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Research Article

Pre-Intake Attrition or Non-Attendance of Intake Appointments at an Ethnic-Specific Mental Health Program for Asian American Children and Adolescents

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Abstract

This study examines the relationship of client demographic, clinical, client-therapist match, and service program factors to the rate of pre-intake attrition or the non-attendance of intake appointments for 236 Asian American children and adolescents (18 years and younger) at an Asian-oriented ethnic-specific mental health program. The results showed that urgency status or the need for the earliest intake appointment, ethnic match with the prescreening interviewer, and the assignment of the prescreening interviewer as the intake therapist were significantly related to attendance of intake appointments for Asian American children and adolescents. In contrast, older age was found to reduce the likelihood of intake attendance for Asian American youth clients. Specific implications of these results to program evaluation and service improvements in mental health care delivery to Asian American youth groups will be discussed.

Introduction

Pre-intake attrition or the non-attendance of intake appointments for children, adolescents, and their families is a significant problem for mental health service providers. For general child and adolescent populations, previous research has reported a wide range in pre-intake attrition, with intake non-attendance ranging from 15 percent to 58 percent (Benway, Hamrin, and McMahon, 2003; Lerman and Pottick, 1995; McKay et al., 1998; Minty and Anderson, 2004; Szapocznik et al., 1988; Valleley et al., 2007). These elevated figures on pre-intake attrition for youth groups are troubling when one considers that less than 20 percent of the children

with a mental health problem sought out professional services (U.S. Department of Health and Human Services [DHHS], 1999). Among children and adolescents (aged 6-17 years) who were described as needing mental health services, 79 percent did not receive any clinical treatment for their psychological problems (Kataoka, Zhang, and Wells, 2002). This issue of pre-intake attrition may pose an even greater problem for Asian American children and adolescents because of a long history of service underuse and a strong reluctance to seek professional mental health care (Akutsu, 1997; U.S. DHHS, 2001; Zhang, Snowden, and Zhu, 1998). For example, recent studies in California found that Asian American and Pacific Islander youth made up only 3 percent of the clients in the public mental health system even though these ethnic groups comprised more than 9 percent of the general population (Mayberg, 2008, 2009).

Despite the critical need to examine pre-intake attrition for new clients seeking mental health services, little is empirically known about the non-attendance of intake appointments for Asian American youth populations. A comprehensive review of the literature failed to identify a single study that examined the non-attendance of intake appointments for Asian American children and adolescent samples. Previous research studies on pre-intake attrition have typically not included Asian American youth in their samples or the few Asian Americans in a given sample were combined with other ethnic minority groups to create a single aggregate, preventing specific conclusions to be drawn about the pattern of failed intake attendance for Asian American youth. However, a recent study on pre-intake attrition for Asian American adults showed that a client's urgent care status or need for the earliest intake appointment as well as Asian language match with the prescreening interviewer and the assignment of this prescreening interviewer as the intake therapist all helped to increase intake attendance (Akutsu, Tsuru, and Chu, 2004). In contrast, older age of the client and gender match with the prescreening interviewer decreased the likelihood of intake attendance. Southeast Asians in this study were also found to report with a higher rate of intake attendance than East Asian groups. What was unique about this study on pre-intake attrition for Asian Americans was the specific inclusion of culturally responsive variables (e.g., client-therapist matching) and service program factors (e.g., decisions about the

need for "urgent" care or "continuity" of care). Over the years, many clinicians and researchers have supported the critical need to conduct more critical examinations on how culturally responsive strategies may help to improve service delivery to ethnic minority groups. This study provided one of the first investigations on pre-intake attrition of Asian American youths that focused on culturally-responsive procedures to increase client engagement, such as client-therapist ethnicity and language matching, as well as the benefits of responsive clinical practice, such as the assignment of prescreening interviewers as intake therapists to foster continuity of care in the early stages of treatment.

