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LOMA LINDA UNIVERSITY  
School of Science Technology  
in conjunction with the  
Faculty of Graduate Studies

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Adolescents' Perceptions of Services Received  
at County Behavioral Health Care Centers

by

Mary Ann Long

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A Dissertation submitted in partial satisfaction of  
the requirements for the degree of  
Doctor of Philosophy in Social Policy and Social Research

---

June 2011

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Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

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Annette Ermshar, Assistant Professor of Social Work and Social Ecology

---

Ignatius Yacoub, Professor of Social Work and Social Ecology

---

Colwick Wilson, Professor of Counseling and Family Services

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## ABSTRACT OF THE DISSERTATION

Adolescents' Perceptions of Services Received  
At County Behavioral Health Care Centers

By

Mary Ann Long

Doctor of Philosophy, Graduate Program in Social Policy & Social Research  
Loma Linda University, June 2011  
Dr. Annette Ermshar, Chairperson

This quantitative study of 460 adolescents examined levels of satisfaction in a number of different domains such as general satisfaction, access to treatment, cultural sensitivity, functioning of the client, treatment planning, outcome of services, and social connectedness, of adolescents who received mental health treatment in a county's behavioral health care system. Additionally, this study accounted for the differences in age, race/ethnicity, gender, length of time in treatment, and treatment outcomes. While there were no statistical differences found based on the gender, racial/ethnic groups, and contact with the legal system, mean differences in age was observed. That is, younger adolescents reported lower levels of satisfaction with general satisfaction, perception of access, and treatment planning in their encounter with mental health services as compared to older adolescents. Also, adolescents receiving treatment for more than one year reported higher levels of satisfaction in four of the seven domains assessed. Specifically, those adolescents in treatment for more than a year showed higher levels of general satisfaction, treatment planning, outcome of services, and perception of function. Finally, looking at the differences in arrests both before and after treatment, encounters with the police, expulsions/suspensions from school before treatment and after treatment,

did not produce any statistical differences in the two groups. Overall, a large percentage of subjects were expelled/suspended from school regardless of whether they were in treatment for less than a year or longer. The results of this study points to the importance of accessing adolescent's perceptions of their experiences as recipients of mental health services. Important policy concerns exist with regards to the delivery of mental health services to adolescents.

**CHAPTER ONE**  
**INTRODUCTION**

**Legislative Issues**

The mental health of adolescents remains a topic of interest to researchers, clinicians, and policy makers. One area that continues to engage mental health professionals is the delivery of adequate services to adolescents in multiple settings. In particular, mental health service providers in county mental health settings are increasingly seeking to understand ways in which they could improve the quality of care that they provide to adolescents. The perceptions of the adolescents who access mental health services in the county mental health systems in the U.S. are critical to the continuing efforts to enhance the quality of care provided in these systems. This study seeks to assess the perceptions of adolescents who have experienced mental health services in a major county mental health system in California. To accomplish this task, this study will examine the development of the county behavioral care system and its related practices to the delivery of mental health services to adolescents. Appropriate policy implications will be addressed as a result of the focus on the perceptions of adolescents about their experiences with the county mental health system.

There are specific policies that guide in the development of current county mental health services to adolescents. The California legislature passes laws called acts or statutes, and the California Department of Mental Health takes the laws and interprets them into policies that guide the counties in providing services to their consumers. This process is employed in counties throughout the state and thus, the policies for the San Bernardino California Department of Mental Health in which this study is embedded, is

no exception. The Department of Mental Health then issues the policies for the San Bernardino Behavioral Health Care for the county's adolescents. This study reviews the following three laws and the policies that emerged: (a) the Bronzan-McCorquodale Act of 1991, (b) the County Performance Contract of 1993, and (c) the Mental Health Services Act of 2004.

Over the past few years, there has been a growing trend in California and nationally toward the measurement of consumer outcomes and cost effectiveness in mental health service systems (California Department of Mental Health [CDMH], 2007). California passed the Bronzan-McCorquodale Act of 1991, also known as the Realignment Act, specifically mandating that counties report data on established performance measures to the Director of Mental Health (CDMH, 2007).

Nationwide there has been a trend toward greater involvement with consumers in the services they receive, and the operations of Mental Health Systems output services ask for consumer participation in the integral part of assessment, evaluation, and intervention (CDMH, 2007). This is now being implemented with consumers and their family's involvement with mental health services in California.

Realignment in the counties in California requires the development of a local managed mental health care plan with a beneficiary satisfaction component. Measuring a consumer-centered outcome system encompasses consumer empowerment, involvement, and perceptions of care. This system involves the consumer as the central part of the mental health system and the provision of service, rather than simply a recipient of services (CDMH, 2007).

The California Mental Health Programs were developed by the California Department of Mental Health (DMH), in cooperation with the California Mental Health Planning Council (CMHPC) and the California Mental Health Directors Association (CMHDA). These organizations adopted a performance outcome measurement system that brought together the views of the clinical team, consumer, and family members of the consumer (CDMH, 2007). Thus the consumer was encouraged to provide his or her perception of the system and services involved.

This outcome measure model is supported in the empirical literature. Research indicates that consumer satisfaction is important in evaluating primary health care and explaining health-related behaviors (CDMH, 2007). Patient satisfaction can serve as an outcome measure of the quality of health care, it provides a consumer perspective that contributes to a complete, balanced evaluation of the structure, process, and outcome of services. Therefore, patient satisfaction should be considered as one of several sources of information for program and evaluation (CDMH, 2007).

Prior to passage of the Realignment Act, consumer satisfaction was left up to each of the 59 local mental health counties. After the Realignment Act was passed, a system was established that made all the counties uniform across the state. All counties now collect data using the same survey instrument. The Act requires the development of a uniform comprehensive statewide consumer-based information system that includes performance outcome measures. The counties report these data to the DMH, who ensures that the information is provided to the California Legislature, local mental health boards, and consumers, as well as National Stakeholders. These instruments assess consumers'

perceptions of quality of the outcome of care and are currently being used for broad-based evaluation of California consumer-based Mental Health Services (CDMH, 2007).

### ***The Bronzan-McCorquodale Act***

Specifically, the Bronzan-McCorquodale Act (1991) is under the Welfare and Institutions Code. It articulates the extent to which resources are available. That is public mental health services in the state of California should provide services to priority target populations in systems of care that are client-centered, culturally competent, and fully accountable (CDMH, 1991). According to the CDMH (1991), these services should include the following factors:

1. Client-centered approach, which means that all services designed for persons with mental disabilities, should be client-centered, in recognition of varying individual goals, diverse needs, concerns, strengths, motivations, and disabilities.
2. Persons with mental disabilities are the central and deciding figures, except where specifically limited by law, in all planning for treatment and rehabilitation, based on their individual needs.
3. Planning should include family members and friends as a source of information and support. Mental health services should therefore be viewed as a total of clients and members of families and their communities. This process is designed to assist clients in returning to the most constructive and satisfying lifestyles of their own definition and choice.
4. Service should be provided by qualified individuals trained in the client-centered approach and should be based on measurable outcomes in order to deliver those

services in environments conducive to the client's well-being.

5. State and local mental health-care systems should develop outcome measures based on client-centered goals that can be evaluated by measurable client outcomes.
6. Each county mental health system shall comply with reporting requirements of the department of Mental Health, there shall be uniform requirements among counties in reports.
7. The mental health department shall develop unique client identifiers that permit development of client-specific cost and outcome measures and related research and analysis, all consistent with clients' constitutional and statutory rights to privacy and confidentiality. Any costs associated with the performance of the duties of the committee shall be absorbed within the resources of the participants.
8. The Performance Outcome Committee shall develop measures of performance for evaluating client outcomes and cost effectiveness of mental health services provided pursuant to this division. The performance measures shall take into account resources available overall, resource imbalance between counties, other services available in the community, and county experience in developing data and evaluative information.
9. The committee should consider measures in the following areas: number of persons in identified populations served, estimated number of persons in identified target population in need of services, treatment plans, development for members of the target population served, stabilization of living arrangements, reduction of law enforcement involvement and jail bookings, increase in employment or education activities, percentage of resources used to serve children and older adults, number of patients' rights advocates and their duties, quality assurance activities for services,



including peer review and medication management identification or special projects, incentives, prevention programs, and areas identified for consideration by the committee for guidance study.

10. Counties shall annually report data on established performance measures to the local mental health advisory board and to the Director of Mental Health. The Director of Mental Health shall annually make available to the Legislature, no later than March 15, data on county performance (CDMH, 1991).

### ***The County Performance Contract***

The California Welfare and Institutions Codes document the Performance Contract (1993), which each of the 59 counties is to abide by, and these codes follow:

The board of supervisors of each county, or boards of supervisors of counties acting jointly, shall adopt, and submit to the Director of Mental Health in the form and according to the procedures specified by the director, a proposed annual county mental health services performance contract for mental health services in the county or counties. The proposed annual county mental health services performance contract shall include all of the following: the county shall provide all data and information set forth in Sections 5610 and 5664, assurances that the county shall comply with all applicable laws and regulations for all services delivered, and other information determined to be necessary by the director, to the extent this requirement does not substantially increase county costs (CDMH, 1993).

Welfare and Institutions Codes further state that county mental health systems shall provide reports and data to meet the information needs of the state. The department

shall not implement this section in a manner requiring a higher level of service for state reporting than that which it was authorized to require prior to July 1, 1991 (CDMH, 1993). The Director of Mental Health shall review each proposed county mental health services performance contract to determine that it complies with the requirements of this division. The director shall require modifications in the proposed county mental health services performance contract which he or she deems necessary to bring the proposed contract into conformance with the requirements of this division. Upon the approval of both parties, the provisions of the performance contract shall be deemed to be a contractual agreement between the state and county (CDMH, 1993).

One problem that counties face is obtaining the funding to start up new programs for training needs, funding problems that result in shortage of workforce personnel, shortage of general infrastructure needs, housing for persons in all age groups, programming for special needs groups, and programming for senior citizens' needs. In November 2004, Proposition 63 was brought before the voters of California for consideration. It imposes a 1% income tax on personal income of persons making in excess of \$1 million statewide. The income generated by this proposition would go to fund mental health programs throughout the state. The Proposition passed, resulting in prospects for more funding for county operations (CDMH, 2004).

### ***Mental Services Act***

Specifically, this proposition was named The Mental Health Services Act (MHSA) and was projected to generate approximately \$254 million in fiscal year 2004-2005, \$683 million in 2005, and 2006 and increasing amounts thereafter (MHSA, 2004).

However, while the intent was to increase the financial resources available for mental health services, this goal has not necessarily materialized. This is largely due to multiple factors directly related to the existing economic downturn in the state of California (MHSA, 2004).

Nonetheless, much of the funding is distributed to county mental health programs upon approval of their plans for each component of the MHSA: (a) Community Planning funds to involve the public in identifying local funding priorities; (b) Community Service & Support funds to provide integrated mental health and other support services to those whose needs are not currently met through other funding sources; (c) Prevention & Early Intervention funds to reduce the stigma and discrimination associated with mental illness and provide preventative services to avert mental health crises; (d) Innovative Programs funds to improve access to mental healthcare; (e) Capital Facilities & Technology funds to improve the infrastructure of California's mental health system; and (f) Workforce Education & Training funds to develop and grow the mental healthcare workforce (MHSA, 2004).

To provide for an orderly implementation of MHSA, DMH has planned for sequential phases of development for each of the six components of the Act. An extensive stakeholder process is being employed to inform the state's implementation efforts. Improvement in client outcomes is a fundamental expectation throughout the implementation process (MHSA, 2004).

The sections of the Act that are especially important to the programs that will be used in the current study are listed below. These sections are taken from the California Codes, the Welfare and Institutions (W&I) Codes, and from the State of California Laws.

Section 3 of the Act: Purpose and intent: the people of the State of California hereby declare the purposes and intent in enacting this Act to be as follows:

W&I 5820.

- (a) To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care (MHSA, 2004).
- (b) To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness (MHSA, 2004).
- (c) To expand the kinds of successful, innovative service programs for children, adults, and seniors began in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness (MHSA, 2004).
- (d) To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs (MHSA, 2004).
- (e) To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public (MHSA, 2004).

Section 5 of the Act: Article 11 (commencing with Section 5878.1) is added to Chapter 1 of Part 4 of Division 5 of the Welfare and Institutions Code, to read: W&I 5878.1.

- (a) It is the intent of this article to establish programs that assure services will be provided to severely mentally ill children as defined in Section 5758.2 and that they be part of the children's system of care established pursuant to this Part. It is the intent of this Act that services provided under this Chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and their family (MHSA, 2004).
- (b) Nothing in this Act shall be construed to authorize any services to be provided to a minor without the consent of the child's parent or legal guardian beyond those already authorized by existing statute (MHSA, 2004).

W&I 5878.2.

- (a) For purposes of this article, severely mentally ill children means minors under the age of 18 who meet the criteria set forth in subdivision (a) of Section 5600.3 (MHSA, 2004).

W&I 5878.3.

- (a) Subject to the availability of funds as determined pursuant to Part 4.5, county mental health programs shall offer services to severely mentally ill children for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable. Other entitlement programs include but are not limited to mental health services available pursuant to Medi-Cal, child

welfare, and special education programs. The funding shall cover only those portions of care that cannot be paid for with public or private insurance, other mental health funds or other entitlement programs (MHSA, 2004).

- (b) Funding shall be at sufficient levels to ensure that counties can provide each child served all of the necessary services set forth in the applicable treatment plan developed in accordance with this Part, including services where appropriate and necessary to prevent an out of home placement, such as services pursuant to Chapter 4 of Part 6 of Division 9 (commencing with Section 18250) (MHSA, 2004).
- (c) The Department of Mental Health shall contract with county mental health programs for the provision of services under this article in the manner set forth in Section 5897 (MHSA, 2004).

Section 6. Section 8257 is added to the Welfare and Institutions Code to read as follows:

W&I 8257.

- (a) The Department of Social Services shall seek applicable federal approval to make the maximum number of children being served through such programs eligible for federal financial participation and amend any applicable state regulations to the extent necessary to eliminate any limitations on the numbers of children who can participate in these programs (MHSA, 2004).
- (b) Funds from the Mental Health Services fund shall be made available to the Department of Social Services for technical assistance to counties in establishing and administering projects. Funding shall include reasonable and necessary administrative costs in establishing and administering a project pursuant to this Chapter and shall be

sufficient to create an incentive for all counties to seek to establish programs pursuant to this chapter (MHSA, 2004).

Section 9. Part 3.2 commencing with Section 5830 is added to Division 5 of the Welfare and Institutions Code to read:

Part 3.2 Innovative Programs.

W&I 5839.

County mental health programs shall develop plans for innovative programs to be funded pursuant to paragraph (6) of subdivision (a) of Section 5892 (MHSA, 2004).

(a) The innovative programs shall have the following purposes:

- (1) To increase access to underserved groups.
- (2) To increase the quality of services, including better outcomes.
- (3) To promote interagency collaboration.
- (4) To increase access to services.
- (5) County mental health programs shall receive funds for their innovative programs upon approval by the Mental Health Oversight and Accountability Commission (MHSA, 2004).

W&I 5847.

Integrated Plans for Prevention, Innovation and System of Care Services.

(a) Each county mental health program shall prepare and submit a three-year plan which shall be updated at least annually and approved by the department after review and comment by the Oversight and Accountability Commission (MHSA, 2004).

Section 16. The provision of this Act shall become effective January 1 of the year following passage of the Act. And its provisions shall be applied prospectively. Each County in California will take part in this Act (MHSA, 2004).

## **County Mental Health Services**

### ***Adolescent Issues***

An important area to consider is how best to conceptualize adolescent mental health needs. Mental health is an essential component of young people's overall health and well-being. It affects how young people think, feel, and act: their ability to learn and engage in relationships; their self-esteem; and their ability to evaluate situations and options and make choices. A person's mental health influences the ability to handle stress, relate to other people, and make decisions. Like adults, children and adolescents can have mental health disorders that interfere with the way they think, feel, and act. When untreated, mental health disorders can lead to school failure, family conflicts, drug abuse, violence, and even suicide.

