characteristics of the sample should reflect those of the population in terms of parameters such as ethnicity, level of education, income, and language spoken at home (Glascoe, 2005). Hill et al. (2004) also argued that the criterion group of an effective screen used to validate a screening procedure should be representative of the population to be screened; otherwise, tests of specificity and sensitivity will not be stable across populations or some individuals will be underrepresented.

Another consideration is the base rate of the target population's condition (Shenasso, 2002). Shenasso (2002) argued that in theory, sensitivity and specificity of screens are independent from the target condition's base rate; however, in practice, these indices are indirectly influenced by the target condition's base rate. For example, in communities with a high base rate, more highly symptomatic individuals will be found in a screening. These individuals are screened more accurately than borderline individuals who are symptom free or are not clearly in need of intervention. Consequently, a screen may have higher sensitivity and specificity in communities with a high base rate of the target condition (Shenasso, 2002). Meehl and Rosen (1955) also noted that the base rate of the expected outcome will have a significant effect on the PPV and NPV of a screen. Hill et al. (2004) indicated that when reporting sensitivity and specificity of tests, one should reference to PPV, NPV, and base rate. For example, base rate is higher in samples from a high-risk population which also results in higher PPV (Hill et al., 2004).

Other considerations regarding screening tests should take into account including evidence of reliability (i.e., test-retest, inter-rater, and internal consistency) and validity (i.e., concurrent validity and discriminant validity) (Glascoe, 2005). For instance, usually reliability figures greater than 80% agreement are accepted. In validity studies, a screening test should show high correlations with a broad range of diagnostic measures, such as tests of language, intelligence, motor, social, and self-help skills. Various and highly prevalent conditions should be detected through the screening as well (Glascoe, 2005).

Screening Programs in the Worldwide Literature. As far as screening programs to early identify childhood mental health problems, Bricker et al. (2004) recognized the need to utilize a system approach. They proposed a system approach of screening childhood mental disorders including involving parents or caregivers in the screening process, using parents to screen their children, permitting low-cost screening, monitoring large groups of high risk children, and linking screening programs to diagnostic services and intervention efforts (Bricker et al., 2004).

There have been broad efforts to determine the extent of child and adolescent mental health problems and improvement of care facilities by utilizing systematic investigation in the United States (Barkmann & Schulte-Markwort, 2005). For example, TeenScreen, formerly known as the Columbia University TeenScreen Program, is the National Center for Mental Health Checkups' flagship program within the United States, offering voluntary screening to teens and their families through more than 500 local TeenScreen sites in 43 U.S. states. TeenScreen Schools and Communities is specifically designed to facilitate the implementation of mental health checkups of youth ages 11-18 within school and community-based settings (TeenScreen, 2009). The screening is conducted in two stages: teens fill out a questionnaire and interviewed by a clinician. If the clinician verifies a positive result, then he or she will recommends a more comprehensive psychiatric evaluation to the teen and the parents (Friedman, 2006). The screening is voluntary and requires the consent of the parents and the teen. Screening results are confidential and are not shared with any school officials (Friedman, 2006).

Another example is the Screening for Mental Health, Inc., (SMH) established the first community-based mental health screenings with the inception of National Depression

Screening Day in 1991 (SMH, 2009). The program is used to reach people with undiagnosed, untreated mental health problems; refer them to appropriate treatment in their local area; and reduce stigma and promote treatment through a simultaneous public awareness campaign (Wallenstein, Kopans, Meszler Reizes, & Jacobs, 2004). SMH now include both in-person and online screenings for depression, bipolar disorder, generalized anxiety disorder, post-traumatic stress disorder, eating disorders, alcohol problems, and suicide prevention (SMH, 2009).

The literature regarding a systematic screening program outside of the U.S. is scarce [i.e., The Community Mental Health Evaluation Initiative (CMHEI) in Ontario, Canada, 1997; and National Survey of Mental Health and Well-being (NSMHW) in Australia (NSMHW 1, 1997; NSMHW 2, 2007)]. However, many countries implemented screening by conducting an epidemiological screening or establishing the prevalence of child and adolescent mental health disorders. Many epidemiological or prevalence studies from different countries are two-step or multi-stage designs with screening and secondary clinical assessments (Bilenberg, Petersen, Hoerder, & Gillberg, 2005). For example, a two-step design includes: first screening 621 children between the ages of 8-9 years from elementary schools using a questionnaire or assessment tool. Second, screen-positive samples and a sample of screen-negative children will be given in-depth child-psychiatric assessment (Bilenberg et al., 2005). According to Bilenber et al. (2005), the advantages of multi-stage designs of epidemiological or prevalence studies yield more precise prevalence estimates due to larger sample sizes; two-step designs are cost-effective. However, disadvantages are including: greater attrition effect and not guaranteed the parent participation at the second step (Bilenberg et al., 2005).

There have been more than 100 studies worldwide on the prevalence of mental health problems in children and adolescents, many of them are two-step studies. For instance, the Isle-of-Wight Studies (England, Rutter, 1998), the Dunedin Study (Anderson, Williams, McGee, & Silva, 1987), the Puerto-Rico Study (USA, Bird, Canino, Rubio-Stipec, Gould, Ribera, Sesman, Woodbury, Huertas-Goldman, Pagan, & Sanchez-Lacay, 1988), and the Great-Smoky-Mountain-Study-of-youth (USA, Costello et al., 1996) are studies with large international feedback (Barkmann & Schulte-Markwort, 2005). There are also a number of comprehensive reviews that summarized the results from different countries (e.g., Angold & Costello, 1995; Bird, 1996; Brandenburg et al, 1990; Ihle & Esser, 2002; Verhulst, 1995). Roberts, Attkisson, and Rosenblatt (1998) reviewed 52 studies from different countries covering the last 50 years, and concluded that prevalence rates of mental health problems in children and adolescents probably vary between 7 and 12% and a mean prevalence of $M=15.8\%$.

With the understanding of worldwide literature on screening projects in mind, now return to the focus on the Clinic-Plus program. This program adopts the concepts of a system approach which is a multi-stage design that links broad-based screenings in natural environments, comprehensive assessments, and evidence-based treatments for children with mental health problems. Screening enables clinicians to early recognize children's emotional disturbance or mental health problems and to provide services during the most critical period of time. Screening is not to yield diagnoses or label children; rather, screening is a starting step for subsequent assessments and interventions (NYOMH, 2008).

The Clinic-Plus Program Screening Tool. The Pediatric Symptom Checklist (PSC) (Jellinek et al., 1988) (See Appendix C) and the Pediatric Symptom Checklist Youth Report (PSC-Y) (Jellinek et al., 1986) (See Appendix D) are widely used by primary care pediatricians as a screening tool to recognize psychosocial dysfunction of youths as part of routine primary care visits. The PSC is a one-page (35-item) questionnaire of children's emotional and behavioral problems that reflects parents' impressions of their children's psychosocial functioning (Jellinek, 1986).

The reasons why the Clinic-Plus program utilizes the PSC or PSC-Y as a screening tool are as follows. Over the past 10 years the PSC has been shown as an easy administrative screening tool that the psychometric properties have been tested as valid and reliable (Jellinek, Murphy, Bishop, & Pagano, 2008). It also met a number of therapeutic, research, and assessment needs in various clinical, educational, and public health settings not only in the US, but also in other countries (Jellinek et al., 2008). Some researchers (Sturner, 1991) have recommended utilizing the PSC as a routine assessment in pediatric settings; others have suggested the PSC as a psychosocial screening tool to meet the standard of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program of Medicaid (Murphy, Ichinose, Hicks, Kingdon, Crist-Whizel, Jordan, Feldman, & Jellinek, 1996; Pagano, Murphy, Pedersen, Mosbacher, Crist-Whitzel, Jordan, Rodas, & Jellinek, 1996). Several states (e.g., Arizona, Massachusetts) now use the PSC or other brief questionnaires to conduct psychosocial screenings during EPSDT (Jellinek et al., 2008). A number of HMOs (Kaiser of Northern California, Neighborhood Health Plan of Massachusetts) begin to utilize the PSC as a routine check for well-child visits (Jellinek et al., 2008). The PSC is also being used as a part of annual screenings in a

variety of non-health care settings like Ventura County, California Head Start (Jellinek, Bishop, Murphy, & Zigler, 2005).