The existing literature on pre-intake attrition with child and adolescent samples has provided inconsistent findings about the contributions of demographic factors to intake attendance. Although most studies found no relationship between age and pre-intake attrition (Haskett et al., 1991; Kourany, Garber, and Tornusciolo, 1990; McKay, McCadam, and Gonzales, 1996; Minty and Anderson, 2004; Swenson and Pekarik, 1988; Valleley et al., 2007), some studies showed that older children presented with a higher risk for pre-intake attrition (Lowman et al., 1984), while other studies concluded that younger children reported with higher intake non-attendance (Armbruster and Fallon, 1999; Baruch, Gerber, and Fearon, 1998). The majority of research reported no clear relationship between gender and pre-intake attrition (Haskett et al., 1991; Kourany et al., 1990; Swenson and Pekarik, 1988; Valleley et al., 2007), but some studies reported higher pre-intake attrition for girls (Lowman et al., 1984), while other studies reported boys with a higher risk for intake non-attendance (McKay et al., 1996). With regard to socioeconomic status (SES), several studies reported that higher pre-intake attrition was more likely for low SES children (Armbruster and Fallon, 1994; Burgoyne et al., 1983; Minty and Anderson, 2004). In contrast, Beer (1991) found no such correlation between SES and intake attendance. Concerning race or ethnicity, several studies showed higher levels of intake non-attendance for ethnic minority children (Armbruster and Schwab-Stone, 1994; Haskett et al., 1991; Sherman et al., 2009), but Kourany et al. (1990) found no such relationship between race and pre-intake attrition. Unfortunately, few of these studies on the influence of ethnicity on intake attendance have included Asian American children and adolescents in their samples. Based on these mixed reports, it is

clear that more research is required to discern the possible contributions of demographic variables to pre-intake attrition for youth populations.

Previous studies on the clinical characteristics of children and adolescents also have failed to provide a consistent relationship to intake attendance for various mental health programs. While several researchers found no relationship between clinical diagnosis and pre-intake attrition (Beer, 1991; Gottesfeld and Martinez, 1972), other studies found a significant correlation between intake attendance and certain types of presenting problems. For example, Lowman et al. (1984) found that children with more behavioral problems or fewer personality problems had reported with higher intake non-attendance. In comparison, McKay et al. (1996) found that pre-intake attrition was higher for children presenting with aggression or attention deficit disorder- hyperactivity. Concerning referral source, a number of studies reported no relationship between the type and source of referral and pre-intake attrition (Beer, 1991; Minty and Anderson, 2004). However, Sherman et al. (2009) found that clients who had a mandated referral for treatment were more likely to report with pre-intake attrition, while McKay et al. (1996) reported the opposite and found that children and their families referred by the juvenile justice system showed higher intake attendance. Other studies found that self-referrals for treatment were more likely to increase intake attendance for youth populations (Baruch et al., 1998; Gaines and Stedman, 1981; Haskett et al., 1991). Specific to previous mental health treatment, Kourany et al. (1990) found that youth clients with no past clinical experience were less likely to attend their intake appointments. In contrast, Armbruster and Fallon (1994) reported no such relationship between prior mental health treatment and pre-intake attrition. Again, the inconsistency in the research findings make it very difficult to draw any definitive conclusions about the relationship of clinical factors to pre-intake attrition, and more research is warranted to better understand this complex issue.

There is some evidence to suggest a longer wait time between the initial contact and the scheduled intake appointment may increase the likelihood for pre-intake attrition for youth populations (Foreman and Hanna, 2000; Kourany et al., 1990; MacDonald, Brown, and Ellis, 2000; Sherman et al., 2009; Stern and Brown, 1994). In comparison, other studies found no such relationship

between wait time and pre-intake attrition for child and adolescent populations (Beer, 1991; Minty and Anderson, 2004; Swenson and Pekarik, 1988). Despite this latter finding in some studies, most clinicians and researchers believe an extended period on a wait list or delayed assignment for intake scheduling can play a significant negative factor in whether the child or youth will attend an intake session or accompany parents/family to an intake session that was scheduled for him/her.

Much of the current research on pre-intake attrition for youth populations has been conducted in the United Kingdom. While these studies focus on mental health care systems which may differ somewhat from those in the U.S., the findings from this research suggests a stronger effort to connect with youth clients and their families before the formal intake process may improve intake attendance. For example, certain "opt-in" procedures have facilitated a stronger commitment to treatment on the part of the client and his/her family and increased intake attendance rates for youth populations (Parkin, Frake, and Davison, 2003; Stallard and Sayers, 1998; Wiseman and McBride, 1998; Woodhouse, 2006). These procedures suggest that attempts to build a stronger bond between the client and the service provider before the intake appointment may reduce pre-intake attrition, particularly for youth clients who are reluctant to seek professional help, like in Asian American groups. Current studies in the U.S. have focused more attention on this important issue and have attempted to examine specific processes that can help to reduce service barriers at initial contact between the client and the mental health provider (Atkins et al., 2006; Benway et al., 2003; Minty and Anderson, 2004).