Untreated mental health disorders can be very costly to families, communities, and the health care system (Substance Abuse and Mental Health Administration [SAMSA], 2003). Mental health disorders in adolescents are caused mostly by biology and environment. Biological causes include genetics, chemical imbalances in the body, or damage to the central nervous system such as head injury. Environmental causes include exposure to environmental toxins, exposure to violence, physical or sexual abuse, stress related to poverty, discrimination, and the loss of important people through death, divorce, or broken relationships (SAMSA, 2003). Many people experience mental



problems at some time during their lives. At least one in five children and adolescents may express a mental health problem in a given year, and in the U.S. it is estimated that one in 10 children and adolescents suffer from mental illness severe enough to cause some level of impairment. However, in any given year, it is estimated that fewer than one in five such children receives treatment (National Institute of Mental Health [NIMH], 2000).

The San Bernardino County Department of Behavioral Health Care Centers were created in 1986 to meet the needs of the youth with mental health issues as well as those involved in the juvenile justice system. County centers work together to combine their resources in an effort to provide a comprehensive and effective continuum of adolescent behavioral health care (San Bernardino, Department of Mental Health, Children's Services, 2007). There are hundreds of adolescents caught up in the mental health and juvenile justice systems at any time in San Bernardino County, California. Of importance is an examination of how the adolescent becomes involved in the mental health and juvenile justice system.

According to the National Institute of Mental Health, the future of our country depends on the young people and their mental health, their physical health, and ability to overcome such health concerns. It is a normal part of adolescence to take on new responsibilities and roles that can incur risks and to negotiate and renegotiate relations with adults in the family. Youth can be part of their community of peers and experiment with things that symbolize adult life and raise questions about the rules and customs of their family and society (NIMH, 2000). Juveniles who get involved with the law, who are arrested and detained will experience at least some emotional disturbance and anxiety

in their lives. As such, it is important to identify these youth and their families, connect them with appropriate resources when they return to the community, and reduce recidivism. Services should include case management, academic and vocational training, job skills, legal resources, physical health services, social skills, and psychological and substance abuse treatment within the juvenile justice system, with a focus on rehabilitation of the adolescent rather than on punishment (San Bernardino County, DMH, Children's Services, 2007).

The rights of minors, and in particular adolescents, can be confusing. Adolescents are individuals who have more mental capacity for decision-making than younger children but are not yet full adults. There are many specific areas regarding consent and confidentiality that are particularly difficult for teens, parents, health-care professionals, and lawmakers to negotiate. These usually surround areas of reproductive health and substance abuse. For example, the question is often raised as to who is authorized to give consent for health care and whose consent is required. The consent of a parent is usually required, but someone else such as a juvenile court, social worker, or probation officer may have to give consent for treatment in certain circumstances. Other issues regarding adolescents include privacy and confidentiality, safety issues, and who is to pay for treatment (Neinstein, 2004). Certainly, how these issues and developmental tasks are managed, and resolved can have a significant impact on their personal health and development of the adolescent (NIMH, 2000).

### *Adolescents and Mental Health Problems*

Just like adults, adolescents can experience emotions, thoughts, and behaviors that are distressing, disruptive, and disabling. Most of the time these represent normal phases of development, but when these signs and symptoms are of unexplained frequency, timing, or duration, they may indicate a mental disorder (World Health Organization [WHO], 2004). Since the late 1970s, a number of theoretical frameworks have been proposed for the development of children and adolescents and their understanding of physical health and mental illness or psychiatric problems. These have received relatively little attention (Gooseens et al., 2002; Graham & Ridley-Johnson, 1995; Juvonen, 1991; Peterson, Mullins, & Ridley-Johnson, 1985; Sigelman & Begley, 1987; Hennessy & Heary, 2009).

According to the WHO (2004), the most common types of mental disorders among youth are anxiety disorders, depression, mood disorders, and behavioral and cognitive disorders. If adolescent mental health problems go untreated, this can affect their development, school attendance and performance, and relationships with others. Adolescents' mental health affects how they view others, as well as themselves, and how they evaluate and relate to situations. Their mental health also affects how they make choices, what choices they make, and what actions they take. Given the significance of the issues adolescents face, it is critical to address treatment globally and comprehensively, including an evaluation of the adolescents own perceptions regarding mental health treatment. To date, adolescents' understanding of mental health has not been well established (Hennessey & Heary, 2009).

Because their mental health affects their judgment, emotional disturbances and mental disorders can be a risk factor for acting out and violence (WHO, 2004), including disturbed childhood behavior. The most serious of the behavioral disorders is Conduct Disorder, which is characterized by behavior in which the basic rights of others or societal norms are violated. Some of these behaviors can include bullying and destruction of property. Oppositional Defiant Disorder is a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures. Attention-Deficit/Hyperactivity Disorder (ADHD) may also lead to disruptive and impulsive behaviors and finally, Adjustment Disorder may occur in the context of a psychosocial stressor (Richmond, 2009).

### *Parental Versus Peer Pressure*

Youth are influenced by their peers, families, the media, and a wide range of environmental factors. Peer pressure is very strong among adolescents. It is essential that youth have the influence of peers, but sometimes peers exert a negative influence. Having delinquent and antisocial friends may lead the child to develop behavioral or emotional problems (Leon-Guerro, 2005). Children need a nurturing social environment in childhood, plus early academic successes in school to help them develop a health lifestyle. If these are lacking, they may drop out of school and develop associated mental health symptoms (Aufseeser, Jekielek, & Brown, 2006). A study found that over three-quarters of all parents report very close relationships with their adolescent children; 15-year-olds report difficulty talking with their mothers and fathers about things that really bother them; adolescents who live with two parents are more likely to have parents who

know their whereabouts after school; adolescents with better educated parents are less likely to be exposed to smoking and heavy drinking by their parents; and adolescents whose parents exercise are less likely to be sedentary themselves (Aufseeser, Jekielek, & Brown, 2006).

Another recent opinion poll by the research group Child Trends found that while less than one-third of parents say they influence their teens more than friends or peers do, most teens report that they think highly of their parents, want to be like them, and enjoy spending time with them (Independent Living Programs, U.S. Government Accountability Office [GAO], 2005).

### *Substance Abuse*

Substance Abuse and Mental Health Services Administration (SAMHSA) reports that more than 4 million youth ages 16 to 20 drove under the influence of either alcohol or drugs in 2002 and 2003—representing more than 20 percent of all youth in that age group. Combining data for both of these years from the National Survey of Drug Use and Health (NSDUH), SAMHSA found that 14 percent reported driving under the influence of illicit drugs, 17 percent reported driving under the influence of alcohol, and 8 percent reported driving after consuming a combination of drugs and alcohol. Only 4 percent of youth who reported driving under the influence had been arrested for a DUI offense in the year preceding the survey (SAMHSA, 2005). A study on illicit drug use found that by age 14, 35 percent of youth have engaged in some form of illicit drug use. By the end of high school, more than 50 percent will have tried at least one illegal drug, and teens who begin using illegal drugs before the age of 15 are more likely to develop a lifelong

dependence on illegal substances. The most common drugs used by adolescents are marijuana, ecstasy, and cocaine (McDowell, 2002).

### *Adolescents and Risk Factors*

It is developmentally typical for adolescents to take on new responsibilities and roles that can incur risks, to negotiate relations with adults in the family and community and with peers, to experiment with things symbolic of adult life, and to raise questions about family and societal roles or customs (WHO, 2004). It is how an adolescent chooses to express these developmental tasks, the frequency and intensity with which this is done, and its overall impact on personal health and development that are of public health concern (WHO, 2004).

Accidents, violence, and suicide are among the three most common causes of death in adolescence. Impaired mental health is a precursor or consequence of any health-risky behaviors, such as substance abuse; unwanted or unprotected sex; physical, sexual, or emotional abuse (as a victim or as a perpetrator); reckless driving or excessive risk-taking; extreme eating habits; and excessive influence by advertising and other forms of the media (WHO, 2004). Some consequences of drug abuse can include mental and physical health problems, increased likelihood of drug use later in life, involvement in illegal activities, and increased likelihood of death (McDowell & Futris, 2002). There are other behaviors and attitudes that are also linked to adolescent mental health: aggressiveness and disregard for laws or the rights of others; school avoidance and school failure; isolation from peers, family, and other emotional relationships; and the inability to keep one's disappointments in perspective (WHO, 2004).

## **Parental Relationships**

Our society is geographically mobile, which can mean that children do not have easy access to grandparents and other relatives. In urban areas there is not a lot of interaction and interdependence among neighbors. A consequence of these circumstances is that children must then put all their emotional dependence on their parents or caregiver (Adams, 2001). If the parents are under stress or if they are not at home, the child has no place to seek solace. A more complex level of problems arises if the parents are separated or divorced and the child is shifted between them, or if a parent dies. Certainly, when understanding adolescent development and mental health, one must consider parental relationships and the importance of communication when dealing with any type of risk taking behavior (McDowell & Futris, 2002). Childhood is a very competitive time, particularly in the school system, where students are constantly being rated and compared (Leon-Guerro, 2005). The seemingly endless struggle between what adults want for the child and what the child wants to do can cause a lot of anxiety in both the child and the family (Leon-Guerro, 2005).

## ***Adolescents and Family Income***

The income level of the family can create different family lifestyles and can have an impact on adolescent development and mental health. Lower income families tend to use more physical punishment and view child-rearing as a custodial job. Lower income parents often have to work two or more jobs just to pay the bills, and are therefore not present when the children come home from school. This parental absence can contribute to increased behavior problems in the youth (Adams, 2001). Middle-class, more educated

parents tend to have increased focus on child-rearing and more time to spend with their children (Adams, 2001). However, this does not always result in better behaved children or reduced mental health (Leon-Guerro, 2005). The seemingly endless struggle between what adults want for the child and what the child wants to do can cause a lot of anxiety in both the child and family (Leon-Guerro, 2005).

One traditional belief is that parents are usually suited for child rearing, however, not all parents are equally prepared for the job (Leon-Guerro, 2005). Although there is strong cultural pressure to have children, not all parents are able to handle this level of responsibility. Stresses impinging on the family, such as poverty or marital dissension between the parents, as well as parent's own mental health limitations can result in struggles for both the child and parent (Adams, 2001).

### *Adolescents and Abuse*

Some children are exposed to various forms of abuse or mistreatment, such as physical abuse (which can result in brain damage or ruptured organs) or psychological cruelty or neglect (WHO, 2004). By action or inaction, parents shape the lives of their children from birth through adulthood. In adolescence, peers take on greater importance, but research clearly demonstrates the continued significance of parents in shaping the behaviors and choices of teens as they face the challenges of growing up (Aufseeser, Jekielek, & Brown, 2006). Since there is a strong tradition in our society of not interfering in what is considered a family matter, neighbors and relatives are sometimes reluctant to report incidents of abuse or to get involved (Adams, 2001). Some cases of child abuse are associated with misguided and cruel child-rearing practices, especially if



the parents are doing what their parents did to them (Richmond, 2009). Children are essentially at the mercy of their parents. Dysfunctional families know very well that above all else they must do their best to look functional. Broken by adultery, alcoholism, divorce, drug use, emotional abuse, physical abuse, sexual abuse, and violence, the whole family usually makes a tremendous effort to keep family secrets, so much so that each family member adopts a discrete role to play in the deception held up to the outside world (Richmond, 2009).

Child neglect is another aspect of the problem (Adams, 2001). Child abuse and neglect are often associated with low level of education and/or income, broken homes, and situations where the parents are themselves abused (Leon-Guerro, 2005). Close parent/adolescent relationships, good parenting skills, shared family activities, and positive parent role-modeling all have well-documented effects on adolescent health and development. These areas are where social policy can help support parents in taking such steps (Aufseeser, Jekielek, & Brown, 2006).

Many societal forces on the adolescent are at cross-purposes. A source of conflict has to do with the status of adolescents in society (NIMH, 2004). Adolescents are neither children nor adults, but somewhere in between. They operate in an ambiguous situation, with mixed rights and duties that can fluctuate with the situation, parental tolerance, and their own behavior. This ambivalence toward adolescents creates confusion among them and adults alike (NIMH, 2004). That is why close relationships, healthy open communication, and perceived parental support are especially important during adolescence, as children experience many physical and emotional changes during this stressful period (Aufseeser, Jekielek, & Brown, 2006).

### *Adolescents and Cultural Practices*

In some cultures, there are rites of passage into adulthood. In some cultures children may go through various rituals to get past childhood and move on into adulthood (Leon-Guerro, 2005). Cultural practices can vary from group to group even though they may speak the same language. An example of this is the Spanish language, there are peoples from the Caribbean regions, the southern parts of the Americas, and the Pacific regions all speaking versions of Spanish. Hispanic or Spanish parents are less likely than white and Black/African-American parents to know who most of their adolescent's friends are. In a 2003 study results that showed that 88 percent of non-Hispanic white adolescents ages 12 to 17 had parents who knew most or all of their friends, compared with 73 percent of non-Hispanic, African-American adolescents, and 66 percent of Hispanic adolescents who did not (Aufseeser, Jekielek, & Brown, 2006). There are different Asian groups who come from the Far East, who may have very different cultural practices and speak different dialects (Leon-Guerro, 2005). Foreign-born adolescents are more likely than their native-born peers to eat meals with their family (Aufseeser, Jekielek, & Brown, 2006). In addition, there are Native American groups, who have various cultural differences among themselves (WHO, 2004).

People of European descent currently outnumber other cultural groups. But they have a variety of different cultural values, mores, and native languages among themselves (WHO, 2004). Over the years many of these groups from other countries have joined the American family. We cannot assume that an individual from one specific group will have the same cultural values and will act like others from a similar ethnic group (WHO, 2004).

So why do adolescents differ in their actions? One reason is that parental habits can shape adolescent health behaviors by increasing easy access to cigarettes or alcohol in the home. On the positive side, adolescents can have ready access to healthful foods (Aufseeser, Jekielek, & Brown, 2006). The family environment can be a strong source of support for developing adolescents, providing close relationships, strong parenting skills, good communication, and the modeling of positive behaviors. Other reasons may be cultural, ethical, biological, religious, and even environmental (Aufseeser, Jekielek, Brown, 2006).

### ***Adolescents and Peer Pressure***

Peer pressure is very strong among adolescents. It is essential that youth have the influence of peers, but sometimes peers exert a negative influence. Having delinquent and antisocial friends may lead the child to develop behavioral or emotional problems (Leon-Guerro, 2005). Children need a nurturing social environment in childhood, plus early academic successes in school to help them develop a healthy lifestyle. If these are lacking, they may drop out of school and develop associated mental health symptoms (Aufseeser, Jekielek, & Brown, 2006).

### ***Adolescents and the Legal System***

There are hundreds of adolescents in the San Bernardino Behavioral Health Care System that have been involved with the legal system. The juvenile justice system is primarily a local responsibility for more than 98 percent of all juvenile offender cases, typically through their probation departments, which provide rehabilitation services and

community supervision (Legislative Analyst Office [LAO], 2007). Adolescent experiences in their interactions with police and other legal actors subtly shape their perceptions of the relationship between individuals and society. These experiences influence the development of adolescents' notions about law, rules, and agreements among members of society, and about the legitimacy of authority to deal fairly with citizens who violate society's rules. It is likely that these beliefs influence compliance with the law, both among adolescents in general and among juvenile offenders in particular, after they have been sanctioned for their offences (MacArthur Foundation Research, 2009).

When juveniles are released after being incarcerated, they return to their home communities. Because the enforcement of law differs by neighborhood, adolescents growing up in neighborhoods of different social composition experience the law in very different ways (MacArthur Foundation Research, 2009). Counties already administer many of the programs these individuals need to reduce the likelihood of recidivism, such as drug and alcohol treatment programs and mental health treatment (LAO, 2007). Adolescents who have a mental health diagnosis and have been incarcerated in the juvenile system receive services at the San Bernardino Behavioral Health Care Centers when they are released from custody. The Centers work with the school system to try to keep adolescents in school (LAO, 2007).

### ***Current Study***

The purpose of this study is to examine perceptions of the adolescent consumers that contact San Bernardino County Behavioral Health Care Centers for mental health

services. There has been a trend toward consumer involvement in the programming they receive, and even in the operations of the mental health system. Realignment calls for this consumer involvement in the assessment, intervention, and evaluation of their treatment, by creating a beneficiary satisfaction component (DMH, 2007).