Validity and Reliability of the Pediatric Symptom Checklist. Jellinek and his colleagues (1988) found that by using a Receiver Operating Characteristic Curve, a PSC cutoff score of 28 has a specificity rate of 68%, a sensitivity rate of 95%, and a false-positive rate of 32% when compared to clinicians' ratings of children's psychosocial dysfunction. It means that 68% of the children identified as PSC-positive will also be identified as impaired by a clinician. Conversely, 95% of the children identified as PSC-negative will be identified as unimpaired (Jellinek, et al., 1988). Similarly high rates of validity have been reported for the PSC-Y and for the translations of the PSC (Jellinek, et al., 1988).

The range of test-re-test reliability of the PSC was reported from .84 to .91. The case/not case classification over time ranges from 83% - 87% (Jellinek et al., 1988; Murphy, Arnett, Jellinek, Reede, & Bishop, 1992). Studies conducted by Murphy and Jellinek (1988) and Murphy et al. (1996) also indicated strong (Cronbach alpha = .91) internal consistency of the PSC items and highly significant ($p < 0.0001$) correlations between individual PSC items and positive PSC screening scores.

In summary, the PSC has been found to be an easy administrative screening tool widely used by various settings, programs, and states. The psychometric properties of PSC indicate that it is a valid and reliable instrument. As a result, the PSC and PSC-Y have been found to meet the assessment needs of the Clinic-Plus program as a screening tool to identify psychosocial dysfunction of youths.

Why the Clinic-Plus Program Chooses Clinic Settings?

New York Office of Mental Health recognizes that the majority of children being treated for emotional disturbance in New York receive their care in clinic programs. Services are theoretically-based and provided in office settings. While this approach works for some, many families find an insurmountable gap between what they hear in the clinic visit and what they need to do at home (NYOMH, 2008).

While there has been a significant effort to provide services in school and community-based locations, most services are still provided in a clinic-based setting. In addition, due to the demands for services and pressures to generate revenue, providers have had difficulty keeping up with current evidenced-based research on early recognition and the engagement and treatment of emotionally disturbed children and their families. Child and Family Clinic-Plus calls for more aggressive community education, improved access, training and clinical development in effective treatment models and short term in-home skill building and support (NYOMH, 2008).

Action Research: The Role of Self-Reflection

In the field of human services or mental health, many professionals conduct action research or self-evaluate their practices to improve quality of their services. According to Stringer and Dwyer (2005), “action research enables human service professionals to work in partnership with clients, community groups, colleagues, and others to explore significant issues and to take therapeutic action to resolve problems” (p.iii). Kemmis and McTaggart (1988) suggested action research is “a form of collective, self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own social or educational practices, as well as their understanding of

these practices and the situations in which these practices are carried out” (p.6).

Practitioners who engage in action research are strongly committed to improving themselves and their professional practices through the process of critical self-reflection (Koch, Arhar, & Rumrill, 2004).

Self-reflection is an active process that describes, analyses, and evaluates experience (Reid, 1994). It enables the practitioners to learn from their own experience and develop effective practice (Johns, 1995). Action research is specifically used to enable clinicians to understand the nature of their situation and validate their practice (Carr & Kemmis, 1986; Hart & Bond, 1995). Action research grounded in the belief that effective solutions to significant problems are more likely to emerge where all “stakeholder” who are affected or have an effect on an issue are involved in the process of inquiry (Stringer & Dwyer, 2005). According to Stringer and Dwyer (2005), the processes of an action research study constitute a number of cycles of observation, reflection, and action. Observation requires practitioners to observe relevant settings and clarify the nature of the research problem. Self-reflection requires practitioners to develop a clearer understanding of what is happening, how it is happening, and who is involved in the stakeholder groups affected by or affecting the issue. Action requires practitioners to plan their next steps and implement appropriate activity (Stringer & Dwyer, 2005). Continuing the cycles of the process enables practitioners to refine the details of their investigation (Stringer & Dwyer, 2005). As a result, mental health practitioners through the use of action research and self-reflection can find an effective solution to the problem that they confronted or improve the quality of their practice.

Summary

The Child and Family Clinic-Plus Program is aimed at improving the mental health well-being of children. It recognizes the importance for transformation of clinic treatment to early detection of childhood mental illness. The review of literature has shown the impact of childhood mental disorders and how mental illness renders children vulnerable to serious social, academic, and emotional difficulties (Kessler, Avenevoli, & Ries Merikangas, 2001). The literature also reviewed the importance of screening (Bricker, Davis, & Squires, 2004), the characteristics of the Clinic-Plus program screening tool (Jellinek, Murphy, Robinson, Felins, Lamb, & Fenton, 1988), the reasons that utilize clinic settings to conduct screening, action research, and the role of self-reflection for clinicians to improve the quality of mental health services. The aim of this research is to seek strategies to improve the mental health screening rate for the Child and Family Clinic-Plus program in a clinic setting. By examining the effective models of screening processes, the researcher will make recommendations for practitioners to improve the screening rate in a clinic setting.

Method

Study Design

The method used in this action research was conducting a survey. The survey instrument (See Appendix A and B) used using open ended questions to obtain participants' perspectives and experiences on the Clinic-Plus screening process. Obtaining feedback and effective screening strategies from participants was an obvious aim of survey data collection. The purpose of the survey was to investigate effective screening settings, models, or strategies utilized by the Clinic-Plus providers participating

in the study. The survey questions were formulated by the researcher, the Clinic-Plus program screener, clinical supervisor, and the director at community mental health agency in a mid-sized city in the northeast United States, which is also one of the Clinic-Plus program providers. There were 10 open-ended questions mailed to the participants asking their perceptions and experiences conducting the Clinic-Plus screenings including: settings utilized to conduct the screenings, reasons and characteristics of the settings, who actually conducts the screenings, description and effectiveness of the models, challenges and problems conducting the screenings, strategies to solve problems, recommendations for increasing screening rate, and helpfulness of learning collaborative meetings for providers (See Appendix B). Along with the survey instrument, a written consent (See Appendix A) was provided to the participants. It was made clear by the researcher that participation in the survey was completely voluntary and anonymous. Participants that completed the questionnaire could mail it to the researcher by enclosed stamped and addressed envelope.

Sample of the Study

The population of the participants in this project is the Clinic-Plus Program clinicians in Western New York. The subjects in this research project are people who actually completed the survey and mail it back to the researcher. There are as many subjects will be recruited via letters sent to them. Participants are Clinic-Plus providers in Western New York as well as people who are conducting the program, such as mental health counselors, school counselors, social workers, project screeners, or parent advocate person.

Participants were recruited by letters sent to them. This recruitment device (See Appendix A) will indicate that: (a) participants are voluntary to complete the survey; (b) the survey is anonymous; (c) the questionnaire is asking the participants their experience of conducting screenings for Clinic-Plus program and strategies of improving the screening rate; (d) if they are interested in participating in the study, they should complete the survey and mail it back so that the researcher can analyze the data and make recommendations.

Procedures

The research focus is on the screening part of the Clinic-Plus program. The researcher collected the contact information of the Clinic-Plus clinicians in Western New York. The researcher mailed out the informed consent and the survey to participants. The consent form described the purpose of the research project, rights of participants, and the nature and procedures of the survey. The researcher gave participants researcher and agency contact information and provided a description of the study if necessary.

After collecting data from mail-in surveys, the researcher began analyzing the data and summarizing effective strategies identified in the study. Then the researcher assembled a written report and constructed an action plan for mental health providers in this clinic.