The present study examines several client demographic factors (ethnicity, gender, age, and primary language) and clinical characteristics (previous mental health treatment and the number and type of presenting problems, such as depression, behavioral problems, and family problems) to determine if these variables were related to pre-intake attrition for Asian American children and adolescents who sought out an Asian-oriented ethnic-specific mental health program. Culturally responsive variables such as matching factors between the client-prescreening interviewer (ethnic, Asian language, and gender match) and responsive clinical practices (clinical decisions about urgency of care or the need for an earlier appointment and continuity of care or the assignment of the

prescreening interviewer as the intake therapist) were also studied to see if these factors were associated with intake attendance.

It was hypothesized that culturally responsive aspects of an Asian-oriented ethnic-specific mental health program (gender, ethnic, and Asian language match with the prescreening interviewer) and responsive clinical practice procedures (for instance, the clinical decision that a client is in need of urgent care or the earliest available appointment and the assignment of the prescreening interviewer as the intake therapist) would predict higher rates of intake attendance for Asian American child and adolescent clients.

Method

Participants

The sample consisted of 236 consecutive Asian American children and adolescents (129 East Asian and 107 Southeast Asian Americans) who had made contact with an Asian-oriented ethnic-specific mental health program in northern California to seek out professional treatment for the first time. The data for this study was derived from a larger longitudinal study (1988-2004) and secondary data analysis was conducted on the youth clients in the most recent seven-year period with valid information. The specific criteria for inclusion in this study were the following:

1) Self-identification as a member of a specific Asian American ethnic group to allow for the creation of an ethnic match variable with the prescreening interviewer;

2) Complete and valid information on all demographic, clinical, matching, and serving program variables in the study; and

3) Only clients who had been assigned to an intake appointment at this ethnic-specific program were included, as some clients were determined in the prescreening interview to be better candidates for referral to another service agency due to specific clinical needs or ineligibility for clinical services.

Of the clients who sought services, only five were referred to another provider or deemed inappropriate for clinical services at this ethnic-specific program.

Table 1 provides a summary of the overall characteristics of the Asian American child and adolescent sample for this study. Slightly more than half of the sample was male (54.2%) and spoke

Table 1. Demographic, Clinical, and Programmatic Characteristics Between Attendees and Non-Attendees of Intake Appointments

Variables	Overall Characteristics (N = 236)	Attendance of Intake Appointment	
		Non-Attendees (N = 86)	Attendees (N = 150)
Gender			
Female	45.80%	40.70%	48.70%
Male	54.20%	59.30%	51.30%
Age (in years)			
	13.27 (3.78)	13.94 (3.75)	12.88 (3.75)*
Ethnicity			
East Asian American	54.70%	54.70%	54.70%
Southeast Asian American	45.30%	45.30%	45.30%
Primary Language			
English	48.30%	46.50%	49.30%
Asian Language/Dialect	51.70%	53.50%	50.70%
Previous Mental Health Treatment			
Yes	6.40%	5.80%	6.70%
No	93.60%	94.20%	93.30%
Number of Reported Problems			
	1.67 (0.47)	1.67 (0.47)	1.67 (0.47)
Type of Reported Problems			
Depression			
Yes	34.70%	29.10%	38.00%
No	65.30%	70.90%	62.00%
Behavioral			
Yes	36.90%	40.70%	34.70%
No	63.10%	59.30%	65.30%
Family			
Yes	26.70%	34.90%	22.00%*
No	73.30%	65.10%	78.00%
Urgency of Care or Need for Earliest Intake Appointment			
Yes	41.90%	25.60%	51.30%***
No	58.10%	74.40%	48.70%
Matching with Prescreening Interviewer			
Gender Match			
Match	47.00%	39.50%	51.30%‡
Non-Match	53.00%	60.50%	48.70%
Asian Language Match			
Match	41.10%	33.70%	45.30%‡
Non-Match	58.90%	66.30%	54.70%
Ethnicity Match			
Match	44.90%	33.70%	51.30%**
Non-Match	55.10%	66.30%	48.70%
Prescreening Interviewer Assigned as Intake Interviewer			
Yes	38.60%	24.40%	46.70%**
No	61.40%	75.60%	53.30%

Note: Asterisks denote a significant difference between attendees and non-attendees of intake appointment for each specific variable. For continuous variables, t-tests were performed. For categorical variables, chi-square tests for pair-wise comparisons were performed. Standard deviations for age and number of reported problems are presented within the parentheses in the table.