Consumers are given the survey instruments to complete twice a year. These instruments were created to elicit the adolescents' perceptions of the services they receive. The data collected can be used to provide better services, and services that the adolescents believe they need to help them attend school, take care of their mental health problems, keep themselves out of the juvenile justice system, and to help them keep family and loved ones together. Hopefully, it provides a more successful experience for the adolescents who attend the San Bernardino County Behavioral Health Centers. Now we will look at the research that has been conducted on this subject matter.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **The Role of Perceptions**

This study will look at the perceptions of adolescents regarding mental health services received in San Bernardino County, California as there have been few studies conducted on adolescent perceptions, especially regarding their views on the mental health services they have received. The literature shows that most of the studies completed regarding adolescents and their mental health services have been conducted by interviewing the caregivers, probation officers, judges, psychologists, the media, and in some cases the family. The studies that have been conducted regarding adolescents' own perceptions have involved other topics, such as their views on advertising, smoking, and in some cases, their peers.

Many cognitive psychologists hold that as we move about in the world, we create a model of how the world works. That is how we sense the objective world, but our sensations map to percepts, and these percepts are provisional, in the same sense that scientific hypotheses are provisional. As we acquire new information, our percepts shift, thus solidifying the ideas that perception is a matter of belief (Robles-De-La-Torre & Hayward, 2001).

Cognitive theories of perception assume there is a poverty of stimulus (Robles-De-La-Torre & Hayward, 2001). A different type of theory is the perceptual ecology approach (Gibson, 1987). Gibson rejected the assumption of poverty of stimulus by rejecting the notion that perception is based on sensations. Instead, he investigated what information is actually presented to the perceptual systems. Specification is a 1:1

mapping of some aspect of the world into a perceptual array; given such a mapping, no enrichment is required, and perception is direct (Gibson, 1987). The Oxford American Dictionary (2006) describes perception as “an act or faculty of perceiving, intuitive recognition of a truth, aesthetic quality,” (p. 904).

### **Adolescents’ Perceptions of Services they Received**

As noted above, there is a dearth of literature on adolescents’ perceptions of their services received. A study by Garland Besinger (2005) regarding adolescents’ perceptions of outpatient mental health services they received, found that in general the adolescents were very satisfied with the services they received. Gender, race/ethnicity and treatment site were not related to satisfaction scores, nor was the adolescents’ perceived choice in seeking services. There was however, found that some significant gender differences in both in terms of satisfaction as well as the adolescents’ perceptions of their reasons for initiating counseling and the perceived goals and benefits of counseling. In general adolescents were able to generate informative, sophisticated responses to questions regarding their perceptions of mental health services, and demonstrated that adolescents are capable of evaluating services they receive (Garland & Besinger, 2005).

Another study by Smith (2004) found that understanding the adolescent viewpoint on mental health counseling is important for theory development and service enhancement. One of the few studies on the topic is, a study of college males who presented their viewpoints on perceived health needs, barriers to help seeking, and the adoption of healthier lifestyles (Davies, McCrea, Frank, Dochnahi, Pickering, Harris,

Zakrzewski, & Wilson et al.; Smith, 2004). They found that these college males knew they had health needs, yet took no action. Additionally, their socialization to be independent and to conceal vulnerability was cited as a major barrier (Smith, 2004). In other words, male and female college students were assessed regarding likelihood of seeking counseling, type of helper, type of problem, responsibility for problem solution, and type of counseling approach (Rule & Gandy, 1994; Smith, 2004). An important finding in this study was that males in 1989 were less likely than those in 1976 to seek counseling for problems related to work or school. The males seemed to have shifted toward a more do-it-yourself perspective (Smith, 2004). In a study by Getsinger and Garland (1976), male students reported that a counseling psychologist could be a source of help for emotional, familial, and sexual problems (cited, Smith, 2004). The Davies et al. (2000) study also identified restrictive emotional openness as a reason for not seeking help, and advanced the notion that seeking mental health counseling carried a more negative stigma than seeking medical help (Smith, 2004).

Nabors, Weist, Reynolds, Tashman and Jackson (2004) concluded in their study that adolescents' satisfaction with mental health services is an important program evaluation activity. Their perceptions of whether services were beneficial and resulted in improved functioning are indices of treatment quality. Their study involved assessment of adolescent satisfaction with school-based mental health programs whereby the adolescents completed satisfaction surveys. The participants were predominantly minority youth residing in an urban area. Results indicated that students were satisfied with their mental health services. The students valued the therapeutic relationship,



“catharsis” associated with therapy, and skills they learned during therapy (Nabors et al., 2004).

This study by Lee, Munson, Ware, Ollie, Scott and McMillen (2006) was conducted with foster care youths and their mental health services. They found that youths’ comments generally centered on several aspects of their mental health relationship with their mental health provider, the level of professionalism of their provider, and the effects of the treatment, including medication management. The youths who reported negative experiences with their treatment, had less positive attitudes towards services than other youth, but were not any more likely to have experienced changes in service use or medication six months later (Lee et al., 2006). Lee et al (2006) concluded that soliciting feedback from youths about mental health services is important in the provision of high-quality care, and this study suggests that medication management plays an important role in the acceptability of the treatment you receive.

Buston (2002) conducted a study regarding mental health services of mentally ill adolescents. The author found that the majority of the adolescents had both positive and negative experiences, relating to the doctor-patient relationship, treatment received, the health-care system, and the environs of the hospital or clinic. Buston concluded that the views and experiences of young people with regard to their health care must be taken in to account for efforts to boost help-seeking, attendance and compliance rates and, generally, to improve child and adolescent mental health services. In particular, further attention needs to be given to the development of empathic communication skills by health professionals working with adolescents with mental health problems (Buston, 2002).

Lindsey, Korr, Broitman, Bone, Green and Leaf (2006) looked at depression among African American adolescent boys. They write that African American adolescents who reside in urban, high-risk communities may be among the most underserved populations. African American adolescents experience depression more than adolescents from other racial and ethnic groups (Garrison, Jackson, Marsteller, McKeown, & Addy, 1990; Roberts, Roberts, & Chen 1997; Wu et al., 1999; Lindsey et al., 2006). Because African American adolescents are more likely than other groups to live in low-income households, they may be at particularly high risk of depression. Depression among African American adolescents boys, in particular, has been linked to having fewer perceived future opportunities (Hawkins, Hawkins, Sabatino, & Ley, 1998); and violent behavior in African American adolescent boys living in an urban, high-risk setting (DuRant, Getts, Cadenhead, Emans, & Woods, 1995; Lindsey et al., 2006).

Researchers have recognized that few African-American children and adolescents in need of mental health services receive such services (Angold et al., 2002; HHS, 2001). Further, there has been little discussion of the attitudes and beliefs of the youths, their families, and their peers that might contribute to the underutilization of mental health services (Lindsey et al., 2006). A majority of African-American adults use informal help sources exclusively or in combination with professional help in response to psychological distress (Chatters, Taylor, & Neighbors, 1989; Lindsey et al., 2006). African-American adolescents and their families are therefore, likely to have many negative perceptions (and experiences) of mental health that reduce the likelihood of their seeking care even when it is available. These processes are particularly important to consider when discussing adolescents, because adolescents turn first to family members and friends

when experiencing a mental health problem (Boldero & Fallon, 1995; Offer, Howard, Schonert, & Ostrov, 1991; Saunders, Resnick, Hobermann, & Blum, 1994; Lindsey et al., 2006). Findings from this study can inform social work practitioners and other mental health providers in their efforts to facilitate this group's use of services through better understanding of the role that network members play. There is also a need to increase the number of services perceived as acceptable and effective to this underserved group through the design of more culturally appropriate interventions and engagement strategies (Lindsey et al., 2006).

### *Perceptions of the Neighborhood*

There have been some studies in the literature of perceptions of adolescents and the activities in their neighborhoods. Ecological models stress the significance of the neighborhood context for understanding youth development (Bronfenbrenner, 1986; Jessor, 1992, 1993; Bass & Lambert, 2004). These studies highlight two aspects of the neighborhood context as important for youth mental health outcomes (a) neighborhood structural characteristics and (b) subjective experience or perception of neighborhood structural characteristics, and subjective experience or perception of the neighborhood environment (Aneshensel & Sucoff, 1996, Jessor, 1992; O'Neil, Park, & McDowell, 2001; Bass and Lambert 2004). Subjective assessments of the neighborhood environment have included measures of perceived safety and risk or danger, and perceived neighborhood hassles, each of which has demonstrated associations with adolescent adjustment (Bass & Lambert, 2004). Adolescents' perceptions of neighborhood risk, such as gang activity and fighting, have been linked with alcohol, cigarette, and marijuana use

(Scheier, Miller, Ifill-Williams, & Botwin, 2001), as well as symptoms of anxiety and depression, and oppositional defiant behavior and conduct problems (Aneshensel & Sucoff, 1996; Bass & Lambert, 2006).

Perceptions of the neighborhood context have also been linked with educational outcomes. Perceived neighborhood deterioration relates negatively to grade point average and intention to complete school and is positively associated with school suspensions among high school students (Williams, Davis, Cribbs, Saunders, & Williams, 2002; Bass & Lambert, 2004). Perceived neighborhood disorganization has been found to be negatively associated with self-reported educational behavior among middle and high school students. In contrast, positive perceptions of the neighborhood appear to protect against adolescent problem behaviors, such as early adolescent sexual activities (Lynch, 2001; Bass & Lambert, 2004). Hadley-Ives and colleagues (2000) reported positive associations between adolescent perceptions of neighborhood quality and census measures of neighborhood socioeconomic status (e.g., percent below poverty). Additionally, perceived neighborhood quality distinguished high crime neighborhoods from neighborhoods with lower crime rates. Herrenkohl, Hawkins, Abbot, Guo, and the Social Development Research Group (2002) found that the perception of neighborhood disadvantage and disorganization (e.g., crime, drug sales, and gang activity) varies systematically at the census block group level (Bass & Lambert, 2004).

These youth's perceptions were significantly and positively associated with a census-driven neighborhood residential stability index. These findings suggest that youth's perceptions of their neighborhoods correspond to census-level reports and highlight particular aspects of census data that might be relevant for understanding

youth's perceptions of their environment. Associations between youth's perceptions and census measures of the neighborhood context suggest that perceptions of the neighborhood context vary according to spatial location, with adolescents living in close proximity reporting similar perceptions of their neighborhoods (Bass & Lambert, 2004).

Males tend to have greater access and exposure to the neighborhood and report more witnessing of and victimization by violence in their neighborhoods; consequently, they may report more negative perceptions of the neighborhood than females do (Bass & Lambert, 2004). Family socioeconomic status may have implications for adolescent exposure to and experiences in the neighborhood context, because families with few economic resources tend to reside in poorer areas (e.g., environments characterized by multiple stressors and few resources). Adolescents in these families may have more negative perceptions of their neighborhood environments than adolescents in families with more economic resources (Bass & Lambert, 2004).

### *Educational and Learning Issues*

Although most young people move through many changes associated with early adolescent years with few difficulties, up to 25 percent of the adolescents in the United States between the ages of 13 and 18 manifest academic, emotional, and behavioral difficulties that can affect their long-term educational attainments, emotional well-being, and occupational success (Roeser, Eccles, & Sameroff, 1998). Certainly, in an effort to better understand the difficulties manifest during early adolescence, including characteristics of the adolescent's social environment, one should look closer at family relationships and educational performance (Eccles et al., 1993; Lessor, 1993; Roeser et

al., 1998). Two areas of the adolescent's early functioning are emotional or mental health and educational development. These early years are marked by developmental changes in motivation at school, psychological functioning, and academic achievement (Roeser et al., 1998).

From an educational perspective, adaptation to the demands of school life is a central life task of early adolescence that contributes to the individual's overall sense of emotional well-being (Eccles, Lord, Roeser, Barber, & Jozefowicz, 1997; Erickson, 1968; Roeser, 1996; Roeser et al., 1998). The adolescents' motivation to learn not only predicts their actual effort, learning, and achievement in school, but also represents one important intra-psychic process that links academic functioning with emotional functioning. Two specific motivational processes, adolescents' beliefs about their competence as learners and their valuing of school, are important to emotional functioning. For instance, studies on the self indicate that children's confidence in their academic abilities can promote feelings of general self-worth (Covington, 1992; Hart, 1985; Lord & Eccles; Roeser et al., 1998). Adolescents who believe that school is interesting and important for them to reach their goals have a sense of hope, purpose, and direction that manifests itself in a positive outlook on the future (Eccles, 1983; Erickson, 1968; Finn, 1989; Roeser et al., 1998). Adolescents who value and are committed to school achieve more, experience less psychological distress, and are less likely to engage in problem behaviors (e.g., delinquent acts, substance abuse) as compared to youth who see less value in schooling (Dryfoos, 1990; Newcombe & Bentler, 1989; Roeser et al., 1998).

### *Emotional Adjustment*

From a mental health perspective, the quality of adolescents' emotional adjustment is viewed as an important precursor to their academic functioning. Epidemiological data show that psychological distress during adolescence can reduce future educational attainments (Kessler, Foster, Saunders, & Stang, 1995; Roeser et al., 1998). The intra-psychic processes by which emotional distress can impact academic attainments are many, including motivational and cognitive processes. In terms of motivational processes, there is evidence that when sufficiently intense, children's feelings of anger, hopelessness, and sadness can negatively color their beliefs about themselves, their future, and their interpretation of events, including how they perceive their academic competence (Cole, 1991; Nolen-Hoeksema, Girgus, & Seligman, 1986; Roeser et al., 1998).

In their study Roeser, Eccles, and Sameroff (1998) found that adolescents' perceptions of organizational, instructional, and interpersonal processes were related to the support of competence, the support of autonomy, and the quality of teacher-student relationships and interactions while they were in middle school. Two constructs assessed adolescents' perceptions of the support for competence in their middle school: perceived teacher regard and academic goal structures. The adolescents' view of their teachers' expectations and positive regard was assessed with a single item asking whether the adolescents believed that their teachers viewed them as a good student. Items that tapped adolescents' perceptions of school level goal structures were adapted from the work of Midgley, Macher, and their colleagues (Macher & Midgley, 1996; Midgley et al.,

1995; Roeser et al., 1996) for reliability and predictive validity information (Roeser et al., 1998).

### *Perceptions of Advertising*

Public health advocates and some researchers claim that image advertising of tobacco and alcoholic beverages influences adolescents' attitudes toward these types of products (Covell, 1992; Kelly & Edwards, 1998; Unger, Johnson, & Rohrbacher, 1995; Slater, & Karan, 2002). Image advertising is often described as advertising that focuses on the lifestyle and/or the image of the user of the product rather than on the intrinsic value or merits of the product itself (Snyder & Debono, 1985; Kelly et al., 2002). Concerns about image advertising's ability to influence adolescent attitudes about certain products led policymakers to propose restricting promotion of these products to text-only advertisements. The Food and Drug Administration (FDA) proposed restricting cigarette magazine advertising to tombstone advertisements—text-only advertisements that exclude photographs or drawings—in magazines with a large youth readership (Federal Register, 1996). Likewise, the Children's Protection from Alcohol Advertising Act (PUB. L. HR 3473, 1996) was introduced to the House of Representatives and proposed similar tombstone restriction on alcohol advertising (Kelly et al., 2002).

The rationale behind proposals to restrict cigarette and alcohol advertising seems to be that the visual element of image advertisements (typically attractive models and appealing social situations) is believed to influence adolescents' perceptions regarding the



desirability of smoking cigarettes (Kelly et al., 2002). Such a presumption has a reasonable foundation in social cognitive theory; however, this presumption has not been subject to direct empirical test. Public health researchers argue that advertisements influence attitudes and cognitions about a product category (Evans et al., 1995; Fischer et al., 1991; Hastings & Aitken, 1995; Madden & Grube, 1994; Pierce, Lee, & Gilpin, 1994; Unger, Johnson, & Rohrbach, 1995; Kelly et al., 2002). They propose that when advertisements affect adolescents' attitudes about the desirability of a brand, they also affect attitudes about the desirability of the product category itself (Kelly et al., 2002).