Data analysis

The survey text was analyzed and interpreted by utilizing qualitative data analysis procedures. After collected survey material, the researcher read through data to obtain a general sense of material. Next, the researcher organized data for analysis, for example organizing the materials by each survey question. Then the researcher analyzed data by

hand and coded the text by dividing text data into segments, labeling the segments with codes, examining codes for overlap and redundancy, and collapsing these codes into broad themes to be used in the research report.

Results

The results would be presented from each item of the survey question responded by the participants. Eight out of 17 survey results were collected from the Clinic-Plus program clinicians in Western New York.

Item 1: What Settings do you or Your Agency Utilize to Conduct the Clinic-Plus Screenings?

The most frequently utilized setting that the majority of participants (6/8, 75%) responded was “schools” (see Table 1 and Figure 1). For example, participants reported that they attended “school fairs”, “parent-teacher conferences”, “PTA”, “registrations”, “school orientations”, “after-school programs”, and “pre-kindergarten and kindergarten” to conduct screenings.

“Head Start Programs” were utilized by almost 37.5% (3/8) of the providers. Head Start is a national program that promotes school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social and other services to enrolled children and families (Office of Head Start, 2009). The Head Start program provides grants to local public and private non-profit and for-profit agencies to provide comprehensive child development services to economically disadvantaged children and families, with a special focus on helping preschoolers develop the early reading and math skills they need to be successful in school (Office of Head Start, 2009). For example, one participant responded “We conduct

screenings through Head Start programs...with home-based visitors and family support workers conducting the screenings”.

Health related fairs were also utilized by almost 37.5% (3/8) of participants. They reported that they went to “health fairs”, “family medical practice”, and “public health early intervention” to conduct screenings.

Twenty-five-percent (2/8) of the participants responded that they went to “community centers” or “community events” to conduct screenings. For instance, one participant responded that they went to “Festivals” to conduct screenings.

Another twenty-five-percent (2/8) of the participants responded that they utilized “agency”, “outpatient clinic on-site school sites”, or “outpatient clinic setting itself”. For example, one participant responded that “We also try to have clinicians at our agency complete screenings on family members of existing clients.” Another participant reported that they conducted screening “in clinic-setting itself- (by) utilizing family advocates”.

Finally, participants provided lists of other settings that they utilized to conduct screenings, such as “Chemical dependency program“, “Homeless and housing sites”, “Prevention program”, “Pediatrician office: well child visits”, “Youth court”, and “Probation” (See Table 1 and Figure 1).

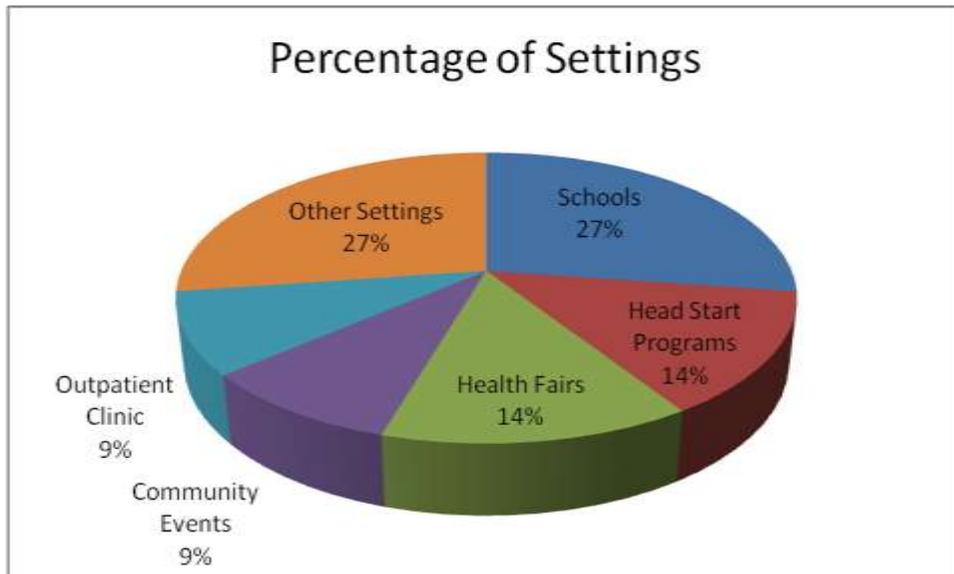
Table 1

Settings Utilized by Participants

| Settings | Responses (n=) | Percentage |
|---------------------|----------------|------------|
| Schools | 6 | 75.0% |
| Head Start Programs | 3 | 37.5% |
| Health Fairs | 3 | 37.5% |
| Community Events | 2 | 25.0% |
| Outpatient Clinic | 2 | 25.0% |
| Other Settings | 6 | 75.0% |

Figure 1

Percentage of Settings Utilized by Participants



Item 2: What Reasons or Characteristics Drew You to Choose these Settings?

Participants listed various reasons to choose their settings which included “Accessibility, available and willing supports to facilitate the screenings”, “Available population/ Relationships with providers/ Target population in the setting”, “The settings and places that parents and their children will be”, “...the programs were internal”, and “...seem to be the easiest and least time consuming”. One participant even responded “Face to face contact seems to be the most successful in engaging the parent/guardians. This also allows privacy and allows us to respect confidentiality.”

Item 3: Who Actually Engages the Parents or Children to fill out the Screening Form in the Settings You Chose?

Participants provided lists of personnel to complete the screening form depending on the setting. For example: (See Table 2 and Figure 2)

1. “Clinic-Plus screeners”: Providers hired a screener to operate the Clinic-Plus program. For instance, one participant responded that they hired “Masters level or a Bachelors position with at least four years experience working with child mental health. The Clinic-Plus Screeners are full time staff dedicated to the Clinic-Plus program.”
2. “School staff”: They utilize school staff such as teachers, counselors, or “school collaborates” to conduct screenings.
3. “Clinicians”: Many participants responded that they use clinicians or counselors who are on-site, such as at the Head Start Program, outpatient clinic, probation, or youth court.

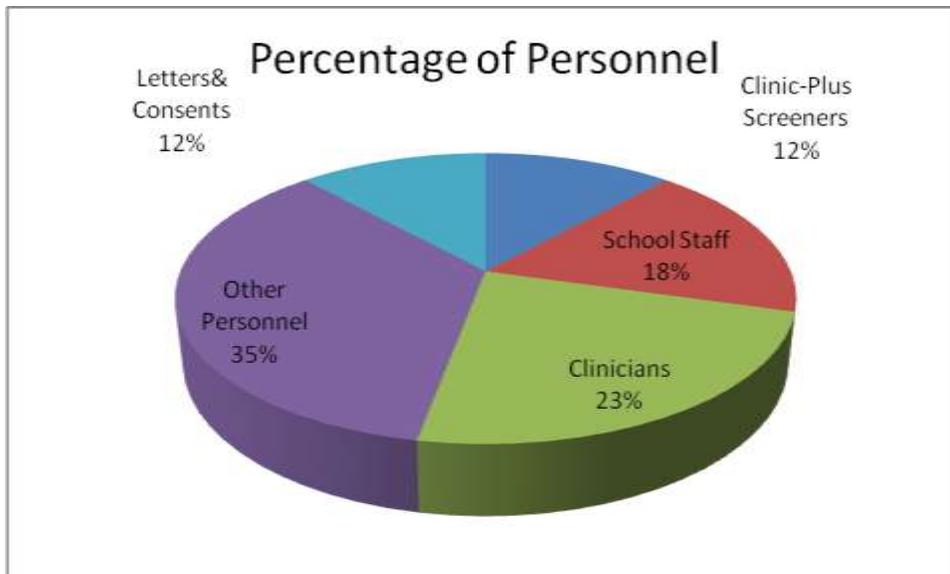
4. Other personnel: Participants also reported other personnel who are available for them, such as “Caseworkers”, “Home-based visitors”, “Family support workers”, “nurses”, and “Family advocates”.
5. “Letters and consents”: In addition to the above mentioned personnel, letters and consents were sent to families to conduct the screenings. For instance, participants responded that “Letters and consents are sent home through all county public schools.” “Screeners then go into school to work with students for whom we received consents.” “Pediatric office hands out letter, consent, and screening tool during well child checks. Then screenings are sent to us.”