‡$p < .10$. *$p < .05$. **$p < .01$. ***$p < .001$.

an Asian language or dialect as their primary language (51.7%). The age of the sample ranged from 3 to 18 years, with a majority reporting as adolescents (13-18 years): Less than 6 years (5.1%), 7-9 years (12.7%), 10-12 years (19.1%), 13-15 years (28.4%), and 16-18 years (34.7%). The sample consisted of eleven Asian ethnic groups, with the largest percentages made up of the Chinese (27.1%), Vietnamese (16.9%), Iu Mien (9.3%), Cambodians (9.3%), Laotians (8.9%), and Filipinos (8.5%). A small percentage of this sample (7%) reported with some type of past mental health care, but none were previous clients of the current mental health program. The average client was found to report two clinical problems in the prescreening interview and these problems were typically not viewed by the pre-screening interviewer to require urgent care or assignment to the earliest intake appointment. The most commonly reported psychological problems in this sample were behavioral problems, depression, and family problems. Slightly less than half of the clients were matched with the prescreening interviewer in terms of gender (47%), Asian language (41%), and ethnicity (45%). For continuity of care, only 39 percent of the youth clients in the study were assigned their prescreening interviewer as the intake therapist. At this ethnic-specific program, 36 percent of the Asian American youth clients did not attend their scheduled intake appointments.

Variables

For this study, the clients were asked to provide information on four demographic variables:

1) Gender (Male =1, Female =2);

2) Age (in years);

3) Ethnicity (e.g., Korean, Chinese, Japanese); and

4) Primary language of choice by the client (English =1, Asian language/dialect = 0).

The client's ethnicity was first used to create the ethnicity match variable with the prescreening interviewer and subsequently it was used to create a dichotomized ethnicity category to represent "East Asians" versus "Southeast Asians." In a previous study on pre-intake attrition with Asian American adults, Southeast Asians were found to report with higher rates of intake attendance than more established East Asian American groups (Akutsu, Tsuru, and

Chu, 2006) and it was proposed that these dichotomized ethnic variables should be included in the statistical analysis to assess and control for its possible contribution to pre-intake attrition in the present study.

Specific clinical information was also collected from the client to serve as independent variables in the study:

1) Previous mental health treatment (Yes = 1, No = 0);

2) Number of reported problems; and

3-5) Type of reported problems (i.e., behavioral, depression, family).

Although the clients reported several types of clinical problems to the prescreening interviewer, the three most commonly reported problem types were dummy-coded to test their significant contribution to pre-intake attrition: Behavioral problems (Yes = 1, No = 0), depression (Yes = 1, No = 0), and family problems (Yes = 1, No = 0).

The prescreening interviewers and intake therapists in the study consisted of forty members of the clinical staff at this ethnic-specific program. Each prescreening interviewer and intake therapist held a post-baccalaureate degree in a mental health profession (e.g., social work, psychology) and was bilingual in English and at least one Asian language/dialect. The majority of the pre-screening interviewers were women (73.3%). The clinical staff in the study represented ten ethnic groups with the largest percentages, including Chinese (36.9%), Japanese (12.7%), Koreans (14.0%), Filipinos (9.3%), Vietnamese (8.9%), and Iu Mien (8.5%). Demographic information about the prescreening interviewer was used to create three matching variables with the client:

1) Gender match with the prescreening interviewer (Yes = 1, No = 0);

2) Ethnic match with the prescreening interviewer (Yes = 1, No = 0); and

3) Asian language match with the prescreening interviewer (Yes = 1, No = 0).