Within marketing, there is a great deal of research on the effects of visual stimuli on the processing of advertising (Bone & Ellen, 1992; Miniard et al., 1991; Scott, 1994; Smith, 1991), and pictures have been found to enhance the impact of persuasive communications under conditions of varying involvement (Miniard et al., 1991; Kelly et al., 2002). Miniard and colleagues (1991) found that the images evoked by pictures play an important mediating role in the persuasion process and that the impact of visual imagery declines if there is no product-relevant information as involvement increases. In other words, it seems likely that advertisements with visual, image-oriented content will evoke more positive attractiveness than advertisements that are devoid of visual imagery (Kelly et al., 2002).

The theories underlying self-monitoring, sensation seeking, and imaginary audience ideation, moreover, suggest that adolescents may have a stronger preference for lifestyle/image advertisements than adults (Kelly et al., 2002). Furthermore, several studies have found that adolescents are highly attracted to image advertising (Covell,

1992; Kelly & Edwards, 1998; Madden & Grube, 1994) and, that aspects of tobacco and alcohol image advertising may be particularly appealing to children and teenagers (Aitken et al., 1998; Aitken, Leather, & OHagan, 1985; Slater et al., 1996; Kelly et al., 2002). Pictures and colors have particular appeal to children and adolescents under 18 years of age, and these elements of an advertisement have been found to be more important to children and adolescents than other aspects of the advertisement (Huang et al., 1992; Kelly et al., 2002).

### *Relationship Styles*

There is an area of study that focuses on youth mentoring in an urban context, that looks at the perceptions of adolescent relationship styles. Volunteer mentoring programs have been advocated increasingly in such diverse areas as welfare reform, education, violence prevention, school-to-work transition, and national service (Freedman, 1993; Rhodes, 2002; Langhout, Rhodes, & Osborne, 2004).

Approximately 2.5 million youth are involved in mentoring programs, including more than 10,000 matches in Big Brothers/Big Sisters nationwide (Phodes, 2002). These evaluations of volunteer mentoring programs provide evidence of positive outcomes, including improvement in youths' self-concept and academic achievement (Linnehan, 2001; McPartland & Nettles, 1991), lower recidivism rates among juvenile delinquents. (Davidson et al., 1987), and reductions in substance abuse (Adeltine et al., 2000; LoSciuto et al., 1996; Langhout et al., 2004).

An impact study by Grossman and Tierney (1998) of Big Brothers/Big Sisters provides additional effectiveness of mentoring. Control youth were placed on a waiting list for 18 months, and the experimental group was matched with mentors. The two

groups were compared on a number of outcomes. Relative to the control group, matched participants reported skipping fewer days of school, lower levels of substance initiation and use, less physical aggression, higher scholastic competence, attendance, and grades. In addition to these behavioral and academic outcomes, mentoring relationships were associated with improvement in the youths' relationships with their parents and peers (Langhout et al., 2004).

Research from the counseling and parenting literature provides additional insights into the structure and support in helping relationships and the various approaches that adults take when working with children and adolescents. In the counseling literature, Howard et al. (1986) have conceptualized psychotherapists as providing some combination of high or low support and high or low direction (Langhout et al., 2004). They assert that one style is not necessarily indicative of a better therapeutic relationship than another. Rather, it is the clients' characteristics and readiness to change that should determine whether high/low direction and high/low support would best develop the therapeutic relationship. One should take context into consideration when determining how best to work with the client (Langhout et al., 2004).

### ***Perceptions of Peer Behaviors***

Prinstein and Wang (2005) did a study on adolescents' perceptions of their friends' behavior. They believed that the behavior of friends strongly predicted adolescents' own behavior; however, these perceptions are often erroneous (Prinstein & Wang, 2005). Numerous mechanisms may help to explain the remarkably powerful effects of peer contagion across a wide range of behaviors and domains of functioning. Dishion and

colleagues (2002) have offered compelling evidence for a behavioral model of deviancy training in which adolescents' utterances regarding maladaptive attitudes or aggressive behaviors are particularly likely to elicit positive reinforcement (i.e., laughing, smiling) from a friend in a deviant dyad, and this reinforcement is associated with increased deviancy over time (Dishion & Owen, 2002; Dishion, Spracklen, Andrews, & Patterson, 1996; Wang, 2005). Other research in these areas has suggested that peer contagion may be affected by implicit peer modeling, explicit peer demands (i.e., peer pressure), or adolescents' beliefs that their emulation of peer attitudes and behavior may earn them specific social rewards within the social hierarchy (examples of greater levels of status or acceptance by peers: Prinstein et al., 2003; Simons-Morton, Haynie, Crump, Eitel, & Saylor, 2001; Urberg, Cheng, & Shyu, 1991; Urberg, Shyu, & Liang, 1990; Prinstein & Wang, 2005).

Data from other models, gleaned from the large body of literature on associations between adolescents' and their friends' behaviors, have provided important evidence regarding the role of adolescent perceptions. Results from studies using different methodologies to assess contagion effects have yielded a notable pattern of results. When adolescents' friends' behaviors are assessed using adolescents' own report (thus, a measure of adolescents' perceptions), correlations with adolescents' own behavior are generally two to three times stronger than when adolescents' friends' behaviors are measured by friend-report—i.e., indicating friends' actual reported behavior (Jannotti & Bush, 1992; see Kandel, 1996; Prinstein & Wang, 2005). Studies utilizing both methodological approaches have supported a mediator model, indicating that adolescents'

perceptions are ultimately more proximal predictors of adolescents' and their friends' actual behaviors (Fromme & Ruela, 1994, Prinstein & Wang, 2005).

Numerous theories largely discussed within the social psychology literature offer good reason to predict that adolescents' perceptions of their friends' behavior may be erroneous and largely based on social projection (Graham, Marks, & Hansen, 1991; Kandel, 1996; Marks, Graham, & Hansen, 1992; Orive, 1988; Sherman, et al., 1990; Wilcox & Udry, 1986; Prinstein & Wang, 2005).

The examination of adolescents' perceptions and the false consensus effect in particular, may have important implications for understanding peer contagion. It has been hypothesized that false consensus may produce a rigid and self-reinforcing cycle between behaviors and beliefs (Fiske & Taylor, 1991; Prinstein & Wang, 2005). Adolescents who engage in deviant or health risk behaviors will be more likely to over-estimate the frequency of their peers' behavior. This may apply to adolescents' estimates of the behavior among peers in a community setting or within an intervention group.

Individuals use these (often erroneous) estimations of the frequency of others' behavior as a benchmark to strive toward in order to achieve or maintain social rewards (Bandura, 1973; Prinstein & Wang, 2005). The interaction between adolescents' behavior and their perceptions of peers' behavior is cyclically reinforcing. It raises the threshold of behavior that adolescents believe is normative or associated with social rewards in the peer group and perhaps above the level of behavior that adolescents would otherwise engage in (Prinstein & Wang, 2005).

Findings indicate that young adults are prone to overestimate their peers' favorable attitudes toward and engagement in health risk behavior, including use of

nicotine, alcohol, hard drugs, and risky sexual behaviors (Botvin, Botvin, Dusenbury, & Goldberg, 1992; Sherman et al., 1983; Prinstein & Wang, 2005). Findings also indicated that adolescents associate aggressive and health risk behaviors with high levels of reputation-based peer status (Prinstein et al., 2003; Prinstein & Cillessen, 2003; Prinstein & Wang, 2005).

### **Parenting Styles Affect Adolescents**

Differing parenting styles have been identified, as determined by the relative emphasis that parents place on supportiveness and control (Baumrind, 1968, 1971; Holmbeck et al., 1995; Langhout et al., 2004). Although parenting that is relatively high in both domains is generally considered to be most conducive to favorable developmental outcomes (Lamborn et al., 1991; Steinberg et al., 1995), others have emphasized the importance of considering the context of parenting, including social class and ethnicity (Arendell, 1997; Mason et al., 1994; Portes et al., 1986; Langhout et al., 2004). Middle-class and upper-class mothers grant more autonomy and equality, are less restrictive and punitive, and are more permissive and child-centered than working-class and working poor mothers (Hoff-Ginsberg & Tardiff, 1995; Jarrett, 1995, 1999; Langhout et al., 2004). These comparisons should not be viewed as pointing to deficits, but should instead be viewed as evidence in the importance of context. It is also important to note age and developmental processes when considering parenting styles (Langhout et al., 2004).

### *Cultural Diversities*

Abarca, Plunkett, and Sands (2004) did a study on Mexican-American youth who are at-risk of high drop-out rates and academic failure. Yet some Mexican-origin youth are able to succeed academically despite the numerous obstacles in their environment. These youth may be considered educationally resilient (Wang, Hartel, & Walberg, 1994; Abarca et al., 2004). Protective factors of resiliency include individual and environmental qualities that allow an individual to overcome adversity and succeed, while risk factors hinder or prevent an individual from succeeding. Understanding the risk and protective factors that contribute to educational resiliency in Mexican-origin youth will help in the development, as well as the modification, of programs that encourage academic success (Abarca et al., 2004).

Family characteristics may have considerable influence on youth academic outcomes. For example, many Mexican-American parents receive very little formal schooling, a factor that can lead to unfamiliarity with the education system, thus leaving parents unable to support or advocate for their children (Bandura, 1982; Sherer et al., 1982; Abarca et al., 2004). Another factor that can influence academic success is parental monitoring. Parental oversight of adolescents' activities and friends may help prevent adolescent behaviors that hinder academic success (e.g., delinquent behaviors). In addition, parental monitoring of adolescents' schoolwork and school activities may demonstrate to adolescents the high value the family places on academics. Perceived parental encouragement of academics has been found to help Mexican-American adolescents develop higher motivation to succeed academically (Arellano & Padilla, 1996; Abarca et al., 2004). Mexican-origin adolescents who perceived their

neighborhoods as having more protective factors (e.g., educational role models, wealth, employment) and fewer risk factors (e.g., violent crime, unemployment) will report higher academic outcomes than those adolescents who rated their neighborhoods more negatively (Suarez-Orozco, 2001; Abarca et al., 2004). In the study, they found that adolescents' perceptions of neighborhood qualities, parental help with schoolwork, and parental academic encouragement were related to academic motivation and grades (Abarca et al., 2004).

Another study by Chen, Tisak, Tisak, and Goldstein (2006) examined the cultural differences in Chinese and American adolescents and their parents' perceptions and evaluations of adolescent misconduct behaviors. Although there is not one particular stage in which children are easy to manage, adolescence seems to be an especially challenging period of time for parents across cultures. While a flood of physical changes lead to an adult-size body and sexual maturity, most adolescent children remain economically dependent on their parents (Steinberg, 1987; Chen et al., 2006). Struggling with developing their own identities, adolescents report feeling less close to their parents during this period of time (Holmbeck, 1996; Chen et al., 2006).

### *Cross-cultural Comparisons*

Although adolescent misconduct has been a major concern in almost every society, only a few studies have directly compared cross-cultural differences in perceptions and evaluations of adolescent misconduct behaviors. Cross-cultural comparisons are important because they help reveal the underlying social processes that influence adolescent misconduct in different cultures. For example, Weisz and colleagues



(Weisz, Chaiyasit, Weiss, Eastman, & Jackson, 1995; Weisz, Sigman, Weiss, & Most, 1993) compared 11- to 15-year-old Embu children in Kenya, Thai children, African-American children, and Caucasian-American children. American adolescents were reported by their parents to be more likely than Asian and African youth to display under-controlled problems (arguing, disobedience at home and cruelty to others, (Chen et al., 2006). These behavioral differences have been attributed to cultural values and socialization processes. Specifically, American and European cultures emphasize individualism and independence, whereas Asian and African cultures stress collectivism and interdependence. A collective culture values harmony in home and public places, such as school. These cultural values may lead to, fewer adolescent misconducts in these domains (Chen et al., 2006).

Thai and American teachers may differ in considering certain behaviors problematic. The current study employed a new methodology to compare 11- to 19-year-old American and Chinese adolescents on their perceptions and evaluations of adolescent misconduct behaviors. Instead of presenting adolescents with experimenter-generated misconduct behaviors to evaluate, the current study asked participants to make a list of adolescent misconduct behaviors and then evaluate how wrong they consider each behavior to be (Chen et al., 2006). One advantage of using participant-generated misconduct behaviors is that cultural differences in specific misconduct behaviors can be examined. Dating may be considered perfectly normal by American adolescents but is wrong in the Chinese culture. Holding certain religious beliefs (such as Falun Gong) is illegal in China but is within the law in the United States. Another advantage is that only culture-relevant behaviors are evaluated. It is especially important for cross-cultural

studies to avoid using misconduct behaviors that are differentially relevant in different cultures. By asking participants to evaluate misconduct behaviors named by themselves, the current study was able to examine cultural differences not only in specific behaviors considered misconduct, but also in degree of wrongness of culture-relevant misconduct behaviors (Chen et al., 2006).

Other differences may help account for the conflicting results of cross-cultural studies on adolescent misconduct behaviors. Feldman, Rosenthal, Mont-Reynaud, Leung, and Lau (1991) conducted a cross-cultural study of high school students from the United States, Hong Kong, and Australia (Chen et al., 2006). The results showed that Hong Kong high school students reported a lower level of misconduct than did their American and Australian counterparts. However, Chen et al. (1998) found that junior high school students from southern California, Taipei, Taiwan, and Beijing, China showed similar levels of self-reported misconduct. The two studies differed in a number of sampling characteristics, including age group (i.e., high school versus junior high) and residences, such as Hong Kong versus Mainland China. Arnett and Balle-Jensen (1993) also suggested that city size and laws were important when conducting cross-cultural studies.

The results of the study revealed cultural differences in a number of misconduct behaviors. Americans generated more adolescent misconduct behaviors in the categories of weapons offenses, illicit drugs, minor drugs, and prudential behaviors than Chinese, whereas Chinese generated more adolescent misconduct behaviors in the categories of vandalism, school conventional violations, home conventional violations, social conventional violations, romantic relationships, and religious violations than Americans. These cultural differences may reflect cultural and societal differences in

laws, religion, and socialization processes (Arnett & Balle-Jensen, 1993; Tisak et al., 2001; Chen et al., 2006).

### **Mental Illness, Drugs, and Delinquency**

Mental illness and substance abuse, which often co-occur among juvenile offenders, can contribute substantially to delinquent behavior. Studies have consistently found very high prevalence rates of mental illness among detained and incarcerated juveniles, and juvenile offenders generally. While estimates of the percentage of juvenile offenders who have mental health problems vary widely (e.g., between about 30-90 percent, depending upon what is included as a mental illness), most estimates are substantially higher than the roughly 20 percent prevalence rate found in the non-delinquent adolescent population. Indeed, many juvenile offenders have multiple mental health problems, and about 15-20 percent have a serious mental illness. Lack of appropriate treatment in adolescence may lead to further delinquency, adult criminality, and adult mental illness (Lexcen & Redding, 2000).

Psychosocial and environmental risk factors also contribute to juvenile offenses. Multiple diagnoses of mental illnesses (co-morbidity) are common among juvenile offenders; finding multiple disorders within a single adolescent is not uncommon. The most common diagnoses for juvenile offenders are conduct disorder, oppositional defiant disorder, alcohol dependence, major depression, attention deficit hyperactivity disorder, bipolar disorder, generalized anxiety disorder, and post-traumatic stress disorder. Other psychosocial and environmental stressors include the quality and quantity of parental support and supervision, which are especially

important. Parental psychiatric problems, lack of parental support, and the absence of one or both parents from the home are all predictive of delinquency. Boys whose parents remarry while they are between the ages of 12 and 15 engage in more fighting and theft than their peers and tend to have less parental supervision and less emotionally warm relationships with their parents (Lexcen & Redding, 2000).

### ***Family Abuse Can Predict Delinquency***

Lexcen and Redding (2000) have written that exposure to violence is another vulnerability found in juvenile offenders. Exposure to violence may make them more likely to perceive hostility in ambiguous situations and to accept aggression as a normal part of interpersonal relationships. Family abuse and exposure to violence are the most significant predictors of juvenile violence when comparing delinquents with non-delinquents. The same holds true when comparing more violent and less violent youths. Comparing less violent juvenile offenders with more violent juveniles, one may find that more violent youths have been severely abused physically, sometimes leaving them with injuries to the central nervous system that make it difficult to resist behaviors motivated by strong emotion or impulsivity. Exposure to violence is also linked to post-traumatic stress disorder. Half the youths in a California Youth Survey who met full criteria for post-traumatic stress disorder (32 percent) or partial criteria (20 percent) described witnessing an event of domestic violence as the traumatizing event associated with the disorder (Lexcen & Redding, 2000).