Table 2

Personnel Utilized by Participants

| Personnel | Responses | Percentage |
|-------------------|-----------|------------|
| Screeners | 2 | 25.0% |
| School Staff | 3 | 37.5% |
| Clinicians | 4 | 66.7% |
| Other Personnel | 6 | 75.0% |
| Letters& Consents | 2 | 25.0% |

Figure 2

Percentage of Personnel Utilized by Participants

Item 4: Could You Describe the Models You or Your agency Use to Conduct the Screenings?

Many participants were able to describe specifically the model that they used (See Table 3). For example: One participant responded that “Typically we set up a face-to-face meeting with 1 or 2 screeners. Parents are more likely to complete (the screening) if the screener assists.” Another respondent reported that “We explain the intent of the screening and services available... with an emphasize on confidentiality and the screenings being voluntary.” Or “We adapted the language to be more parent-friendly and refrained from using words, such as mental health. We have also offered incentives to the parents who complete the screenings.” Lastly, one participant responded that “We use a Prevention/Public Health/Wellness Model. Clinical terms are avoided and we focus on behaviors and emotional wellness.”

However, two out of eight participants misunderstood the survey question and answered the screening tool that they used (PSC or YPSC).

Table 3

Models to Conduct Screenings

| Models | Description |
|---------------------------------|---|
| Meeting face to face | Set up a meeting face to face with screeners, and parents are more likely to complete the screening if provided assistance. |
| Explaining to the families | Explain the purpose and services available to the families and emphasize confidentiality and voluntary of the screen. |
| Adopt parent-friendly languages | Adapted the language to be more parent-friendly and avoid clinical terms. |
| Offer incentives | Offered incentives to the parents who complete the screenings. |

Item 5: In Terms of the Models you or Your Agency Use to Conduct the Screenings, what Works well, and what does not?

Participants found that sitting with parents and helping them complete the screen really worked well (See Table 4). For example, they reported: “Meeting with the family face to face,” “Sitting with parent and helping them complete screen,” “Direct, visual contacts work well,” and “using parent friendly language works well. Meeting face to face to answer all questions and concerns seems to put the parents at ease.”

Other models also worked well reported by participants including “Offering incentives to the parents and children have shown success.” “Attending registration normalizes the screenings as part of the process similar to eyes, ears, emotional health.” “When parents are immediately available to complete info/consent work better.” “Using the screeners (screenings) as part of an overall approach to prevention and surveillance makes it relatively easy for parents to understand the role of screeners.” And “The client completes the form during the course of their usually contact with the agency.”

However, in terms of what does not work well, almost 37.5% of the participants reported that mass mailings were not working. For example, one respondent indicated that “We have found that mass mailings do not work.” Another participant reported that mailings do not work because of the “low response (rate)”.

Another model that does not work well according to one participant: “We have not found that attending school parent meetings has translated in higher number of screenings, although we recognize that it brings exposure to the program.”

Table 4

Models that Works Well to Conduct Screenings

| Models that Works Well | Models that do not Work Well |
|---|--|
| Sitting with parents and helping them complete the screen | Mass mailings because of the low response rate |
| Offering incentives | Attending school parent meetings |
| Normalizing the mental health screen | |
| Immediately complete the screen | |
| Using screening as a prevention approach | |

Item 6: Do you or Your Agency Experience Any Challenges or Problems when you Conduct the Screenings?

Participants reported several challenges or problems when conducting the screenings.

For instance:

1. Difficulty with contacting families or parents: Participants reported “Difficulty following up w/ families” or “Difficult to reach by phone the parent within 7 days”. One participant responded they conducted screenings at “Homeless and Housing Sites” and one of their difficulties was: “There is some question as to the ability to locate families once they leave the shelter.”

2. Stigma associated with mental health: Participants found that “Parents sometimes refuse to complete the screen due to the negative stigma associated with mental health and counseling”, “Parents question of their child is being targeted”, and “Teachers and administrative personnel feel screenings are not necessary in their schools”.
3. Mental health issues are not families’ first priorities: One participant responded that “In our Homeless Program, the priorities of figuring out where the next meal is coming from or what if anything will be available to eat takes priority over assessing a son or daughter’s mental health.”
4. Weakness about the screening tool: Some clinicians responded they “Needing to explain the survey question to parents”, and “Workable challenges are to score (the screen) promptly” so that they can explain the results for parents.
5. Questions about the Clinic-Plus program itself: Participants reported their “Biggest problem is getting parents together in a large forum to explain the benefit of the program to them”, “Parents ask if further assessment is recommended and if it will be mandatory”, and “Confusion with the program itself”.
6. Mass mailings: For providers who used mass mailings, they found “Low mass mailings return rates”, and “incompletion of survey and consents”.

Item 7: What Causes the Challenges or Problems when Conducting the Screenings?

The reasons that caused the above mentioned challenges or problems encountered by participants including:

1. Reasons regarding contacting families or parents: Difficulty “keeping contact with everyone involved”, or difficulty following up with families because phone numbers “out of order” or “parents not providing contact information”.
2. Reasons regarding stigma associated with mental health: Participants found that “Stigma prevents people from being open to screening”, and they also found it hard to engage parents because “Lack of support in the communities.”
3. Reasons regarding families’ other priorities: One participant recognized for some families their basic needs are more important than their children’s mental health, for example: “the priorities of figuring out where the next meal is coming from or what if anything will be available to eat takes priority over assessing a son or daughter’s mental health”.
4. Reasons regarding the screening tool: Participants recognized that they needed to explain the survey questions to parents because of various reasons such as “Parents inability to read and comprehend the screening questions”, “poor literacy skills”, “language barrier in Spanish version of screening tool”, and “There is a lack of interpreters and the cost to use an interpreter poses a financial problem. There is a high need for different interpreters for the refugees in the area”.
5. Reasons regarding the Clinic-Plus program itself: Participants found it “hard to explain and difficult to differentiate all the different programs for families”.
6. Reasons regarding mass mailings: Participants found that “mass mailings return rates are low” or “poor response”.

7. Other reasons: Participants provided a list of other reasons that caused their difficulties, such as: difficult with “living in a rural area”, “economics”, “staff availability”, and “no (gain from) education provided”.

Item 8: If you are Experiencing Challenges or Problems, what are some of the Strategies you have tried to Resolve these and what were the Results?

Participants responded their strategies to solve their problems:

1. Strategies to contact families or parents: One participant responded that they “make sure there is contact information prior to the parent leaving” for following up.
2. Strategies to reduce stigma associated with mental health and better engage families: One participant responded that they used “news articles, TV segments, talking to service organizations, societies, and schools” And the results were “about 10% of parents return screenings”.
3. Strategies to engage families whose first priorities are not mental health: One participant responded that “The only strategy we have come up with is to add another screening site; one which avoids the characteristics that were problematic in our existing sites.”
4. Strategies to solve the weakness of the screening tool: Participants tried to “have the screener to assist” parents who have poor literacy skill, “hiring translators (or bilingual person)” and “revising the letters and consents” to reduce language barrier. One participant shared their strategy to score the screening tool promptly: “To score as they (families) come in”, “Scoring the screener and sending the response letter is

done as quickly as possible to minimize chances that the screener is tabled accidentally.”

5. Strategies to inform the public about the Clinic-Plus program: One participant reported “We have tried to have meetings with the teachers, principals, and other staff to explain the program to try and get the schools on board.” Another participant suggested “It would be quite helpful if there were a statewide TV publicity campaign similar to Child Health Plus, so parents would recognize the project when approached.”
6. Strategies regarding mass mailings: Some participant responded that they “do not use mass mailings” and “go to as many direct contact events and encourage screens to be completed on-site”.