For the ethnic match variable, the client and prescreening interviewer had to self-report with exactly the same ethnicity (i.e., Korean American client with a Korean American prescreening interviewer, Vietnamese American client with a Vietnamese American

prescreening interviewer). This operational definition of "exact" ethnic match is consistent with previous studies on premature termination, length in treatment, and treatment outcomes with Asian American samples (e.g., Maramba and Nagayama Hall, 2002; Sue, et al., 1991; Zane et al., 1994) and ensured that both the client and prescreening interviewer would be sharing a common ethnic background and heritage which might help to foster a more positive connection or client engagement in the prescreening interview. It was also suggested that an exact ethnic match might help to create a stronger sense of cultural obligation to the prescreening interviewer and the Asian-oriented ethnic-specific program, and increase the likelihood for attendance of the intake appointment.

Specific information was also collected with the service agency to assess the possible influence of specific decisions in the prescreening interview process that may predict higher attendance of the intake appointment:

1) The need for urgent care or assignment to the earliest intake appointment (Yes = 1, No = 0); and

2) Continuity of care: The assignment of the prescreening interviewer as the therapist for the intake appointment (Yes = 1, No = 0).

The dependent variable for this study assessed whether the client attended his/her scheduled intake appointment (Yes = 1, No = 0).

Procedures

This study performed secondary data analyses on client, staff, and program data that were recorded in the management information system at this Asian-oriented ethnic-specific program. Once a client made initial contact with this clinic, the administrative support staff would first request the client's language of choice and then contact a clinical staff member to conduct a brief prescreening interview in the client's preferred language. Each clinical staff member was trained to complete the prescreening interview using a standardized form and protocol of questions. The prescreening interview included specific questions about contact and client demographic information (e.g., age, gender, ethnicity, spoken languages), previous history of mental health care (e.g., past/current treatment and/or medications), financial/insurance status (e.g., Medi-Cal, private insurance), risk assessment (e.g., harm to self or others), and

the main problems that helped to initiate clinical inquiry. While the majority of these prescreening interviews were conducted by telephone, a small percentage (estimated to be about 5-10 percent by the support staff) was completed in face-to-face interviews with a clinical staff member at this ethnic-specific clinic. Specific procedures for collecting data in face-to-face conditions did not deviate from the standardized procedures that were outlined above for completing the telephone prescreening interviews. Based on the information that was collected from this prescreening interview, an intake therapist was then assigned by the clinical management team to contact the client and schedule an intake appointment.

Results

A series of chi-square analyses and t-tests were performed to determine if there were significant group differences on certain demographic, clinical, matching, or program variables between the clients who had attended versus those who had not attended their intake appointments. A summary of the significant group differences between attendees versus non-attendees of these intake appointments are reported in Table 1. First, intake attendees were found to be slightly younger in age than the intake non-attendees, $t(234) = 2.13$, $p = .035$. Second, intake attendees reported fewer family problems as a specific reason for seeking help than intake non-attendees, $\chi^2 (1, N = 236) = 4.64$, $p = .042$. Third, more intake attendees were ethnically matched with their prescreening interviewers than intake non-attendees, $\chi^2 (1, N = 236) = 6.85$, $p = .009$. Fourth, more intake attendees were determined by prescreening interviewers to require urgent care or the need for the earliest intake appointment than intake non-attendees, $\chi^2 (1, N = 236) = 14.89$, $p < .001$. Fifth, more intake attendees were assigned their prescreening interviewer as their intake therapist than intake non-attendees, $\chi^2 (1, N = 236) = 11.42$, $p = .001$. A marginally significant difference between intake attendees and non-attendees was also found for gender match and Asian language match with the prescreening interviewer. Specifically, more intake attendees were matched by gender—$\chi^2 (1, N = 236) = 3.05$, $p = .081$—and Asian language—$\chi^2 (1, N = 236) = 3.39$, $p = .065$—with their prescreening interviewer than intake non-attendees.

A logistic regression analysis was performed to determine which of these demographic, clinical, matching, and program variables would be significant predictors of intake attendance after

controlling for the significant contribution of other variables in the model. Specific tests for multicollinearity were conducted on these independent variables and there was no evidence to support that this was a significant problem for this regression model. The results of this logistic regression analysis are reported in Table 2. The logistic regression model was found to be significant in predicting intake attendance for Asian American youths, χ^2 (14, N = 236) = 43.30, p < .001, and reported with an estimated Cox-Snell R-square of .17. Several independent variables were significantly related to intake attendance for Asian American children and youth. Specifically, ethnic match between the client and the prescreening interviewer, *OR* (1, N = 236) = 2.21, p = .041, urgent care determination or recommended assignment to the earliest intake appointment, *OR* (1, N =