Adequate parental involvement, nurturance, and support all serve as an important buffer protecting juveniles from delinquency. Parenting education programs, particularly

those teaching effective discipline practices, may be effective in improving the quality and quantity of parental involvement. Violence where the juvenile learns to accept aggression, and aggressive responses as a normal part of interpersonal relationships, can result in delinquent behaviors (Lexcen & Redding, 2000).

### *Impact of Stigmatization*

Corrigan (2005) conducted research on mental illness and stigmatization. Their research has shown that adults tend to stigmatize people with mental illness and people who abuse alcohol more harshly than they do those with other health problems, but there has been very little research done on this topic regarding adolescents. Advocacy and government groups have argued that modifying negative attitudes among children and adolescents, might stop them from developing into adults who stigmatize persons with mental illness. This can lead to full-blown social injustice.

The first aspect of the stigma of mental illness is that it is worse than that of other health conditions. People with mental illness are viewed as being more responsible for their condition than those with cancer or heart disease. One model, based on Weiner's attribution theory, posits that individuals who view people as responsible for their mental illness or alcohol abuse will likely be angry with them and will not be willing to help them. Members of the general public who view people as victimized by their mental illness or alcohol abuse will be likely to experience pity and be willing to help (Corrigan et al., 2005).

This study sought to extend to adolescents the models of stigma of mental illness and alcohol abuse that had been validated with adults. Results showed that adolescents

tended to differentiate among health conditions in a manner similar to that of adults. Peers who abuse alcohol were viewed more negatively than those with mental illness or leukemia, especially in terms of blame, anger, and dangerousness. Adolescents with leukemia, for instance, were viewed more benignly than adolescents in the other groups. Stigma ratings of mental illness typically fell between the other two health conditions. Stigma diminished when mental illness was reported to be caused by a brain tumor. Participants rated the teen with the brain tumor as less dangerous, less likely to be feared, more worthy of help, and less likely to be avoided than the teen with mental illness without organic cause. One might think that this difference is due to blaming the teen with the brain tumor less. However, the results showed no difference between the two groups on responsibility attribution (Corrigan et al., 2005).

Adolescents who viewed peers as responsible for their mental illness tended to have less pity and to be angrier. Pity was directly linked to helping, whereas anger showed an inverse relationship to helping. In terms of dangerousness, adolescents who viewed peers as dangerous tended to fear and avoid them. Adolescents who looked at alcohol abuse negatively mirrored the attitudes toward mental illness; these attitudes were markedly higher in some cases. In other words, adolescents who blamed peers for alcohol abuse tended to be angry, less sympathetic, and less likely to offer help than adolescents who blamed peers for mental illness. Teens who viewed their peers who abuse alcohol as dangerous tended to fear and avoid them altogether (Corrigan et al., 2005).

Adolescents seem to have a fair amount of contact with people with mental illness. About half the sample was aware of at least one classmate who had a serious mental illness. Adolescents who were more familiar with mental illness endorsed greater

attributions of responsibility and dangerousness to the sufferers. Rather than diminishing stigma, contact seemed to increase it. Information showed that teens tended to discriminate among psychiatric conditions, viewing substance abuse more harshly, that they tended to view blame and dangerousness as important variables leading to discrimination, and that contact may have had a paradoxical effect on them (Corrigan et al., 2005).

### **Gender Differences in Mental Health**

Johansson, Brunnberg, and Ericksson (2007) conducted a study to analyze the concept of mental health from the perspective of adolescent girls and boys and to describe what they regard as important determinants of mental health. The study showed that the adolescents perceived mental health as an emotional experience, where positive as well as negative health is part of the concept. Family is the most important determinant for young people's mental health, closely followed by friends. Neither girls nor boys believed that there were any large differences in mental health between girls and boys. Age differences seemed to be more important than gender in the perspective of mental health by children (Johansson et al., 2007).

Bolognini, Plancherel, Bettschart, and Halfon (1996) conducted a longitudinal study of a general population of mean age 13, carried out between 1990 and 1993. They attempted to answer the following questions: Is there a global change in self-esteem during early adolescence? If so, does the way in which the young person perceives himself vary according to the social and relational environment? What are the differences between boys and girls in the development of self-esteem? What is the relation between

self-esteem and mental health? Regarding the specific gender differences; the results show that girls tend to have poorer self-esteem than boys, whatever the domains taken into consideration. Differences are more significant with reference to appearance and athletic performance. As far as the development of self-esteem is concerned, there is no major change, notably when considering global perception. Results of a factor analysis underscore the fact that girls' self-esteem is more global and less differentiated by domain, whereas boys separate the scholastic and behavioral part of their experience from the social. Global self-esteem has more influence on the level of depressive mood in girls than in boys (Bolognini et al., 1996).

### ***Increase of Girls in Juvenile Justice System***

Veysey (2003) writes that over the past decade the number of girls involved with the juvenile justice system has increased substantially. Research has shown that large numbers of girls have serious mental health problems often associated with histories of sexual or physical abuse or neglect. Delinquent girls with serious mental health problems pose a significant challenge to the juvenile system because of the complex set of problems they present and, if their needs go unmet, their prognosis for harmful acts. Without appropriate gender, rape, and trauma-specific treatment, these girls are likely to experience high rates of criminality, substance abuse, early pregnancy, and continued interpersonal violence. Assertive interventions are needed. Between 1989 and 1999, the number of adolescent girls arrested increased by forty-five percent, to an estimated 670,800, reports the American Bar Association. By contrast, the number of male juveniles arrested decreased by almost ten percent (Snyder, 2000; Veysey, 2003).



Existing studies suggest that many of the girls in contact with the juvenile justice system have mental health disorders. Furthermore, the research suggests that a majority of girls in the system meet the criteria for at least one mental disorder. In some studies, girls show higher prevalence rates than boys (Veysey, 2003).

Timmons-Mitchell and colleagues (1997) estimated that eighty-four percent of girls compared to twenty-seven percent of boys had evidence of serious mental health problems. Kataoka and associates (2001) found that eighty percent of the females exhibited symptoms of a mental or substance use disorder (Veysey, 2003).

Perhaps more significant is the fact that girls are more likely than boys to be diagnosed with more than one disorder, particularly a mental disorder with a substance use disorder. Studies of psychiatric co-morbidity consistently report higher prevalence rates among girls in detention than comparable boys (Veysey, 2003).

The history of physical and sexual abuse is virtually universal among girls in contact with the juvenile justice system today. Abuse often results in significant and long-lasting mental health problems and involves self-harming behaviors and involvement in status offenses and delinquency. Specific sequelae include suicide attempts (Miller, 1994; Miller et al., 1982; Rohde et al., 1997), depression and anxiety disorders (Davis, 1997; Prescott, 1998), running away (Calhoun et al., 1993; Chesney-Lind, 1989; Figueira-McDonough, 1985; Rosenbaum, 1989), and increased likelihood of future sexual assault, rape (Gruber, 1984; Levin & Kanin, 1987), prostitution (Calhoun et al., 1993), property offenses, drug sales (Rhodes et al., 1993), substance abuse/dependency, and arrests for violent crime (Widom & Maxfield, 2001; Veysey (2003).

### *Families' Perceptions of Burden Caring for Family Members*

A study was conducted on the families' perceptions of the burden they have when they care for their mentally ill relatives. Families are an integral part of the care system for the chronic mentally ill. The success of the movement toward care of the mentally ill in the community might well depend on the capabilities of families to provide a large portion of that care (Francell, Conn, & Gray, 1988). Families struggle to provide and obtain care for their mentally ill loved ones in the face of legal restrictions and bureaucratic mismanagement. Pepper and Ryglewicz (1986) state that families of the mentally ill, especially of young adult patients, are placed in the position of primary caregivers much of the time and caregivers of last resort the rest of the time.

This difficult and frustrating position is often poorly understood by mental health professionals. Results of the study showed that family caregivers felt totally responsible for their relatives when psychiatric crises occurred, and some felt deserted at crucial times by mental health care providers. Caregivers expressed weariness and frustration related to their long-term roles as patient advocates and case managers; families described the lack of community resources as a significant contribution to their burden; families perceived a frustrating lack of continuity in treatment approaches, medical therapy, and even record-keeping. Some caregivers perceived some mental health professionals as incompetent because they avoided direct conversation and consistently used intermediaries to communicate with families. As a consequence, families consistently expressed dissatisfaction with their inclusion in the treatment process (Francell et al., 1988).

### *Perceptions of Adolescents' Cognitive Abilities*

A study by Zukerberg and Hess (1996) with adolescents regarding their perceptions was conducted using interviews to elicit responses. Adolescents may provide special challenges in terms of both their cognitive ability and the quality of data they provide. Sussman et al. (1993) found that most teenage respondents lacked the ability or motivation or spontaneity to articulate their thought processes, according to the study. This articulation of the thought process is necessary for cognitive interviewing, which often relies on pauses to encourage respondents to think harder about a question (Zukerberg & Hess, 1996).

One of the substantive areas included in the questionnaire was parent-child conflict. Respondents were asked to report the amount of conflict they have with their parents in several areas, including spending money, use of alcohol or drugs, completion of household chores, how well they do in school, and how late they stay out at night. The cognitive interview uncovered two problems with the series of questions on parent-child conflict. First, the term conflict is ambiguous; most respondents paraphrased the question on asking how often they have disagreements. However, respondents defined conflict in a variety of ways, including having two different opinions about the same thing, yelling, or arguments. When they actually started answering the questions, it became apparent that many respondents were counting any discussion of these items as a conflict. Some respondents indicated that they were counting simple reminders or nagging as a conflict (Zukerberg & Hess, 1996).

According to the foregoing study, Zukerberg and Hess (1996) used another substantive area of concern to reviewers: the adolescents' perception of their future. The

series of questions on adolescent perceptions of the future asked the respondents to speculate on the chance of certain events happening to them by the time they were twenty, twenty-five, and thirty-five years old. These events include graduating from high school and college, getting pregnant, having enough money to buy a home, and being employed. They found that most adolescents did not have a difficult time talking about what their life would be like when they are twenty years old, but some have a more difficult time projecting to ages twenty-five and thirty-five. However, most respondents were able to do this. Their answers indicated that they were evaluating possibilities (Zuckerberg & Hess, 1996).

Some respondents talked about their plan to finish school by a certain age. After this, they expected to have a job which would pay well enough for them to buy a home. A couple of respondents interpreted the questions that asked about having enough money to buy a home and/or a car differently than intended. They were thinking more in terms of whether or not they wanted a car or home rather than if they would be able to afford one. Experience suggests that conducting cognitive interviews with adolescents may not be that different from similar research using adult respondents. Adolescents are able to handle the demands of the cognitive interview and to provide valuable information to questionnaire designers (Zuckerberg & Hess, 1996).

### **National Policy Forum on Mental and Juvenile Justice**

Over the last decade, there has been a significant increase in the attention being paid to youth with mental health disorders who are in contact with the juvenile justice system (National Center for Mental and Juvenile Justice [NCMHJJ], 2003). There are a

number of factors contributing to this heightened sense of concern and awareness. These include the higher rates of mental health disorders among youth in the juvenile justice system. Whereas traditionally there has been a lack of empirically sound studies on this issue, the data that exist suggest that the rates of mental health disorders among youth in the juvenile justice system are two to three times higher than among youth in the general population (Otto et al., 1992; NCMHJJ, 2003). Another factor in the documentation of inadequate and inappropriate care and treatment of youth with mental health disorders in the juvenile justice system is the fact that many of these youth are also experiencing some co-occurring substance use disorder. While research has just begun to focus on youth, Greenbaum, Foster-Johnson, and Petrilla (1996) find that approximately half of all adolescents receiving mental health services in the general population are reported as having a dual diagnosis (NCMHJJ, 2003).

In response to these other concerns, the NCMHJJ was established in 2001 to promote awareness of the mental health needs of youth involved with the system and to assist the field in developing improved policies and programs based on the best available research and practice. The Center's policy development activities are aimed at using the developing knowledge base, as well as experiences from the field, to influence changes in national, state, and local policies that affect youth with mental health disorders in contact with the juvenile justice system (NCMHJJ, 2003).

One of the suggestions that have been provided is multi-systemic therapy, which is an intensive family-based intervention program for juvenile offenders with serious antisocial behavior who are at imminent risk of out-of-home placement. Another approach is functional, family therapy, which is a program designed to improve family

communication and problem-solving skills. This program targets youth with problems of delinquency, violence, and substance abuse. Multidimensional treatment in foster care is a family-based foster care program used as an alternative to institutional care for juvenile offenders with severe antisocial behavior (NCMHJJ, 2003).

Outcomes from extensive evaluations of all three interventions indicate that these programs result in reduced long-term rates of re-arrest, decreased psychiatric symptomatology, reduced rates of out-of-home placement, and, from a cost-benefit perspective, significant taxpayer savings when compared to program cuts. Agencies that have been involved in these programs include the National Association of State Mental Health Program Directors (NASMHPD), the Council of Juvenile Correctional Administrators (CJCA), the National Alliance for the Mentally Ill (NAMI), the National Mental Health Association (NMHA), the Federation of Families, the Youth Law Center (YLC), and the Coalition for Juvenile Justice (CJJ); (NCMHJJ, 2003).

The availability of service dollars does not determine the quality of the services provided. Services should be strength and competency-based and should be predicated on need at each point in the mental health and juvenile justice system. It is believed that there should be a continuum of community-based services, beginning with prevention and moving through evidence-based diversion practices to create an overall strategy that eliminates temporary fixes. Participants noted that while there have been dramatic advances in screening and assessment over the past several years, there is clearly more to be accomplished. Additional research will help further refine and expand our knowledge by focusing on developmental stages, race, gender, culture, and co-occurring substance use disorders (NCMHJJ, 2003).

There are other issues that policy-makers and advocates should focus on that are imperative in helping youth with mental health and legal issues. These include the roles of families and caregivers; the critical role of schools, particularly in terms of early identification and intervention; the need for coordinated and effective advocacy; the exploration of forensic issues such as a youths' competency to stand trial; staff training around these youth's needs within juvenile justice settings; and the increasing recognition of the importance of community reintegration and aftercare for these youth (NCMHJJ, 2003).

The national organization suggests that a series of meetings be convened between members and officials of the Council of Juvenile Correctional Administrators (CJCA) and the National Association of State Mental Health Program Managers (NASMHPM) to develop a joint policy or series of policy statements on how to integrate mental health and juvenile justice policy to improve outcomes for youth with mental health disorders in the juvenile justice system. This would include clarifying and specifying mutual roles and responsibilities with respect to the planning, delivery, and funding of mental health services for justice-involved youth. The goal is to develop and release a policy statement that can be endorsed by both associations and serve as a blueprint for improving policy at the state and local levels (NCMHJJ, 2003).

### ***Perceptions that Treatment does Not Help***

Fed by innumerable examples of children committing some more severe crimes, the news media reported the skyrocketing numbers and declared a juvenile crime epidemic. By the early 1990s something akin to a public hysteria about juvenile crime

existed, and federal, state, and local governments began taking action against delinquents, most of whom were Black/African-American or Hispanic, urban and poor. News reports of kids who seemed to act without remorse or conscience fed the public perception that juvenile courts were unable to deal with this new danger (Kresnak, 2003).

Kresnak (2003) reports on several acts of violence. The first occurred in October 1997, when a 16-year-old boy in Pearl, Mississippi killed his mother, then went to his high school and shot nine students, two of them fatally. He got life in prison. In December 1997, a 14-year-old killed three students and wounded five others at his high school in West Paducah, Kentucky. He pleaded guilty but not mentally ill, and was then sentenced to life in prison. In March 1998, two boys, ages 11 and 13, killed three students at their middle school in Jonesboro, Arkansas. Although both were convicted, they were too young to be sent to prison and instead were ordered to undergo treatment in the state's juvenile system until age 21. A wave of school shootings culminated in the massacre at Columbine High School in Littleton, Colorado, on April 20, 1999, when two students killed 12 people and wounded 23 others before committing suicide. Schools across the country stepped up their security by placing security guards and metal detectors at every entrance. Children who even write a note or express the thought that they might want to blow up their school are thrown into detention and sometimes charged as adults with the crime of threatening to commit a violent act (Kresnak, 2003).