Item 9: How helpful were the Learning Collaborative Meetings in terms of changing your Screening Models to Improve the Screening Rate of the Clinic-Plus Program?

Six out of eight (75%) participants responded that the learning collaborative meetings were very helpful because they can “hear how other agencies are doing and incorporate what works to fit into the various settings”, “Very helpful in getting the pulse of what other counties were successful at and also struggling with”, “The impact in terms of recognizing that everyone was having problems was helpful”, and “The Learning collaborative meetings were helpful in setting the norm and redefining success”.

One out of eight participants responded minimally helpful; another one reported “However, it was not that useful in adding to the success of the project.” The other one participant did not respond the question.

Item 10: What Models or Strategies do you Recommend to Better Engage with Parents and Improve the Screening Rate?

The majority of participants recommended the most helpful strategy is having a screener face to face meeting with parents and assisting them with the screen (See Table 5). For example, they responded “Meeting face to face with parents to more fully explain the program and provide them with education”, “One on one assistance with a screener is the best”, and “Attend face to face events and offer incentives”.

Other suggestions included: “Expand on-site clinic settings-including in orientation information given to families which is completed immediately”, “It also helps to have teachers and staff be involved with promoting the Child and Family Clinic Plus”, “Including the screeners as part of registration has been very helpful for us”, “Have a representative at the point of contact. Continue to interact on an on-going basis with the contact person who is linked to the parent, even when not in the screening periods”, “Go settings where parents are already present and available”, and “Consider the sustainability of the pool of potential clients and insure that the size of the pool is large enough”. Only one participant responded “Unsure”.

Table 5

Strategies Recommended by Participants

| Recommended Strategies | Description |
|--|--|
| Having a screener face to face meeting with parents and assisting them with the screen | Meeting face to face with parents to more fully explain the program and provided them with education or assistance |
| Offering incentives | Offering incentives after completing the screen |
| Expanding on-site settings | Including the screen in school orientation or registration and complete the screen immediately or go setting where parents are already present and available |
| Involving school staff to promote the Clinic-Plus Program | To have school teachers and staff be involved with promoting the program |
| Having a representative at schools | Have a representative and continue to interact on an on-going basis, even when not in the screening periods |

Discussion

This action research produced recommendations from the Clinic-Plus clinicians and a broad range of practices for improving program screening rates. The following pages include reflections on the main themes from the survey results, the relationship between the literature review and survey results, limitations of the study, recommendations for future research, and implications for clinicians. These reflections are derived from ongoing conversations with study participants, written feedback from participant evaluations of the study, and also from the authors' own perspectives.

Main Themes from the Survey Results

Utilizing Multiple Sites. The first theme from the survey results was that most of the program providers in order to maximize their screening rates, they expand their on-site clinic settings to other different settings where they are able to meet the target populations, easily access to the setting, and those settings provide supports for them, such as schools like public schools and private schools, programs like Head Start, court systems like youth court or probation, medical settings like pediatrician offices, and community centers like community events, to conduct the screenings.

Utilizing Multiple Personnel. The second theme was that service providers utilized multiple personnel to conduct the screenings, for instance, clinics hired the Clinic-Plus program screeners or utilized clinicians to conduct the screenings. At schools, school staff such as teachers, social workers, or counselors, were used to conduct the screenings. Other personnel at different settings including caseworkers, home-based visitors, family support workers, and family advocates helped conduct the screenings as well. In addition to personnel, letters and consents were sent to parents for some settings.

Face to Face Encounter Really Works. The model that most providers utilized to conduct screenings was actually sitting down with families, explaining the purpose of the screening, emphasizing the importance of confidentiality and voluntary screen, and informing the services availability. Those clinicians found it really worked well when they actually sat with the family and provided the family direct assistance, explanation, or translation in order to complete the survey questions and screenings.

Their Challenges or Difficulties. The areas of challenges or difficulties can be categorized as follows:

1. Difficulty following up with families: Clinicians have trouble reaching out to families because they were not able to obtain contact information or the correct information from parents; therefore, they have difficulty following up with the family or provide the subsequent services for the family.
2. Stigma associated with mental health: Clinicians found it hard to engage family to screenings because stigma associated with mental health and counseling prevents people from being open to screening. Parents worried if their child would be targeted or labeled. They even worried if further assessment or treatment would be mandatory.
3. Mental health issues are not families' first priorities: One participant suggested that when families are struggling with their basic needs, their children's mental health may not be their first priorities.
4. The weakness of the screening tool and the language barriers: Clinicians found that the person who actually conducted the screenings had to assist parents in completing the survey questions either because parents' poor literacy skills or the

language barriers in Spanish version (See Appendix E) of the screening tool or translating to languages other than Spanish. Without assistance, parents might have difficulty completing the screen.

5. Confusion of the Clinic-Plus program itself: Clinicians also found it hard to help parents understand the program or the benefits of it because parents might have difficulty differentiating all the different programs.
6. Low mass mailings return rates: The mass mailings return rates were low and incompleteness of survey and consents were commonly seen by clinicians. Some of the reasons might associate with the above mentioned problems, such as parents needed assistance to complete the survey question or due to negative stigma, parents were not willing to do the screen.
7. Other challenges: Some clinicians suggested geographical differences, i.e., living in a rural area, and the poor economics right now might add to their difficulties of conducting the screenings.

Strategies to Solve Screening Problems. In order to solve their challenges or problems, those providers have tried some strategies:

1. To follow up and contact families: Those clinicians ensured that they obtained correct contact information from families so that they can contact the family and provide further services.
2. To reduce stigma associated with mental health and counseling: Clinicians tried to or suggested to have meetings with schools or organizations and use media to

educate the public, such as using news articles, TV segments, or statewide TV publicity campaign.

3. To engage families whose first priority are not mental health issues: One participant responded that in order to solve this problem on their site, they added another screening sites which avoids this problem.
4. To overcome the weakness of the screening tool and reduce language barriers: Some providers offered screeners or translators to assist the families to complete the survey. Those providers also revised the letters and consent forms in order to reduce the literacy or language barriers.
5. To inform the public about the Clinic-Plus program: One provider tried using media and direct meeting with service organizations, societies, and schools to educate the benefits of the program. The results seemed to be helpful in terms of increasing the screening rate for that particular agency.
6. To solve low mass mailings return rates and incompleteness of survey and consents: Some providers decided not to use mass mailings; rather, they went to as many direct contact events and encouraged screens to be completed on-site.

Learning Collaborative Meetings were Helpful. One theme emerged from the results was that the Learning Collaborative meetings provided by Office of Mental Health were helpful to most of the participants because they can hear other agencies' experience and incorporate what works well to their own practice despite the fact that there may be constraints or barriers within their own agency. Even hearing other providers' struggles related to the program and why they had such struggles were helpful to them.

Recommendations to Engage Families. A majority of the participants recommended a strategy to engage parents and improve the screening rate is to have a person (a screener, clinician, or representative) face to face meeting with families and provide them with assistance to complete the screening. They found that direct encounter to assist families with the screen, answer their questions, and educate them about the Clinic-Plus program is the best way to engage parents.

Other recommendations seemed helpful including offering incentives, including the screenings as part of the routines of student orientation or registration, having school personnel be involved with promoting the Clinic-Plus program, and continuing working closely with school personnel.

The Relationship between Literature Review and Survey Results

From the literature review, we learned that the New York State Office of Mental Health (NYOMH) acknowledges the importance of changing current clinic service structure to effective and flexible services (NYOMH, 2008). Because the onset of mental disorders often begins in childhood or adolescence, it has a great impact on social development and life course role transitions. However, children with emotional disturbance or behavioral disorders often go untreated or delay treatment. Therefore, the Clinic-Plus program stands out as a proactive role to help families early recognize children's mental health needs and provide early intervention to prevent adverse outcomes of childhood mental disorders. From the survey results, a majority of the program providers recognized the need to expand their current clinic settings and utilized multiple screening sites. This seems to match the notion of the Clinic-Plus program.