Table 2. Logistic Regression Analysis for Predicting Client Attendance of Intake Appointment at an Asian-Oriented Ethnic-Specific Program

Variable	***OR***	**95% CI**
Gender: Female[1]	1.04	[0.52, 2.08]
Age (in years)	0.87**	[0.80, 0.95]
Ethnicity: East Asian American[2]	0.65	[0.33, 1.29]
Primary Language: English[3]	1.33	[0.71, 2.49]
Previous Mental Health Treatment[4]	0.85	[0.25, 2.92]
Number of Reported Problems	1.11	[0.53, 2.30]
Type of Reported Problems		
Depression[5]	1.06	[0.47, 2.39]
Behavioral[6]	0.88	[0.43, 1.82]
Family[7]	0.71	[0.32, 1.59]
Matching with Prescreening Interviewer		
Gender Match[8]	1.67	[0.85, 3.29]
Asian Language Match[9]	0.92	[0.44, 1.92]
Ethnicity Match[10]	2.23*	[1.04, 4.80]
Urgency of Care or Need for Earliest Intake Appointment[11]	2.57*	[1.24, 5.35]
Prescreening Interviewer Assigned as Intake Interviewer [12]	2.50**	[1.30, 4.83]

Note: N = 236. The estimated Cox-Snell R-square for this logistic regression model was 0.17.

[1] 1 = Male, 2 = Female. [2] 0 = Southeast Asian, 1 = East Asian.

[3] 0 = Asian Language/Dialect, 1 = English. [4-12] 0 = No, 1= Yes.

*p < .05. **p < .01.

236) = 2.58, $p = .011$, and the assignment of the prescreening interviewer as the intake therapist, OR (1, $N = 236$) = 2.51, $p = .006$, were all significantly associated with increased attendance of the intake appointment. Older age of the client, OR (1, $N = 236$) = 0.87, $p = .002$, was also significantly related to decreased attendance of the intake appointment.

Discussion

The present findings showed that specific program components and decision-making at an Asian-oriented ethnic-specific program can help to facilitate a decrease in pre-intake attrition for Asian American youth clients. Specifically, the results showed that clinical staff and administrators at mental health programs can play a critical role in decisions that can impact intake attendance. For example, when Asian American children or adolescents were determined by prescreening interviewers to require urgent care or the earliest intake appointment available, these clients were 2.6 times more likely to attend intake appointments than clients who were not viewed as requiring urgent care. Also, clients who continued with the prescreening interviewer as their intake therapist were 2.5 times more likely to attend intake appointments than clients who were assigned a different intake therapist. These findings suggest that ethnic-specific mental health providers may have some control over responsive clinical procedures that could help to reduce pre-intake attrition in Asian American youth clients. This is an important consideration when treating a clinical population with a long history of ambivalence and distrust of professional mental health care (Akutsu, 1997; U.S. DHHS, 2001; Zhang et al., 1998).

Other results suggest that clients who shared a common ethnic background with prescreening interviewers were 2.2 times more likely to attend intake appointments than clients who not matched ethnically with prescreening interviewers. This is an intriguing finding, as past research has often spoken about the benefits of ethnic matching between the client and therapist for ethnic minority groups. However, the current study showed that "exact" ethnic matching (e.g., Korean American client with a Korean American prescreening interviewer) was more beneficial to intake attendance than "general" ethnic matching (e.g., Korean American client with Chinese American prescreening interviewer) between an Asian American youth client and a prescreening interviewer. Despite this present finding,

we believe there are still certain benefits for Asian American clients who may be seen by an Asian American therapist who may not be of the same Asian ethnic background because of common values and beliefs that are often shared across different Asian ethnic groups such as cultural obligation, reciprocity, and collectivism.