The National Youth Violence Prevention Resource Center (NYVPRC) (2000) believes that children and adolescents with mental health problems are most often handled by the school or juvenile justice systems, which are generally ill-equipped to recognize and address mental disorders. Recent studies have indicated that between



seventy and eighty percent of children with diagnosable mental disorders who receive mental health services are served within the school system, primarily by school psychologists or guidance counselors (NYVPRC, 2000).

In an effort to deal with young offenders committing serious crimes, California voters have recently passed initiatives like Proposition 21, the Gang Violence and Juvenile Crime Prevention Act, in March 2000. Proposition 21 made it easier for juveniles to be transferred into the jurisdiction of adult criminal court by adding other transfer mechanisms, enumerating more crimes requiring mandatory transfer, and lowering the age limits at which the criminal court can take jurisdiction. Legislation like Proposition 21 shifts the focus of juvenile justice from rehabilitation to punishment, as the number of waivers continues to increase nationwide (Cruz, 2002).

Many studies have shown that juveniles who receive adult court sentences have higher recidivism rates than young offenders who remain in the juvenile system (Cruz, 2002). In the past five years, most states have made it easier to charge and punish children as adults. Thirteen-year-olds are therefore getting mandatory life without parole sentences. At this time there is nothing appellate courts can do to help them. We have effectively discarded these lives. The questions need to be asked: Should we make 11-year-olds eligible for life behind bars? Nine-year-olds? Seven-year-olds? We are inching closer and closer to a moral line (Cloud, 1998; Cruz, 2002).

### *Perceptions of Correctional Facilities*

A few things have been learned about the perceptions of mental health services in correctional facilities. With continued growth in prison construction, overcrowding, and

incarceration of mentally ill offenders, without concomitant increases in staffing, service options, or mental health screenings, a few investigations have been conducted of inmate service utilization, including types of services offered and attitudes toward and willingness to seek mental health services. Little is known about the factors regarding the alarming discrepancy between inmate mental health needs and service utilization. As many as forty-five percent of inmates with severe psychiatric illnesses, do not receive mental health services. However, female inmates and Caucasian inmates have been found to be more likely to utilize mental health services than male inmates and ethnically diverse inmates (Morgan, Steffan, Shaw, & Wilson, 2007).

Mental health service utilization is a concern in jails as well, because most jail inmates do not access available mental health services. In fact, ten percent or fewer of jail inmates utilized mental health services, a rate lower than that of inmates in prisons. These results are particularly disturbing considering that jail inmates are more likely than prison inmates to commit suicide (Morgan et al., 2007). Barriers to inmates' willingness to seek mental health services have been questioned for years. Only recently have empirical investigations begun to systematically examine inmates' perceptions and attitudes toward mental health services. Skogstad and Williams (1999) conducted a study in New Zealand among prisoners: those with a positive attitude toward mental health treatment and those with a previously helpful experience were more likely to seek mental health service (Morgan et al., 2007). Skogstad and Williams (1999) identified persons from an ethnic minority group who had more negative attitudes toward seeking mental health treatment. Another study revealed that inmates were more likely to seek

help for a "personal-emotional" problem than for suicidal thoughts (Skogstad & Spicer, 2005; Morgan et al., 2007).

Morgan and colleagues (2007) conducted a study of males in a correctional setting. They found that there were five problem areas in which inmates may request mental health services—behavioral dyscontrol, physical health concerns, negative affect, interpersonal relationships, and institutional relations—and four potential barriers to inmates' willingness to seek mental health services—self-preservation concerns, procedural concerns, self-reliance, and professional service provider concerns. Results further indicated that inmates without such a history fail to seek help for negative affect or interpersonal relationships while incarcerated (Morgan et al., 2007).

### *Judges' Assumptions of Appropriateness of Commitment*

A study by Applebaum and Fisher (1997) examined judges' reasons for ordering pretrial forensic evaluation instead of civil commitment for persons with mental illness who are arrested. In many instances, the arrests and subsequent diversions are associated with minor offenses, such as trespassing, which under ordinary circumstances would likely be dismissed. Police and judges, however, may underestimate the accessibility of civil commitment. The evidence for this criminalization process derives mainly from empirical observations of outcome, such as increased arrest rates or the excess prevalence of petty crimes among the charges brought against persons diverted to the forensic mental health system. These observations have led to inferences that police and judges view the civil mental health system as unable to provide an appropriate degree of social control because of legal restrictions and economic incentives skewed toward

minimizing hospitalization. Thus police officers may rely on the criminal justice system, and judges may rely on the forensic mental health system to fill the gaps left by the civil system (Applebaum & Fisher, 1997).

In their study, Applebaum and Fisher (1997) surveyed 58 judges; 93.1 percent of those who responded acknowledged having concerns about the adequacy of treatment or confinement in the civil mental health system. Results showed that judges endorsed the following of specific concerns leading them to order pretrial forensic evaluations. These judges believe they have no other way to hospitalize persons who need treatment but do not meet dangerousness criteria for civil commitment. Psychiatric hospitals sometimes refuse to keep even offenders who meet commitment criteria unless compelled to do so by an order for pretrial evaluation. Forensic commitments, unlike civil commitments, help ensure that the patient is ready to leave the hospital by requiring a return to court prior to discharge, and judges feel greater confidence in the treatment offered on forensic units than those offered on civil units (Applebaum & Fisher, 1997).

### ***Related Research in California Counties***

A California Department of Mental Health (CDMH) (2005) summary report showed that adolescents completing the Youth Services Survey (YSS), respondents indicated that they were “satisfied” with access to services (indicated by a subscale score of 3.88: 4,453 responses) the cultural sensitivity of their treatment (indicated a subscale score of 4.15: 4,466 responses), participation in treatment planning (indicated by a subscale score of 3.72; 4,609 responses), outcomes (indicated by a subscale of 3.77;

4,558 responses), and services generally, general satisfaction (indicated by a subscale score of 3.92; 4,663 responses) (CDMH Southern California Region Summary, 2005).

A survey conducted in Sacramento County (2006) found that overall youth & their families give the Sacramento County Children's System of Care an "A", youth and caregivers agree on the lowest rated areas which can be targeted for improvement are, participation in treatment planning (Sacramento County Children's System of Care).

Another Sacramento County study (2008) found that on the (YSS), white consumers reported significantly higher satisfaction in access and treatment compared to African-American and other race youth. Non-English speaking youth reported significantly higher satisfaction in outcome of services, function and overall average than English speaking youth. On the (YSS-F) surveys caregivers of African-American youth reported significantly lower satisfaction in all domains compared to caregivers of Caucasian and other race youth, and Hispanic youth reported higher satisfaction in outcomes and functioning than non-Hispanics (Sacramento County Children's System of Care, 2008).

### **Statement of the Problem**

This review of the literature has thus far examined the concept of perceptions in the areas of adolescents' perceptions in their neighborhoods and perceptions pertaining to their educational, early functioning, and learning experiences (Bass and Lambert, 2004). The review examined adolescents' emotional adjustment as an important precursor to their academic functioning. The epidemiological data showed that psychological distress during adolescence can reduce their future attainments in school and in their social growth (Roeser et al., 1998). The literature review looked at the adolescents' perceptions

toward smoking and alcohol consumption (Kelley et al., 2002). A review was done that looked at perceptions of adolescents' relationship styles and also their mentoring perceptions in Big Brother/Big Sister participation (Langhout et al., 2004).

Parenting styles and perceptions of their friends' behaviors showed that these behaviors predicted their own behaviors and perceptions of the world. There were findings that indicate that young adults are prone to overestimate their peers' favorable attitudes toward and engagement in risk behaviors, such as the use of alcohol or cigarettes or engagement in sexual behaviors (Prinstein & Wang, 2005). Family characteristics may have considerable influence on adolescents, especially in various cultural contexts. Adolescents reported feeling less close to their family during the period of their own developing identities. Although adolescent misconduct has been a major problem in most societies, only a few studies have been conducted that compared cross-cultural differences in perceptions of adolescent behaviors (Abarca et al., 2004).

Mental illness, substance abuse, and exposure to violence was found to make adolescents perceive hostility in ambiguous situations and to expect and accept aggression as a normal part of life. Adolescents, who viewed peers as responsible for causing their mental illness, appeared to have less pity and to be angrier than those who did not hold these views (Lexcen & Redding, 2000).

It was found that a few things have been learned about the perceptions of mental health services in correctional facilities. Only recently have empirical investigations begun to systematically examine inmates' perceptions and their use of and attitudes toward mental health services (Lexcen & Redding, 2000).

With the exceptions of the studies conducted in California Counties using the Youth Services Survey (YSS) data, there were no other studies found of mentally ill adolescents' perceptions of the programming they are receiving in public facilities. This study will look at the adolescents in the County of San Bernardino, California using the YSS survey instrument to obtain their perceptions of the treatment they are receiving, and to look at the demographics of the participants according to age, race, gender, length of time in treatment, and the outcomes of services.

After a review of the literature there appears to be a lack of research regarding how adolescents view their mental health services they are receiving. The focus of this study will be to examine the perceptions of adolescents in treatment to elicit their views regarding the mental health services they received. This is why it is believed that this study will make an important contribution to understanding adolescents and their experiences with mental health services.

Given the purpose for this study, the current data will seek to address and answer whether or not treatment in county behavioral health facilities is perceived to be positive or negative by the adolescents receiving the treatments. This study will use the data collected by the San Bernardino County Behavioral Health Care Program and the Youth Services Survey for Youth (YSS) May 2009.

## **CHAPTER THREE**

### **METHODS**

This dissertation employs a quantitative design to evaluate the hypotheses that are described earlier in this document. In short, the study seeks to explore levels of satisfaction in a number of different areas such as treatment planning, access to treatment, functioning of the client, cultural sensitivity, general satisfaction and social connectedness among the adolescents. Additionally, this study seeks to account for these differences in age, race, gender, and length of time in treatment. Finally, this study examines the role of length of time in treatment on specific outcomes such as arrests and encounters with the police. Using a survey methodology, adolescents who have attended programs at a number of County Behavioral Health Care Facilities in Southern California were interviewed. These interviews have provided the adolescents perceptions of their programs for this study.

#### **The Hypotheses for the Study**

1. There will be significant mean differences in the areas of perceptions of a) general satisfaction, b) access to treatment, c) cultural sensitivity, d) treatment planning, e) outcome of services, f) functioning of the adolescents, g) social connectedness among the adolescents aged 13, 14, 15, 16, and 17 years of age.
2. There will be significant mean differences across racial/ethnic groups (Hispanics, African-American, Caucasian, other, and mixed race), in the areas of general satisfaction, access to treatment, cultural sensitivity, treatment planning, outcome of services, functioning of the adolescent, and social connectedness.



3. There will be significant mean differences in the areas of perceptions of a) general satisfaction, b) access to treatment, c) cultural sensitivity, d) treatment planning, e) outcome of services, f) functioning of the adolescent, and g) social connectedness among the adolescents based on their gender, specifically the females will report higher scores than the males on all variables.
4. There will be significant mean differences in the adolescents receiving treatment for more than one year, versus those receiving treatment for less than one year in the following areas, a) general satisfaction, b) access to treatment, c) cultural sensitivity, d) treatment planning, e) outcome of services, f) functioning of the adolescent, and g) social connectedness.
5. After controlling for treatment a) arrests, b) prior arrests, c) encounters with the police, d) expulsions/suspensions from school, e) prior expulsions/suspensions from school, the adolescents in treatment for more than one year versus those in treatment for less than one year will have better outcomes.

Table 1

*Racial/ethnic distribution of sample*

Race	Frequency	%
Hispanic	66	16.0
African-American	46	11.3
Caucasian	127	31.1
Other	13	3.2
Mixed	157	38.4

Table 2

*Age distribution of sample*

Age	Frequency	%
13	103	22.4
14	108	23.5
15	107	23.3
16	77	16.8
17	65	14.1

### **Study Design**

This is a quantitative study with a large number of subjects. Surveys were completed by adolescents in May and November of each year. These participants attended the programs at the San Bernardino County Behavioral Health Care Facilities, in San Bernardino County, California. This study was conducted to examine the hypotheses above. Analyses of all variables were run using the SPSS 17 to obtain results.

### **Subjects**

The subjects in this study consist of approximately 460 adolescent clients who have had contact and received services from the San Bernardino County facilities. The subjects have been admitted to the mental health programs by being referred by Children and Family Services, volunteer admissions, and others are seen and treated through court orders. There are several centers that provide mental health services to these adolescents including county-operated centers and centers that are operated by independent entities. These Behavioral Health Care Centers were created in the mid 1980's to meet the needs of the youth population who had a mental health issue and/or

also were involved in the juvenile justice system. They work together to combine their resources in an effort to provide a comprehensive and effective continuum of adolescent behavioral health care (San Bernardino County, DMH, Children Services, 2007). The goals are to help these youths and their families to identify areas of concern, and to connect them with appropriate resources when they return to the community. In an effort to reduce recidivism the adolescents may repeat the programs more than once. These services include case management, academic and vocational training, job skills, legal resources, physical health services, social skills and psychological and substance abuse treatment (San Bernardino County, DMH, Children Services, 2007). The surveys are distributed between a selected period of time, and/or those who walk into the centers during the period are offered a survey to finish. The client is asked to fill out a Youth Services Survey (YSS) and return it to the center. This study used the data from these YSS surveys to examine the research questions associated with this project (see Appendix A).

Subjects in the study are males and females who range in age from 13 through 17, and are from different racial/ethnic groups (i.e. Hispanic, African-American, Caucasian, other and mixed race). In addition, subjects included in the study have had encounters with the law, been in jail, had problems attending school, had behavioral problems while attending school, suffer from a mental disorder that causes them problems in their functioning, take psychotropic medications, have problems with drugs or alcohol, and/or have problems in their living situation.

Subjects were not financially compensated to complete the YSS forms. Some of the participants speak various languages, such as, Spanish, Korean, and Taglog. Also, some

subjects were provided with help to complete their YSS forms by a mental health advocate, another consumer, a family member, a professional interviewer, a clinician, a staff member, or their case manager.

The questions on the YSS asked the client what their perceptions are concerning their programming. There are also questions regarding their demographic information, their need for help in completing the YSS forms, and whether they take medications, see medical doctors, or have Medi-Cal or Medicare. Some questions on the YSS (i.e. client's living arrangements, birth date, and client identifiers) will be eliminated from this study, as these questions are a part of a longer survey protocol that are identified on the YSS.

### ***Protection of Human Subjects***

The matter of confidentiality is covered in the forms filed with Loma Linda University, Loma Linda, California and the San Bernardino Behavioral Health Care Center's Internal Review Boards. There was no contact with any client, and no identifying data was made available to the investigator of this study. All YSS forms were completed prior to this study. As such, consent was not required from the subject, as data is archival. The San Bernardino Behavioral Health Care Center who maintains of the completed YSS forms granted permission for use of the data for this study.

Permission to do this study was approved by the Internal Review Board (IRB) of Loma Linda University. After the approval was obtained, permission to use the YSS forms was obtained from the Internal Review Board of the San Bernardino Behavioral Health Care Center. The YSS forms will remain the property of the San Bernardino Behavioral Health Care Center. The survey data is stored on a disk, and the utmost care

has been taken to protect the disk. The YSS survey disk was returned to the San Bernardino Behavioral Health Care Center at the completion of the study.

### **Survey Instruments**

The instrument that is used to collect data by San Bernardino County on the adolescents in treatment was developed to be consistent with its program evaluation. The performance outcome data collection instruments, the YSS ensure that quality indicators of specific relevance to California's public mental health system are measured and maintained. These instruments are intended to ensure data comparability with national quality benchmarks. They were developed through the assistance of a Performance Outcomes Steering Committee, with representation from the California Mental Health Planning Council (CMHPC), California Mental Health Directors Association (CMHDA), San Bernardino County program management, county evaluation/quality improvement personnel, and consumers and family members. The California Department of Mental Health adopted the most recent version (10/10/2007). This instrument assesses consumers' perceptions of quality and outcomes of care, and is currently being used for broad-based evaluation of California's community-based mental health services. All instruments are available in several languages in order to accommodate the language needs of California's diverse mental health consumer population.