The literature review examined screening programs in the worldwide literature (CMHEI, 1997; NSMHW 1, 1997; NSMHW 2, 2007; SMH, 2009; TeenScreen, 2009). A similarity was found that most of the screening programs adopted a system approach which consists of a multi-stage design that links screenings, assessments, and treatments for children or adolescents with mental health problems (Bricker et al., 2004; NYOMH, 2008). The Clinic-Plus program adopts the concepts of a system approach that includes multiple service components (NYOMH, 2008). This study mainly investigated the screening part of the Clinic-Plus program because early detection of childhood mental disorders is the key to subsequent assessments and interventions. It would be beneficial to see future research on the effectiveness of all the service components of the Clinic-Plus program.

The literature reviewed the psychometric properties of the Clinic-Plus screening tool, PSC (Jellinek et al., 1988) and PSC-Y (Jellinek et al., 1986). Although PSC (and PSC-Y) has been reported to be an easy administrative screening tool (Jellinek et al., 2008), valid and reliable instrument (Jellinek et al., 1988) and widely used by various settings, programs, and states (Jellinek et al., 2008), some participants suggested the weaknesses of this screening tool to be not user-friendly in terms of parents' reading level and language barriers in the Spanish version. Participants found that they needed to provide assistance for parents in order to complete the screening tool.

The literature also reviewed action research which grounded in the belief that effective solutions to significant problems are more likely to emerge where all "stakeholder" who are affected or have an effect on an issue are involved in the process of inquiry (Stringer & Dwyer, 2005). This action research only focused on the

perspectives of practitioners. Even though participants provided self-reflections on their own practices and made insightful recommendations, it would be insufficient to understand the whole picture of the problem and solve the research issue without the input of all stakeholders, such as service users, managers, care takers, and policy-makers.

Limitations of the Study

Limitations of the study are related to lack of generalizability due to a small sample size of participants and the survey method, insufficient data collection due to participants misunderstanding of the survey questions, and not involving all stakeholders due to difficulties recruiting them.

The potential weakness of this action research is lack of generalizability because of the practical reasons which resulted in a small sample size of participants. There were several practical difficulties recruiting a large number of participants in the study- the researcher had difficulty obtaining the contact information from the sample. Only 17 contact information was obtained by the researcher. As a result, only eight out of 17 participants completed the survey; the survey return rate was 47%.

The researcher had participated in the Learning Collaborative meetings of the Clinic-Plus program, met with those practitioners, and presented the search project to them. However, this study was not approved by the Institution Review Board at that time, so the researcher was not able to conduct the survey to participants who were present at the meeting. If the research project were approved by the Institution Review Board earlier, the researcher could have encouraged the participants to complete the research survey and probably could have obtained 25 to 30 surveys completed on-site. In addition, the persons at the Office of Mental Health (OMH) who are responsible for the operation of

the Clinic-Plus program might have the contact information of all the program providers. If the researcher would have contacted the persons at the OMH to request a list of contact information of program providers, probably the research could have involved more participants and obtained more sufficient data from them.

As a result, if the researcher were able to conduct this study differently, the researcher would collaborate with other practitioners, go to the meetings for program providers, and work closely with persons at the OMH or schools in order to involve as many people as possible to participate in the research.

Another practical reason causing the lack of generalizability was related to the survey method. Sending back and forth the surveys by mailing was time-consuming and the response rate was low. Practitioners might not have time to fill out the research survey by hand and then mailed it to the researcher. Even though the author sent several reminder emails to participants, the response rate was still quite low. Therefore, despite the fact that the results provided valuable reflections about participants' experiences and suggestions to improve the screening rate, it is difficult to make generalizations because of the limited number of participants and insufficient data to understand more perspectives from more participants.

Therefore, the researcher could have done differently to utilize user-friendly investigating methods to gather sources of information from participants. For instance, sending surveys to participants through emails or utilizing online survey tools would be less time-consuming and convenient for those clinicians who already have piles of paperwork on their desk and might increase the likelihood of survey returning rate.

The other limitation of the study is insufficient data collection due to participants misunderstanding of certain survey questions. For example, in the survey question 4: “Could you describe the models you or your agency use to conduct the screenings?” Two out of eight participants misunderstood the question and answered the screening tool that they used (PSC or YPSC) (Jellinek et al., 1986; Jellinek et al., 1988). If the researcher worded the question more understandable for participants, such as using “strategies” instead of “models”, possibly more effective strategies could have been obtained by them.

Another example was that one participant seemed not knowing the “Learning collaborative Meetings” in the survey question 9: “How helpful were the Learning Collaborative meetings in terms of changing your screening models to improve the screening rate of the Clinic-Plus program?” The researcher could have explained to participants that the “Learning collaborative Meeting” was a forum held by persons at the OMH and was for program providers to discuss their progress and difficulties to conduct the program, so that this participant might have provided his or her opinion about this survey question.

The third limitation of the study is not involving all stakeholders in this action research. It is questionable because ultimately action research needs to involve all stakeholders to bring together the experience of practitioners, managers, service users, care takers, and policy-makers through change at service level (Hall, 2006). This action research only involved the experience of practitioners because it is difficult to obtain opinions from service users or parents whom practitioners already had problems to engage them. However, without the experience of all the stakeholders, it may not be

sufficient to understand the whole picture of the problem and the needs or barriers of the families regarding to usage of the Clinic-Plus program.

As a result, it would be beneficial to involve all stakeholders in the study. For example, involve care takers, clients in the outpatient service, school personnel, family advocates, and policy-makers as many as possible in the survey. It would be helpful to understand the needs of families or the experience of service users from their own perspectives and it would provide an opportunity for clinicians to better engage families and improve their practices.

Recommendations for Future Research

Given the above mentioned limitations of the study, there are some recommendations for future research. A further understanding of the Clinic-Plus screening tool will be helpful. There is some room to examine more closely about the Pediatric Symptom Checklist (PSC) and the Pediatric Symptom Checklist Youth Report (PSC-Y). For example, several participants indicated that there are language barriers in the Spanish version of the screening tool; some clinicians reported because the parents' poor literacy skills, they needed to explain the screen questions to the parents. As a result, it allows some room for further research to improve the weaknesses of the PSC or PSC-Y in terms of more user-friendly languages for lower reading level users and reducing language barriers in the Spanish version or other language versions.

In addition, it would be beneficial to see follow up research about implementing the recommendations from participants to increase the screening rate. It will be helpful if the researcher share the survey results to program providers, form an action plan, and then

implement the action plan to increase the screening rate. Then conduct research to evaluate or compare the change of the screening rate after implementing the action plan.

Moreover, evaluating all the service components and examining the treatment outcome of the Clinic-Plus program will be another area to further research. The Clinic-Plus program operated by Office of Mental Health and many service providers invested their efforts on improving children's mental health well-being. It is critical to evaluate the work of their practice and treatment outcome if achieves the goals of the Clinic-Plus program and the effectiveness of the program.

Implications for Practitioners to Involve Families in Screenings

From the above mentioned main themes of the survey results, there are some implications for practitioners and service providers to take into consideration in order to involve children and families in mental health screenings in a clinic setting.

Utilizing Multiple Screening Sites. As a majority of the survey participants responded, multiple screening sites were utilized by service providers outside of the clinic setting itself, such as schools, Head Start Programs, court systems, medical settings, and community events or centers. It can be indicated that the more screening sites service providers choose to utilize, the more screenings they might obtain from the target populations.

Involving Multiple Personnel to Conduct Screenings. Participants also responded that they involved or worked closely with as many personnel as they possibly can or as their convenience. For example, they hired a screener to operate the Clinic-Plus program, utilized clinicians on-site at the clinic, worked closely with school staff, involved family support workers or family advocates from the Head Start Programs to conduct the

screenings. These people can be helpful for actually engaging families, completing the screen, assisting families with their questions, promoting the Clinic-Plus program, and providing families education about the importance of mental health screening. Therefore, collaborating as many as personnel to conduct the screenings can be helpful.