Asian American clients who were older also were 13 percent less likely to attend intake appointments than younger clients. One possible reason for higher intake attendance by younger clients is that they are more dependent on their parents to first seek out mental health treatment for them and then to provide transportation for the scheduled intake appointment. In contrast, older youth may be given more autonomy by parents to make their own decisions about whether to first seek out a mental health program and later to decide whether to attend the scheduled intake appointment. Another reason that younger children may attend intake appointments at a higher rate is their parents may have contacted the mental health program without their consent or knowledge so that they would have little control over such decisions and are forced or coerced to attending the scheduled intake appointment by their parents. A final reason for higher rates of intake non-attendance by adolescents is they may have sought out professional help without parental consent and subsequently decided not to attend their intake appointment due to their fears that parental notification is required by mental health professionals at this ethnic-specific program. In the state of California, where this study took place, minors as young as 12 years of age may request outpatient mental health care without their parents' permission, provided that they can demonstrate a specific level of maturity and these clinical services are determined to be necessary by clinical staff. The current data set does not provide specific information about the level of parental involvement or participation in this process and future research should consider the importance of this factor in decisions about initial inquiries of mental health services and subsequent attendance of scheduled intake appointments for Asian American groups.

In regards to culturally responsive factors, there was clear evidence that an ethnic match with the prescreening interviewer does increase the likelihood of intake attendance for Asian American children and their families, although gender and language matches with the prescreening interviewer were not found to improve intake attendance. This finding may suggest that initial contact with some-

one at a mental health clinic who shares a similar ethnic culture with the child and/or family may help to forge a stronger clinical connection at the beginning of treatment and provide greater motivation to attend the intake appointment. It is important to note that an "exact" Asian ethnic match goes beyond the mirroring of physical attributes. Asian Americans make up over twenty-eight different Asian ethnic groups, each with their own sets of cultural nuances and practices, which include different histories of immigration and reception to the U.S. (Sue, 1999). For Asian American youth and their families, a shared or common ethnic background may be more important than Asian language or gender match at the onset of treatment as many of the problems reported by immigrant Asian American families are often related to issues of acculturation by the children. That is, many Asian American immigrant families report that their children are moving away from traditional values and beliefs of their Asian ethnic group and becoming too American or adopting too many Western ideals and values (Chun and Akutsu, 2009). As such, it may be more important for Asian American parents and families that the therapist is someone who is knowledgeable about the specific values and customs of their Asian ethnic group, and this is more likely to take place if the prescreening interviewer and intake therapist is of the same Asian ethnic background as the family. This status of shared ethnic background could provide greater incentives for the Asian American child client and his/her family to attend at least the intake session. Also, it is possible that having a shared ethnic background with the prescreening interviewer or intake therapist could foster stronger obligations on the Asian American parents or families to attend the intake session to prevent the loss of face for a therapist who shares the same ethnic culture as the client. The social pressure to meet with a therapist who shares the same ethnic culture would be higher for Asian American clients and families than if the therapist was an Asian American from another ethnic group. Whatever the specific process may be concerning higher intake attendance and ethnic matching, past studies have shown that intake attendance may be improved if mental health providers engage in procedures or behaviors which build a stronger connection with prospective youth clients and their families (Minty and Anderson, 2004).

One of the surprising findings of the study is the relatively high rate of pre-intake attrition (36%) at a mental health program that

was specially designed to provide culturally competent services to Asian American clients and their communities. While this reported rate of non-attendance is comparable to rates of pre-intake attrition found in previous studies focusing on general child and adolescent client populations, these results suggest that culturally responsive interventions must be tested after implementation to determine the effectiveness of such programs. With regard to this modest rate of pre-intake attrition for our sample, one must consider this figure could be a significant improvement from rates of intake non-attendance by Asian American children and adolescents at more traditional mental health programs, which may be lacking cultural competence. However, with limited data on the rate of pre-intake attrition for Asian American youth populations, it is difficult to make any definitive conclusions concerning this matter. Although certain advances may have occurred in providing more easily accessible mental health services to Asian American communities, it may be premature to suggest these culturally appropriate service programs have overcome the many cultural challenges and obstacles that still exist for largely monolingual immigrant and refugee populations. It is critical for service providers to Asian American populations to continue to support innovative programs and strategies for delivering culturally responsive and appropriate services to Asian ethnic groups and to conduct outcome studies to determine the value and effectiveness of such unique programs.