The YSS survey instrument asks questions about the adolescents' quality of life after receiving services at the Centers. The participants are asked for their perceptions about the programming they are receiving (e.g. choice of services, choice of treatment goals, ability to talk to someone as needed, location of services, respect for self, religion,

culture, convenience of services, and their ability to get help when wanted). There is a Section with questions on the results of the services the participants received (i.e. doing better in daily life, with family, friends, school attendance, coping skills, satisfied with family life, and able to do things better for themselves). Other questions are geared to helpful services that the adolescents received (i.e. listen and understand self, comfortable with problems, family support, and someone to go to for help). Demographic questions were asked to determine living arrangements, length of time services were received, age, sex, gender, race/culture, arrests, expulsions/suspensions from school, and encounters with the police.

There are seven domains of questions on the survey including general satisfaction, perception of access, cultural sensitivity, treatment planning, outcome of services, perception of functioning, and social connectedness. (See Appendix 1 for specific questions included in each domain). The YSS survey uses a Likert scoring instrument with scores that ranges from 1 to 5. Ratings include the following: 1-strongly disagree, 2-disagree, 3-undecided, 4-agree, 5-strongly agree and not applicable. (See Appendix Section for a copy of the YSS Survey Instrument). The higher scores mean that the adolescent believes the mental health services they are receiving are helping them with their lives. The lower scores mean that the adolescents do not believe the mental health services are making much difference in their lives. The scores are totaled up and divided by the number of subjects to get a mean score.

The directions for scoring the instrument include: Step 1. Recode ratings of “not applicable” as missing values; Step 2. Exclude respondents that are missing more than 1/3 of the items in that particular domain missing; Step 3. Calculate the mean of the items

for each respondent. Note: SAMHSA's Center for Mental Health Services (CMHS) also recommends calculating the percent of scores greater than 3.5. (agree and strongly agree). Numerator: Total number of respondents with an average scale score > 3.5. Denominator: Is the total number of respondents.

An improvement was the use of on-line, internet-based data capture methods that allow direct data-pad entry and provide a paper-form scanning and verification option for larger-volume direct data submission. This new data entry and submission technology provides flexibility for system users, while increasing data uniformity and accuracy.

Data that are transferred to DMH via the new technology are housed in a single database and are therefore quickly available for centralized data analysis and for return to counties for local processing (CDMH, 2007).

### **Analyses**

Seven dependent variables are used in this study: perception of general satisfaction, perception of access, perception of cultural sensitivity, perception of participation in treatment planning, perception of outcomes of services, perception of functioning, and perception of social connectedness.

The independent variables are: length of time receiving mental health services, age, gender, race, number of police encounters, expulsions or suspensions from school, and arrests. For purposes of this study, only the African-American, Hispanic, other, and mixed, and Caucasian races will be used, as there are only a minimal number of other

ages living in the county and among the individuals who participated in this study. The ages to be used are 13, 14, 15, and 16 and 17.

The data collected from the 460 adolescent surveys were input into the SPSS 17. Then various tests were conducted for each hypothesis. The analytical tests conducted included: the t-test which is a statistical test that measures group differences between two group means. ANOVA a hypothesis testing procedure that simultaneously evaluates the significance of mean differences on a dependent variable (DV) between two or more treatment conditions or groups (Mertler & Vannatta, 2002).

T-tests were run on the data to determine whether a set or sets of scores are from the same population. Independent samples t-tests were conducted to compare two means from independent groups (Geroge & Mallery, 2003).

One-way ANOVA were used to compare a sample mean with a known population mean or some other meaningful, fixed value. ANOVA actually takes the total variability and analyzes, or partitions it into two separate components. The numerator is referred to as the between-groups. The variance is the denominator of the F ratio which is called the error variance, or within-groups variability (Mertler & Vannatta, 2002).

ANOVA results (fractions, degrees of freedom for the particular factor and error levels of significance, and effect sizes) are then presented in a narrative format to capture the results of the main differences among the treatment conditions identified in this study. Post hoc test, known as “multiple comparisons” were then conducted. These tests provide comparisons of individual treatments, two at a time, a process known as pair wise comparison, and evaluates whether or not any observed difference is significant.



Scheffe' post hoc tests, which compares all group combinations and identifies any significant pairs, were also conducted on the data. Bonferri's post hoc or multiple comparison tests were conducted to determine which groups were significantly different (Mertler & Vannatta, 2002).

Levene's test of equality of variances was also conducted within ANOVA and indicators of homogeneity of variance within-groups were evaluated. Levene's test involves performing a one-way analysis on data that has been transformed. ANOVA's provide the F ratio, a measure of the statistical significance of the differences between group means, often referred to as Omnibus test (George & Mallery, 2003). All assumptions were met.

### ***Missing Data***

The San Bernardino County Behavioral Health Care Center has verified that there were 877 youth who took the survey for the May 2009 POQI period. Missing data indicated that there were 139 who did not have a date of birth, and 66 who did not fall into the age range of 13 to 17 years of age, and 212 were missing. These surveys were removed from the POQI period, leaving 460 adolescents who met the inclusion criteria for this study. There was a 52.5% completion rate of the adolescents taking the survey.

### ***Charts and Tables***

After analyzing the data, there will be several tables including but not limited to (a) descriptive statistics (means and percentages); (b) mean differences; and (c) Analysis of variance.

## CHAPTER FOUR

### RESULTS

This study attempts to explore the perceptions of adolescents about their experiences in mental health treatment. Specifically, this study sought to understand how these adolescents report their levels of general satisfaction, treatment planning, perception of access, cultural sensitivity, treatment planning, outcome of services, perception of functioning, and social connectedness. This study looked at the demographics of the adolescents by race/ethnicity, sex and age, and how long they have been in the treatment programs. As shown in table 1, the mixed group was the largest (38%) and the other category was the smallest (3%) but there was a sizable group of whites (31%), Hispanics (16%), and African-American (11%). There were more females (59% versus 41%) than males in the study sample. As presented in table 2 the age of the respondents was fairly evenly distributed across the five categories; 13 years old accounted for 22% of all participants, 14 years old were 24% of sample, 15 years old were 23%, 16 years old were 17% and 17 years old were 14% of the adolescents in the study. A little more than two times the number of participants was in treatment for less than a year as compared to those who were in treatment for more than a year (294 versus 138)

Table 1

*Racial/ethnic distribution of sample*

Race	Frequency	%
Hispanic	66	16.0
African-American	46	11.3
Caucasian	127	31.1
Other	13	3.2
Mixed	157	38.4

Table 2

*Age distribution of sample*

Age	Frequency	%
13	103	22.4
14	108	23.5
15	107	23.3
16	77	16.8
17	65	14.1

**Hypothesis One**

The first hypothesis in this study examined whether there were significant mean differences in the areas of the following perceptions; general satisfaction, access to treatment, cultural sensitivity, treatment planning, outcome of services, functioning of the adolescents, and social connectedness among those aged 13, 14, 15, 16, and 17 years of age.

There were four-hundred and sixty subjects who took the survey. The participants were given specific response categories for each question that addressed the topic of this

dissertation. Some subjects answered one question and did not answer the next, this pattern is repeated throughout the survey.

Table 3 presents results from the t-tests that were conducted to test the first hypothesis.

Table 3

*Perceptions of mental health services by age of the respondent*

Perceptions	13	14	15	16	17	Standard Dev
General satisfaction	4.05	4.11	4.22	4.37	4.24	.72
Perception access	4.04	4.02	4.25	4.35	4.35	.76
Cultural sensitivity	4.27	4.29	4.37	4.42	4.49	.63
Treatment planning	3.85	3.84	4.00	4.21	4.01	.77
Outcome services	3.81	3.92	3.94	3.92	4.04	.73
Perception function	3.83	3.91	3.94	3.96	4.01	.73
Social connectedness	4.11	4.16	4.18	4.15	4.23	.70
	Age				F	Sig.
General satisfaction	13 vs. 16*; 14 vs. 16+				3.037	.017
Perception access	13 vs. 14*; 14 vs. 16+; 14 vs. 17*				4.088	.003
Treatment planning	13 vs. 16*; 14 vs. 16**				3.265	.012

+ =  $p < .10$ , \* =  $p < .05$ , \*\* =  $p < .01$ , \*\*\* =  $p < .00$

Overall, there is a tendency for the 16 year olds to report the highest mean scores for three of the seven of the variables in Table 3. The 17 years olds were highest on five of the variables. On the other hand, the 13 year olds were somewhat consistently reporting the lowest score, as seen in five of the seven variables. The 14 year olds had the lowest scores on two of the variables. Statistical differences were observed for 13 year old as compared to 16 year old while there was marginal difference between 14 and 16

year old respondents on the general satisfaction question. With regards to perception of access, differences were noted between 14 and 16 year old participants. Finally, statistical differences were reported for treatment planning; 13 and 16 and 14 and 16 year old respondents were different in reported levels of this perception variable. There was no significant difference in the other four variables of the hypothesis.

Specifically, the highest mean score for general satisfaction was the 16 year olds  $M=4.05$ , followed by the 17 year olds ( $M=4.24$ ), the 15 year olds ( $M=4.22$ ), the 14 year olds ( $M=4.11$ ), and finally the lowest mean score was reported by the 13 year olds ( $M=4.05$ ). The standard deviation for general satisfaction was 0.72 and there was a 0.19 point difference between the highest and lowest scores.

The adolescents who reported that their age was 16 and 17 years old, had the highest mean score ( $M=4.35$ ), for perception of access. The 15 year olds reported ( $M=4.25$ ) followed by the 15 year olds ( $M=4.22$ ), the 14 year olds ( $M=4.02$ ), and the lowest mean score was found among the 13 year olds ( $M=4.04$ ). There is a 0.31 point difference between the highest and the lowest mean scores and a standard deviation of 0.76.

With regards to perception of cultural sensitivity among the adolescents, the highest mean score was reported among the 17 year olds. The age groups mean scores were, 17 year olds  $M=4.49$ , the 16 year olds  $=4.42$ , the 15 year olds  $=4.37$ , the 14 year olds  $M=4.29$  and finally the lowest being the 13 year olds ( $M=4.27$ ). Consistent with the results of the other variables described earlier, there was a 0.22 point between the highest and the lowest scores. Also, the standard deviation for cultural sensitivity was 0.63.

The 16 year old respondents had the highest mean score (M=4.21) for perception of treatment planning variable while the lowest score was reported by the 14 year olds (3.84). Other mean scores for this variable was reported by 17 year olds =4.01, 15 year olds =4.00 and the 13 year olds =3.85. The difference between the highest and lowest scores was 0.37 points and a standard deviation of 0.77 was reported.

Results for the perception of outcome services were as follows, the highest mean score was reported by the 17 year olds (M=4.04), followed by the 15 year olds (M=3.94), the 14 and 16 year olds (M=3.92), and the lowest being the 13 year old (3.81). The difference between the highest and lowest mean scores was 0.23 point and the standard deviation was 0.73.

The 17 year olds reported the highest mean score (M=4.01) for perception of functioning, followed by the 16 year olds (M=3.96), the 15 year olds (M=3.94), the 14 year olds (M=3.91), and the lowest being the 13 year olds (M=3.83). The standard deviation reported for this variable was 0.73 and a 0.18 points difference was noted between the highest and the lowest scores.

Finally, and inconsistent with the results for the other variables, the highest mean score for perception of social connectedness, was reported b the 17 year olds (M=4.23). Other age groups mean score were; the 15 year olds (M=4.18), the 14 year olds (M=4.16), the 1 year olds (M=4.16), and the lowest being the 13 year olds (M=4.11). The difference between the highest and lowest mean scores was 0.12 and the standard deviation was 0.70.

## Hypothesis Two

This study attempts to explore the perceptions of adolescents about their experiences in treatment across a number of key socio-demographic and other contextual variables. Thus, the second hypothesis that was tested in this study was: there will be significant mean difference across racial/ethnic groups (Hispanic, African-American, Caucasian, others, and mixed race) in the areas of perceptions of a) general satisfaction, b) perception of access, c) cultural sensitivity, d) treatment planning, e) outcome of services, f) perception of functioning, and g) social connectedness.

As noted earlier, the number of adolescents who responded to each of the seven perception questions varied across racial and ethnic groups. That is, 66 Hispanics completed the survey, 46 African-Americans, 127 Caucasians, 157 mixed race and 13 individuals selected the “other” category. Table 4 presents results of summary of the one-way ANOVA that was conducted to test hypothesis two.

Table 4

*Perceptions by race and ethnicity*

	Hispanic	African American	Caucasian	Others	Mixed	Standard Dev.	P-value
Perceptions							
General satisfaction	4.16	4.29	4.05	4.26	4.22	.68	.23
Perception access	4.16	4.22	4.08	3.96	4.21	.75	.59
Cultural sensitivity	4.26	4.34	4.31	4.38	4.40	.63	.60
Treatment planning	3.83	4.05	3.96	3.95	3.99	.74	.50
Outcome services	3.93	3.96	3.94	4.01	3.93	.72	.99
Perception function	3.83	3.98	3.98	4.02	3.97	.72	.79
Social connectedness	4.14	4.24	4.00	4.13	4.15	.71	.28

\*= p<.05, \*\*=p< .01, \*\*\*=p<.00).

An examination of the results indicate, that the Caucasians have reported the highest scores on four the variables, followed by the highest by the group other on two of the variables, and the mixed highest on one variable. The Hispanic and the African-Americans consistently scored the lowest on all seven variables tested.

The results show that on the question of general satisfaction the Caucasians scored the highest mean score at a (M=4.29), followed by the other (M=4.26), mixed (M=4.22), African-American (M=4.16), and lastly the Hispanics (M=4.06). The standard deviation was 0.68 for general satisfaction.

On the next question of perception of access the highest mean score was recorded by the Caucasians M=4.22, followed by the mixed M=4.21, African-Americans M=4.16, Hispanics M=4.08, and the lowest being the other group M=3.96. There was a standard deviation of 0.75.

The lowest scores for the question of cultural sensitivity was recorded by the African-Americans (4.26), followed by the higher scores recorded by the Caucasian (4.34), Hispanic (4.31), other (4.38), and the highest by the mixed group 4.40. And the standard deviation for this variable was 0.63.

Again the Caucasians report the highest score, on the question of treatment planning M=4.05, followed by the next highest scores recorded by the mixed M=3.99, Hispanic M=3.96, other group M=3.95, and the lowest the African-Americans M=3.83. A standard deviation of 0.74 was observed for this variable.

The next question of outcome of services the highest mean scores was recorded by the other group (M=4.01), followed by the mean score of (M=3.96), for Caucasian, Hispanic (M=3.94), the lowest mean score was reported by the African-American and the



Mixed group, a score of (M=3.93). A standard deviation of 0.72 was observed for this variable.

On the question of perception of functioning the highest mean scores were reported by the other group (M=4.02), followed by the mean score of M=3.98 for both the Caucasian and the Hispanics, the lowest mean score was reported by the African-American (M=3.8). A standard deviation of 0.72 was reported.

For the last question of social connectedness, the lowest scores were reported by the Hispanic (M=4.00), followed by higher scores of the other group (M=4.13), African-American (M=4.14), mixed group (M=4.15), and the highest again by the Caucasian (M=4.24). A standard deviation of 0.71 was obtained.

Even though there were different mean scores reported by the various racial/ethnic groups there was no statistical difference among the five groups.

### **Hypothesis Three**

The third hypothesis was focused on examining the following: there will be significant mean differences in the areas of perceptions of a) general satisfaction, b) perception of access, c) cultural sensitivity, d) treatment planning, e) outcome of services, f) perception of functioning, g) social connectedness, among the adolescents based on their gender. Specifically, females are expected to report higher scores across all of the aforementioned variables.