Face to Face with Families Works Well. Another important indication from the survey results was that participants found that having a person face to face meeting with families really works well. It is when this person, whether he or she is a school staff, clinician, or family advocate, actually sits down with the family, explains the purpose of the screening, emphasizes the importance of confidentiality and voluntary screen, and informs the services availability that helps the most to complete the screening immediately and increase the screening rate. Personal encounters and engagement is the key to involve the families and makes the screening works.

Providing Families Assistance to Complete the Screening. One issue emerged from the survey was that the mass mailings did not work well because families had difficulty completing the screen either because the weakness of the screen tool itself, parents' poor literacy skills, language barriers of the Spanish version of the screen tool, or the need to translate to other languages. Many participants found that they need to provide assistance for families in order to complete the screen. Therefore, a solution to this issue is to have a person who is aware of the needs of the family and provides them assistance accordingly to the family.

Promoting the Clinic-Plus Program and Providing Education to Reduce Stigma. Some participants noticed that families were not quite sure about the purpose of the Clinic-Plus program or were confused about the program; where as, some clinicians

found that because of the stigma associated with mental health kept families from receiving screenings or services. Many participants suggested using media to educate the public or working closely with school personnel to promote the Clinic-Plus program. One participant even reported their success of utilizing media to promote and reduce stigma and the increase of the screening rate after using the strategy.

Offering Incentives. One participant suggested offering incentives to families or children after they complete the screening. If the incentives are useful to families, they might be drawn to engage in screenings. This might be an area for future research to evaluate the effectiveness of offering incentives to engage families in screenings.

Including the Screening as Part of the Routines. Some participants recommended including the screenings as part of the routines of student orientation or registration which normalizes the mental health screenings similar to the process of physical examination. Working with pediatricians for well child visits or going to health fairs are also examples of viewing mental health screenings as part of the routine checks.

Conclusion

This article set out to consider how action research can be used to seek strategies to engage children and families in mental health screenings in a clinic setting. The Child and Family Clinic-Plus Program is aimed at transformation of clinic setting to early detection of childhood mental illness and improvement of mental health well-being of children. From the literature review, it is evident that childhood mental disorders have impacts on children's social, academic, and emotional development (Birmaher et al., 2004; Egger et al., 2003; Grover et al., 2007; Ialongo et al., 2001; Kessler et al., 2001; Kessler et al., 1995; Shahar et al., 2006). Early screening is essential to prevent delay of treatment and

later consequences of mental illness (Bricker et al., 2004; Costello et al., 2005; NYOMH, 2008). In order to make it happen, engaging families to screenings is the key. Although there are some limitations to this research, such as not including the perspectives of all stakeholders, there are clear indications to involve families in the mental health screening. The research findings were consistent with the literature review (Bricker et al., 2004; NYOMH, 2008) that there is a need to use a system approach, expand the current clinic settings, and utilize multiple screening sites. Future outcome research on all service components of the Clinic-Plus program and re-evaluation of the above mentioned implications will put these indications to the test.

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Appendix A
Statement of Informed Consent

The College at Brockport SUNY Counselor Education Program Research Project
By Yao-Szu Tsou

**Child and Family Clinic-Plus Program: How to Involve Children and Families
in Mental Health Screenings in a Clinic Setting?**

This form describes a research study being conducted with using a survey to seek strategies to improve the mental health screening rate for the Child and Family Clinic-Plus program in a clinic setting. The purpose of this research is to understand the effective models of screening strategies to involve children and families in getting mental health screenings in the Clinic-Plus program.

The person conducting the research is Yao-Szu Tsou, a graduate student of the College at Brockport State University of New York Counselor Education Program. The study will investigate how to involve children and families in mental health screenings in a clinic setting. This will involve a survey of **10** questions that will take approximately **15-20 minutes** to complete.

It is hoped that maximum of 50 Clinic-Plus providers in Western New York will participate in the study. The results will be used to inform Clinic-Plus providers to involve more children and families in screenings and promote better services.

You are being asked to participate in this study and your answers to the attached survey signify your consent to participate. Please do not write your name on the survey. There will be no way in which you will be connected to this survey, and the results will be reported in aggregate form only. You do not have to answer any questions that you do not want to answer, and you may stop participating in the survey at any time.

If you wish to give permission to participate, and you agree with the statement below, please complete the survey and return to the researcher by using the enclosed stamped and addressed envelope.

I understand the information provided in this form and agree to participate in this project. I am 18 years of age or older. I have read and understand the above statements.

If you have any questions you may contact:

| <u>Primary researcher</u> | <u>Faculty Advisor</u> |
|---|--|
| Name: Yao-Szu Tsou | Name: Thomas Hernandez |
| Phone Number: Catholic Family Center Mental Health Clinic: (585) 262-7167 | Department and phone number: The College at Brockport, Department of Counselor Education: (585)395-5498 |
| Address: 87 N. Clinton Ave., Rochester, NY 14604 | Address: 350 New Campus Dr., Brockport, NY 14420 |
| Email address: ytsou@cfcrochester.org | Email address: thernand@brockport.edu |

6. Do you or your agency experience any challenges or problems when you conduct the screenings?

7. What causes the challenges or problems when conducting the screenings?

8. If you are experiencing challenges or problems, what are some of the strategies you have tried to resolve these and what were the results?

9. How helpful were the Learning Collaborative meetings in terms of changing your screening models to improve the screening rate of the Clinic-Plus program?

10. What models or strategies do you recommend to better engage with parents and improve the screening rate?

Thank you for completing the survey.

Appendix C

Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

| | NEVER (0) | SOMETIMES (1) | OFTEN (2) |
|---|--------------|------------------|--------------|
| 1. Complains of aches and pains ----- | 1. _____ | _____ | _____ |
| 2. Spends more time alone ----- | 2. _____ | _____ | _____ |
| 3. Tires easily, has little energy ----- | 3. _____ | _____ | _____ |
| 4. Fidgety, unable to sit still ----- | 4. _____ | _____ | _____ |
| 5. Has trouble with teacher ----- | 5. _____ | _____ | _____ |
| 6. Less interested in school ----- | 6. _____ | _____ | _____ |
| 7. Acts as if driven by a motor ----- | 7. _____ | _____ | _____ |
| 8. Daydreams too much ----- | 8. _____ | _____ | _____ |
| 9. Distracted easily ----- | 9. _____ | _____ | _____ |
| 10. Is afraid of new situations ----- | 10. _____ | _____ | _____ |
| 11. Feels sad, unhappy ----- | 11. _____ | _____ | _____ |
| 12. Is irritable, angry ----- | 12. _____ | _____ | _____ |
| 13. Feels hopeless ----- | 13. _____ | _____ | _____ |
| 14. Has trouble concentrating ----- | 14. _____ | _____ | _____ |
| 15. Less interested in friends ----- | 15. _____ | _____ | _____ |
| 16. Fights with other children ----- | 16. _____ | _____ | _____ |
| 17. Absent from school ----- | 17. _____ | _____ | _____ |
| 18. School grades dropping ----- | 18. _____ | _____ | _____ |
| 19. Is down on him or herself----- | 19. _____ | _____ | _____ |
| 20. Visits the doctor with doctor finding nothing wrong | 20. _____ | _____ | _____ |
| 21. Has trouble sleeping ----- | 21. _____ | _____ | _____ |
| 22 Worries a lot ----- | 22. _____ | _____ | _____ |
| 23. Wants to be with you more than before ----- | 23. _____ | _____ | _____ |
| 24. Feels he or she is bad----- | 24. _____ | _____ | _____ |
| 25. Takes unnecessary risks ----- | 25. _____ | _____ | _____ |
| 26. Gets hurt frequently ----- | 26. _____ | _____ | _____ |
| 27. Seems to be having less fun ----- | 27. _____ | _____ | _____ |
| 28. Acts younger than children his or her age ----- | 28. _____ | _____ | _____ |
| 29. Does not listen to rules----- | 29. _____ | _____ | _____ |
| 30. Does not show feelings ----- | 30. _____ | _____ | _____ |
| 31 Does not understand other people's feelings ----- | 31. _____ | _____ | _____ |
| 32. Teases others ----- | 32. _____ | _____ | _____ |
| 33. Blames others for his or her troubles ----- | 33. _____ | _____ | _____ |
| 34. Takes things that do not belong to him or her ----- | 34. _____ | _____ | _____ |
| 35. Refuses to share ----- | 35. _____ | _____ | _____ |