In reviewing the findings of this study, there are several methodological issues that should be considered. First, it is assumed that failed attendance of the intake session was due to some type of reluctance by the Asian American client and his/her family. However, it is possible the Asian American client and his/her family may have no longer required any type of professional help after the initial contact (Kourany et al., 1990; Lai et al., 1997, Lowman et al., 1984) or may have found help or assistance elsewhere (Carpenter et al., 1981; Kourany et al., 1990; Lowman et al., 1984). For example, although Owens et al. (2002) found that parents who believed their children would improve without professional care reported more barriers to entry than those who did not, there was no significant difference in these two parent groups in reference to reported structural barriers (e.g., fees, location) or negative perceptions about the mental health service itself (e.g., stigma, trust). For future research, it will be important to determine who was instrumental in making the fi-

nal decision of whether to attend the intake session—the client, the parents, or both. For younger children, this decision to attend the intake session is more likely to be in the hands of their Asian American parents or guardians. However, this decision about whether to attend the intake appointment may be quite different for older adolescents who may exhibit higher maturity and responsibilities with increased age. Second, although data for the current study is slightly dated, recent statistics continue to show that Asian Americans still underuse mental health services in California, where this study was completed. Specifically, Asian American and Pacific Islander children and adolescents continue to be underrepresented in the public mental health system, comprising only one-third of the client population that would be expected from their numbers in the general population (Mayberg, 2008, 2009). These findings support the Surgeon General's assertions concerning low service utilization among Asian Americans and their use of mental health services only when conditions have become severe (U.S. DHHS, 2001). It will be important to attempt greater study of this important dynamic concerning mental health services for Asian Americans, particularly child and adolescent populations. Third, the current study did not include an important variable that is often mentioned in past studies of pre-intake attrition—the length of time between the initial contact and the scheduled intake appointment. Unfortunately, the specific number of days between initial contact and the scheduled intake appointment was only available for clients who had actually attended their intake appointments and therefore could not be included as an independent variable to be examined in the study. This study, however, included an urgency of care variable, which had a significant influence on the decisions about scheduling earlier intake appointments for such clients and most likely captured the importance of this essential time period. A post-hoc analysis on clients who attended their intake appointments showed that those who were determined to require urgent care were scheduled earlier intake appointments than those who did not receive this designation from prescreening interviewers. Finally, it will be important to conduct further research on the concept of pre-intake attrition with other Asian American youth groups to determine if these findings may generalize to other ethnic groups and clinical settings. This is one of the first empirical investigations of this unique mental health program for Asian American children and adolescents and this will

require future research attention and examination.

In conclusion, this study suggests that current research may not present an inclusive picture of the so-called treatment barriers that may exist for many Asian American child and adolescent clients. Specifically, the current focus on treatment compliance and maintenance for ethnic minority client groups in the service literature fails to consider steps that may be taken to reduce the likelihood for failed attendance of the first scheduled appointment before formal treatment begins. Often, the decision not to follow through and attend the intake session is accepted by service providers because it is viewed as a natural process of reluctance or ambivalence in seeking out mental health services due to high levels of stigma and shame that are attached to having a mental illness. While there are reports in the literature of such reluctance in seeking out mental health care, the high rate of failed intake attendance is significant and mental health providers and officials must clearly address this recurrent problem due to the clinical and fiscal consequences of ignoring such a pervasive dilemma, particularly for ethnic minority groups, such as Asian Americans, who continually report the underuse of professional services. When one considers that Asian Americans are also more likely to deny mental illness and to delay seeking professional mental health care, it is possible that these relatively high rates of pre-intake attrition may be a significant underestimation of the magnitude of the mental health issues and problems in the Asian American community.

At a time when many county and state mental health departments are facing severe budget cuts, it will be very important for mental health systems and providers to examine multiple strategies and aspects of treatment effectiveness in serving ethnic minority groups such as Asian American populations. It is our hope that mental health officials and administrators will continue to focus on service inequities in these trying times of fiscal difficulties and continue to support new and innovative strategies for improving service access to ethnic minority groups including, Asian Americans. It is only by focusing on the unique issues of ethnic minority groups such as Asian Americans and allocating both clinical and fiscal resources to targeting the special needs of these ethnic communities that significant advances can be made to increase service use and effectiveness for such ethnically diverse populations.

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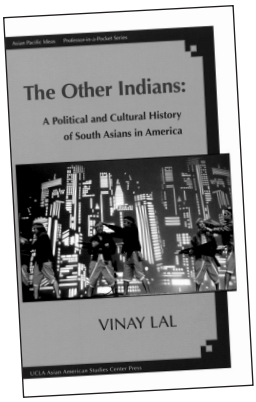

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