Characteristics and Needs of Families in an Urban Mental Health Service System


Many articles presenting descriptive data on children with serious emotional disturbance (SED) have focused primarily on adolescents, with less emphasis on families and/or younger children. Recognizing this gap, the authors of this article present quantitative and qualitative descriptive data on children 9 to 11 years old, and their families, who were receiving services in a large, east coast urban setting.

To be included in the study, children needed to have above average utilization of mental health services, high Child Behavior Checklist (CBCL) total behavior problem scores, a DSM III-R diagnosis, and a global assessment of functioning score below 66. The total sample of 139 children was primarily male (75%) and consisted of a higher percentage of African American children than the total population of children served by the mental health service system. Caregivers were primarily female (96%) and single (77%) and were most often mothers or stepmothers (64%) or grandparents (22%). Families were interviewed using a variety of standardized instruments, including the CBCL, the Diagnostic Interview for Children and Adolescents (DICA-R), the Matson Evaluation of Social Skills for Youngsters (MESSY), the State-Trait Anxiety Inventory for Children (STAIC), the Children's Depression Inventory (CDI), and the Family Assessment Device (FAD). Caregivers were also asked questions regarding the age and behaviors exhibited when children first began to have problems, as well as their assessment of services needed and expectations from mental health services.

Results revealed that children’s problems were first noticed around 5 years of age and that the most frequent behaviors were physical aggression toward others, property damage, or verbal threats (n = 52), as well as oppositional (n = 34) and hyperactive (n = 33) conduct. Nearly half the sample was assigned four or more diagnoses and 91% of children had a primary diagnosis of attention deficit hyperactivity disorder (ADHD). CBCL scores revealed that boys scored significantly higher than the instrument’s clinical norms on all scales except for the somatic complaints syndrome, which was significantly lower, and the sex problems syndrome, which was not statistically different. Similarly, girls’ scores were significantly higher on all scales except for the somatic complaints subscale, which was significantly lower, and the anxious/depressed and internalizing scales, which were not statistically different. Although these scores are not particularly surprising, given that elevated scores on the CBCL total problems scale was one of the criteria for participation in the study, of note is the greater level of severity in comparison to the clinically impaired norms, as well as the preponderance of behavior related problems. Also, as might be expected, children reported high levels of depression and trait anxiety (global, non-specific anxiety) on the CDI and STAIC respectively. Children’s self-report of social skills on the MESSY revealed generally more impaired scores than the norm group, with the exception of the jealousy subscale (boys and girls) and the overconfident subscale for girls, which were not significantly different from the norm. Although family functioning scores were nearly all significantly higher than nonclinical norms, families in the study had significantly better functioning than psychiatric norms in the problem solving, communication, and behavior control scales, indicating a high degree of family functioning despite very challenging environmental situations.

Caregivers reported that their greatest need was for recreational/after-school activities (94%). Other particularly desired services included summer camp (90%), support/self-help groups for children (91%), group therapy (91%), and counseling (90%). Caregivers’ expectations from services included the hope that interventions would lead to positive changes in children’s behavior (43%), to reduced stress in the family and a better home life (25%), and to better performance at school (7%).

Taken together, results describe a young, urban sample of children with SED whose problems began, on average, around 5 years of age. Children’s problems were mostly behavior- and attention-related, although both depression and anxiety scores were also elevated. Children mostly came from “low-income, single parent families of color residing in poor

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urban neighborhoods” (p. 223). Despite stressful life circumstances, families were relatively high functioning in problem solving and communication skills. The greatest family difficulties involved responsibilities for family functions and tasks and the level of interest and concern family members displayed toward each other. It is likely that this finding is directly related to the stresses families face and limited amount of family time available to caregivers. Considering family environment and stress levels, it is not surprising that one of families’ primary needs was recreational and after school activities for children. However, mandatory special education does not require that after school programs are provided and children’s behavioral difficulties may make many of these mainstream programs inaccessible to youth with SED. The authors note:

[This] results in a situation where many low-income single mothers caring for children with special needs are desperate for after school programs that can accommodate their children during work hours...Add to this dilemma the fact that most families were living in risky neighborhoods that can present hazards for typically developing children, let alone those with impaired judgment and poor social skills, and it is clear why caregivers were intensely interested in specialized [after school] programs. (p. 225)

These results suggest that in addition to the traditional services provided by most service systems and desired by caregivers, the addition of services that allow children with SED to participate in “normative recreational activities” (p. 225) would be of great benefit to caregivers as well as children with and without SED.