Total score _____

Does your child have any emotional or behavioral problems for which she/he needs help?----- __No __Yes

Are there any services that you would like your child to receive for these problems? ----- __No __Yes

If yes, what type of services? _____

Appendix D

Pediatric Symptom Checklist - Youth Report (Y-PSC)

Please mark under the heading that best fits you:

| | Never | Sometimes | Often |
|--|-------|-----------|-------|
| 1. Complain of aches or pains..... | _____ | _____ | _____ |
| 2. Spend more time alone..... | _____ | _____ | _____ |
| 3. Tire easily, little energy..... | _____ | _____ | _____ |
| 4. Fidgety, unable to sit still..... | _____ | _____ | _____ |
| 5. Have trouble with teacher..... | _____ | _____ | _____ |
| 6. Less interested in school..... | _____ | _____ | _____ |
| 7. Act as if driven by motor..... | _____ | _____ | _____ |
| 8. Daydream too much..... | _____ | _____ | _____ |
| 9. Distract easily..... | _____ | _____ | _____ |
| 10. Are afraid of new situations..... | _____ | _____ | _____ |
| 11. Feel sad, unhappy..... | _____ | _____ | _____ |
| 12. Are irritable, angry..... | _____ | _____ | _____ |
| 13. Feel hopeless..... | _____ | _____ | _____ |
| 14. Have trouble concentrating..... | _____ | _____ | _____ |
| 15. Less interested in friends..... | _____ | _____ | _____ |
| 16. Fight with other children..... | _____ | _____ | _____ |
| 17. Absent from school. | _____ | _____ | _____ |
| 18. School grades dropping. | _____ | _____ | _____ |
| 19. Down on yourself..... | _____ | _____ | _____ |
| 20. Visit doctor with doctor finding nothing wrong.... | _____ | _____ | _____ |
| 21. Have trouble sleeping..... | _____ | _____ | _____ |
| 22. Worry a lot..... | _____ | _____ | _____ |
| 23. Want to be with parent more than before..... | _____ | _____ | _____ |
| 24. Feel that you are bad..... | _____ | _____ | _____ |
| 25. Take unnecessary risks..... | _____ | _____ | _____ |
| 26. Get hurt frequently..... | _____ | _____ | _____ |
| 27. Seem to be having less fun..... | _____ | _____ | _____ |
| 28. Act younger than children your age..... | _____ | _____ | _____ |
| 29. Do not listen to rules..... | _____ | _____ | _____ |
| 30. Do not show feelings..... | _____ | _____ | _____ |
| 31. Do not understand other people's feelings..... | _____ | _____ | _____ |
| 32. Tease others..... | _____ | _____ | _____ |
| 33. Blame others for your troubles..... | _____ | _____ | _____ |
| 34. Take things that do not belong to you..... | _____ | _____ | _____ |
| 35. Refuse to share..... | _____ | _____ | _____ |

Appendix E

Lista de Síntomas Pediátricos (Pediatric Symptom Checklist –PSC) Spanish Version

La salud física y emocional son importantes para cada niño. Los padres son los primeros que notan un problema de la conducta emocional o del aprendizaje de su hijo(a). Ud. puede ayudar a su hijo(a) a obtener el mejor cuidado de su doctor por medio de contestar estas preguntas. Favor de indicar cual frase describe a su hijo(a)

Indique cual síntoma mejor describe a su hijo/a:

| | NUNCA | ALGUNAS VECES | FRECUENTEMENTE |
|--|-----------|---------------|----------------|
| | (0) | (1) | (2) |
| 1. Se queja de dolores y malestares ----- | 1. _____ | _____ | _____ |
| 2. Pasa mucho más tiempo a solas----- | 2. _____ | _____ | _____ |
| 3. Se cansa fácilmente, tiene poca energía ----- | 3. _____ | _____ | _____ |
| 4. Es inquieto(a), incapaz de sentarse tranquilo(a)----- | 4. _____ | _____ | _____ |
| 5. Tiene problemas con un(a) maestro(a) ----- | 5. _____ | _____ | _____ |
| 6. Está menos interesado(a) en la escuela ----- | 6. _____ | _____ | _____ |
| 7. Es muy activo(a), tiene mucha energía----- | 7. _____ | _____ | _____ |
| 8. Sueña despierto demasiado----- | 8. _____ | _____ | _____ |
| 9. Se distrae fácilmente----- | 9. _____ | _____ | _____ |
| 10. Temeroso(a) de nuevas situaciones----- | 10. _____ | _____ | _____ |
| 11. Se siente triste, infeliz ----- | 11. _____ | _____ | _____ |
| 12. Está irritable, enojado(a)----- | 12. _____ | _____ | _____ |
| 13. Se siente sin esperanzas----- | 13. _____ | _____ | _____ |
| 14. Tiene problemas para concentrarse----- | 14. _____ | _____ | _____ |
| 15. Menos interesado(a) en amistades----- | 15. _____ | _____ | _____ |
| 16. Pelea con otros niños----- | 16. _____ | _____ | _____ |
| 17. Se ausenta de la escuela----- | 17. _____ | _____ | _____ |
| 18. Está empeorando sus notas escolares----- | 18. _____ | _____ | _____ |
| 19. Se siente mal de sí mismo(a)----- | 19. _____ | _____ | _____ |
| 20. Visita al doctor y el doctor no le encuentra nada malo | 20. _____ | _____ | _____ |
| 21. Tiene problemas para dormir----- | 21. _____ | _____ | _____ |
| 22. Se preocupa mucho----- | 22. _____ | _____ | _____ |
| 23. Quiere estar con usted más que antes----- | 23. _____ | _____ | _____ |
| 24. Cree que él/ella es malo(a)----- | 24. _____ | _____ | _____ |
| 25. Toma riesgos innecesarios----- | 25. _____ | _____ | _____ |
| 26. Se lastima frecuentemente----- | 26. _____ | _____ | _____ |
| 27. Parece divertirse menos ----- | 27. _____ | _____ | _____ |
| 28. Actúa más chico que niños de su propia edad ----- | 28. _____ | _____ | _____ |
| 29. No obedece las reglas ----- | 29. _____ | _____ | _____ |
| 30. No demuestra sus sentimientos ----- | 30. _____ | _____ | _____ |
| 31. No comprende los sentimientos de otros ----- | 31. _____ | _____ | _____ |
| 32. Molesta o se burla de otros ----- | 32. _____ | _____ | _____ |
| 33. Culpa a otros por sus problemas ----- | 33. _____ | _____ | _____ |
| 34. Toma cosas que no le pertenecen ----- | 34. _____ | _____ | _____ |
| 35. Se niega a compartir ----- | 35. _____ | _____ | _____ |

Total _____

¿Tiene su hijo(a) algún problema emocional o del comportamiento para el cual necesita ayuda?-----¹No ¹Sí

¿ Hay algunos servicios que Ud. desearía que su hijo(a) recibiese para estos problemas? -----¹No ¹Sí

¿Si contesta sí, cuáles servicios? _____

M.S. Jellinek and J. M. Murphy, Massachusetts General Hospital

Spanish PSC Gouverneur Revision 2-7-03