The Table 5 presents results of the t-tests that were conducted to evaluate this hypothesis. The mean scores for females were highest on five of the seven variables, and lowest on two of the variables. The males mean scores were lowest on five variables, and

highest on two variables. Specifically, the females reported a score of (4.25) for the general satisfaction question while, the males reported a mean of 4.18. Females reported the higher mean scores on perception of access (4.22 versus 4.15), than the males. For cultural sensitivity the females reported a mean score of 4.41, as compared to males with an average score of 4.32. With regards to treatment planning the females reported a mean score of 4.00 and males were slightly lower with an average score of 3.98. The pattern is reversed for customer outcome services, the males reported an average score of 3.99 while females had a mean score of 3.87. For perception function the males had a mean score of 4.01 and the females 3.89. Finally, females had higher mean scores (4.18) for social connectedness as compared with the males (4.13). However, there were no statistical differences by the gender of the respondent for any of the seven variables under consideration. This was not surprising given that the mean scores for males and females were so similar. The largest differences were observed for outcome services and perception of function which were both (0.11), all the others were less than .10.

Table 5

*Perceptions by gender*

Perception	F	M	P-v
General satisfaction	4.25	4.18	.46
Perception access	4.22	4.15	.53
Cultural sensitivity	4.41	4.32	.60
Treatment planning	4.00	3.98	.77
Outcome services	3.87	3.99	.72
Perception function	3.89	4.01	.67
Social connectedness	4.18	4.13	.96

+ =  $p < .10$ , \* =  $p < .05$ , \*\* =  $p < .01$ , \*\*\* =  $p < .00$

The hypothesis that females would report higher levels of general satisfaction, perception of access, cultural sensitivity, treatment planning, outcome services, perceptions function, and social connectedness than males was not demonstrated by these results. The gender of the adolescents did not discriminate across the seven variables that were identified in this study.

#### **Hypothesis Four**

The fourth hypothesis stated that, there will be significant mean differences between the adolescents receiving treatment for more than one year versus those receiving treatment for less than one year in the following areas: of general satisfaction, perception of access, cultural diversity, treatment planning, outcome of services, perception of functioning, and social connectedness. Specifically, it is postulated, that those who were in treatment longer (i.e. more than one year) would report more positive perception of the mental health treatment services that they received.

Table 6 presents results of the t-tests that were conducted to evaluate the aforementioned hypothesis. A total of 294 adolescents who were in treatment for less than one year, responded to the questionnaire, compared to 138 of their peers who were in treatment for more than one year.

Interestingly, all the participants who had completed more than one year in treatment had all the highest mean scores on all variables as compared to the respondents in with less than one year in treatment with the exception of cultural sensitivity where both groups had the same mean score  $M=4.36$ . The adolescents who were in treatment for more than one year report a mean score of (4.27 versus 4.17), and a standard deviation of

0.62. As with general satisfaction the mean for adolescents in treatment for less than one year was 4.14 and the standard deviation was 0.63, for perception of access. As indicated earlier the mean for adolescents in treatment for more than one year was higher (4.06

Table 6

*Mean scores across measures of perceptions by length of time in treatment*

Perceptions	< 1 year	SD	> 1 year	SD	P-v
General satisfaction	4.17	.74	4.27	.62	.09
Perception access	4.14	.81	4.27	.63	.12
Cultural sensitivity	4.36	.66	4.36	.55	.12
Treatment planning	<b>3.93</b>	<b>.79</b>	<b>4.06</b>	<b>.67</b>	<b>.05</b>
Outcome services	<b>3.87</b>	<b>.78</b>	<b>4.05</b>	<b>.61</b>	<b>.01</b>
Perception function	<b>3.88</b>	<b>.76</b>	<b>4.08</b>	<b>.61</b>	<b>.04</b>
Social connectedness	4.13	.73	4.21	.61	.61

+ = p < .10, \* = p < .05, \*\* = p < .01, \*\*\* = p < .00

versus 3.93) for treatment planning. The standard deviation for treatment planning was 0.67. A similar pattern of higher mean scores was observed for the following variables; outcome of services (4.05 versus 3.87 and SD=0.76), perception function (4.08 versus 3.88 and SD=0.61), social connectedness (4.21 versus 4.13, and SD=0.61). As was stated earlier the respondents in treatment for less than one year reported the lowest scores on all, but one variable, cultural sensitivity. However, there was statistical difference shown on treatment planning, outcome of services, and perception of functioning. That is length of time in treatment as defined in this study provided evidence of three variables of meaningful difference among the adolescents with regards to their perceptions of treatment.

### **Hypothesis Five**

The fifth hypothesis examines if there are differences between adolescents who were in treatment for less than one year as compared to those who were in treatment for more than one year across the following outcomes; the following; arrests, prior arrests, encounters with the police, expulsions/suspensions from school, and prior expulsions/suspensions from school. The results for this hypothesis are presented in table 7 below.

No clear pattern emerged in the analysis of differences in prior arrests, arrests, encounters with the police, expulsions/suspensions from school, and prior expulsions/suspensions from school between adolescents who were in treatment less than a year as compared to those who were in treatment for more than a year. However, the adolescents with less than a year in treatment reported higher number of prior arrests (15% versus 9%) and prior expulsions/suspensions from school (32% versus 25%) as compared to those who were in treatment for more than a year. For arrests (14% versus 11%), encounters with the police (45% versus 3%), and expulsions/suspensions from school (30% versus 23%), adolescents who were in treatment for more than one year as compared to their peers who were in treatment for less than a year had higher reported levels of the stated outcomes. Regardless of length of time in treatment, prior expulsions/suspensions from school (23% of adolescents who were in treatment less than one year and 30% who were in treatment more than one year) were the items with the highest frequency of adolescents who were in this category. It should be observed, however, that there, was no statistical difference in the responses between the groups.

The length of time in treatment did not discriminate across the five variables that were identified in this study.

Table 7

*Percent differences in arrests, prior arrests, encounters with the police, expulsions/suspensions from school, and prior expulsions/suspensions from school by length of time in treatment*

Action	N	< 1 year		> 1 year				
		%N	Y	%Y	N	%N	Y	%Y
Arrests	229	89.1	28	10.9	93	86.1	15	13.9
Prior arrests	213	84.9	38	15.1	91	91.0	9	9.0
Encounters	233	97.1	7	2.9	87	95.6	4	4.4
Exp/suspensions	194	76.9	59	23.3	65	69.9	28	30.1
Prior Ex/susp.	168	67.7	80	32.3	68	74.7	23	25.3

+ = p < .10, \* = p < .05, \*\* = p < .01, \*\*\* = p < .00

## **CHAPTER FIVE**

### **DISCUSSION**

This study examined the ways in which adolescents' perceptions of mental health services may vary on account of a number of socio-demographic characteristics such as age, race/ethnicity, gender and a variable that assessed the length of time in treatment. Perception of experiences with county mental health services is an important part of the process that may be consequential for effective outcomes especially with the adolescent population. This study is an important addition to our discussion about the factors that may impact differences in treatment in efforts to meet the needs of the adolescents while taking note of the role of these differences in mental health services outcomes.

This study was important in assessing adolescent's perceptions of their mental health services they received. It is important for practitioners and policy analysts to have a clear picture of how adolescents view their experiences with mental health services. This study helps to understand how adolescent's perceptions about mental health services in San Bernardino, California describe their contacts with the services they receive.

A number of hypotheses were proposed in this study. The first hypothesis made the assumption that age would make a difference in the adolescents' perceptions of their mental health services. Overall, there were minimal age differences across age groups and the seven measures of areas of mental health services received by the adolescents. In general this may indicate that while there may be merit to age specific kinds of treatment interventions, this study does not demonstrate that perceptions of the services received differed dramatically. The perception of services may be different from the content of the intervention or even the treatment modality. It is interesting to note however, that there

were some observed differences for three of the seven measures of perceptions of mental health services across the age groups. The pattern of differences suggests that younger adolescents (13 and 14 year olds) reported lower levels in the following areas; general satisfaction, perception of access, and treatment planning than 16 and 17 year olds. The difference with the 17 year old adolescents was only observed for perception of access. However, the general finding is that younger adolescents were less likely to be satisfied with their overall treatment while accessing mental health services. Not surprising therefore, both 13 and 14 year old adolescents reported that accessing mental health services was not as fulfilling as 16 and 17 year old adolescents in the study. Maybe initial encounter with the mental health services is a little more challenging for younger adolescents and age makes a difference in comfort with negotiating access to the mental health services available. Higher levels of satisfaction with the planning of treatment for the adolescents were also reported by the older (16 year olds) as compared to the younger adolescents. Again, age and maturing in the system may make a difference in comfort with regards to being involved in mental health services especially with regards to treatment planning. Overall, mental health service providers may benefit from paying particular attention to the needs of younger adolescents as they seek to access and engage in the treatment plan once in the mental health services system. Additional analyses that seek to correlate age with length of time in treatment may provide more clarity to this issue.

Hypothesis two assessed racial/ethnic differences in the seven measure of perception of mental health services used in this study. No statistical differences were observed in these analyses as the groups reported similar levels of satisfaction with the



mental health services received. This finding differs from what was expected but point to the context of the services as possible explanation for these results. Adolescents in San Bernardino County may be less different by racial/ethnic groupings with regards to mental health services as in other contexts. Additional study may help clarify this finding in terms of possible explanations for these results.

In hypothesis three the assumption of female scores being higher than the males did not bear out. While some of the actual scores for females would suggest that females were more satisfied with the mental health services, no statistical difference was found between females and males. This is an interesting finding from this study; however, additional studies may help clarify the non significant finding about gender differences (or lack thereof) in perception of mental health services. The distribution of females (59%) and 41 percent for males suggested that the number of individuals in each group was fairly sizable. It should be noted that both groups reported high levels of satisfaction with the mental health services that they received. The satisfaction with the services provided in the county is reportedly high. Additional studies may seek to explore reasons for this high level of satisfaction with mental health services regardless of gender.

The hypothesis four assumed that the adolescents in treatment for more than one year would have higher scores than the adolescents in treatment for less than one year. This assumption was shown to be true except on the question of cultural sensitivity they had a tie score, but overall, there was a statistical difference in four of the seven variables across the two groups. Consistent with expectations, those in services for longer period of time reported higher levels of general satisfaction, treatment planning, outcome services, and perception function. There seems to be merit to staying with the program of mental

health services provided by the county to overall positive outcomes for adolescents who remain in the program. Treatment time of less than one year seems to be a disadvantage for the adolescents. Policy makers may want to suggest that adolescents remain in treatment for beyond a year and explore these data further to determine, at least in this study, what may be optimal time that adolescents would be in treatment for mental health challenge.

Hypothesis five examined the assumption that subjects in treatment for more than one year would have fewer infractions including arrests, police encounters, and expulsions/suspensions from school after treatment. This however was not born out. The length of time in treatment did not prevent adolescents from being arrested or suspended/expelled from school. This hypothesis did not provide any results that were statistically significant.

The overall mean scores for general satisfaction is  $M=4.21$ , access to treatment  $M=4.19$ , cultural sensitivity  $M=4.36$ , treatment planning  $M=3.98$ , outcome of services  $M=3.95$ , perception of functioning  $M=3.95$ , and social connectedness  $M=4.16$ . The adolescents rated cultural sensitivity, access to treatment, and social connectedness the highest of the treatment services they have received for this survey. A score of a mean over 3.50 means the programs are perceived by the adolescents to be working for them, all the scores are over that range.

The adolescents who are in the San Bernardino County Behavioral Health Care Center programs are admitted by being referred by Children's Services, they can volunteer for the programs, some are referred by the school system, and others are referred by the courts. Missing data was a challenge in this study. One may ask why, do

the subjects answer the questions the way they do. Some explanations may be that they are oriented into the program and they are receiving the help they need. Others may not perceive that they are getting what they need from the programs. Since adolescents come from different referral sources, the reasons they answered the questions on the survey the way they did could reflect how they feel about being in the programs. The adolescents coming from the school system and the court system may have a totally different view of what they need and want from the programs. Specifically, the subjects from the court system may not feel they need to be in a program and may not give a positive response as a subject who came to the program voluntarily. The subjects from the school system may feel they are compelled to attend the programs, and some of this group may feel that it is giving them a second chance at getting an education. The subjects who have major medical and psychological problems may feel that being able to see a doctor and get medication that helps them deal with their life's challenges. Future studies should seek to develop strategies to engage adolescents to complete the questionnaire as provided.

San Bernardino County may want to investigate this matter to see why certain individuals did not respond to some of the questions on the surveys and then answered other questions. In order for policy planners to develop better programs they need all the questions answered and as honestly as the subjects can. The data obtained from these surveys can help the county to plan programs that work for the adolescent and also can help the family better deal with each situation they are confronted with, involving the adolescent. San Bernardino County could also administer the Youth Services Survey for the Family (YSS-F) to determine if the youth and the families both believe that the

programs are working for them and give input to what would make the programs better for the adolescents.

### **Related Studies and Findings**

A survey conducted in the in the Southern California Region (2005) by the California Department of Mental Health also shows that there are a lot of adolescents who take the (YSS) in other regions who do not answer all the questions either. Results from this study shows that out of 7,483 Southern California Region (YSS) surveys were attempted and only 5959 (79.6%) were completed. This survey also shows the subjects did not all identify their gender, a total of 306 (5%) subjects did not state their gender. There were 441 (7.4%) who did not respond to their age, and on the question of how long they had received services there was a total of 1,277 (21.4%) out of the group who did not respond. There are a large percentage of subjects who do not complete the surveys as required by the State of California (CDMH, Southern California Region Summary, 2005).

A study conducted in Sacramento County (2006) using the (YSS) with adolescents in that county responding, they had only a completion rate of 69% for the (YSS) and 68% for the (YSS-Family) (Sacramento County Children's System of Care, 2006).

Another study completed in Sacramento County (2008) shows similar results in survey completion rates, 68% of the (YSS) surveys were completed and 62% of the (YSS-F) completed the surveys (Sacramento County Children's System of Care. 2008).

Table 8

*Overall comparison scores*

	So Ca. (2005)	Sac Co. (2006)	Sac Co (2008)	SBDO Co (2009)
General satisfaction	3.92	4.07	4.04	4.21
Perception access	3.88	4.02	4.05	4.19
Cultural sensitivity	4.15	4.27	4.33	4.36
Treatment planning	3.72	3.82	3.88	3.98
Outcome services	3.77	3.83	3.86	3.95
Perception functioning	N/A	N/A	3.88	3.95
Social connectedness	N/A	N/A	4.14	4.16

So.Ca.=Southern California Region, Sac.Co.=Sacramento County, SBDO Co.=San Bernardino County.

When you look at the scores overall that were cited, the picture shows that the counties are similar in their overall responses to the questions identified. The San Bernardino County subjects tended to have overall the highest scores recorded. It might be useful to explore reasons for consistently higher levels of satisfaction with mental health services for adolescents in San Bernardino County as compared to the other regions identified in table 8 above.

### **Limitations of the Research**

A number of limitations are observed for this study. First, this study used data from a single time point and therefore the cross-sectional nature of this project leaves it open to the question of the casual direction of the variables. Additional studies may want to use more than one wave of data to more fully understand perceptions of mental health services among adolescents in this context.

Second, the issue of missing data may affect the validity of the results of the study. Attention should be given to those who don't respond to the survey as they may be a special group of non-respondents. Knowing if the results of this study may be biased by a special group of respondents may be useful for clinicians and policy makers.

Third, the use of self reports could be enhanced by other kinds of data such as key informant interviews or focus groups with adolescents engaged in mental health services. Also, the instrument used in this study the Youth Services Survey (YSS) is of unknown reliability and validity. Additional studies should seek to validate these instruments and to test for reliability over time and across different studies.

Fourth, the data requested in the survey, did not ask about the adolescents' mental or health problems, how they reacted to the juvenile justice system, school system and school problems, or issues with family and friends. If these questions were asked you could get a more detailed view of these adolescents' problems, according to their views of their treatment. San Bernardino County does not conduct the Youth Services Survey for Families (YSS-F), if they did they could get feedback from the families/caregivers to see if their perceptions are near those of the adolescents.

Ohio has similar research conducted to see what is going on in their state, it would be interesting to see how they compare with California. This study should be replicated in San Bernardino County to see if the findings are consistent with this study.

### **Recommendations for Future Research**

It is recommended that future research in the area of program evaluation consider optimizing ways to collect more complete data. The programs are mandated in the

counties to provide services for this population of adolescents, the adolescents need to be getting help from the treatment provided, and this needs to be shown on the surveys. This county is surveyed every six months, and all counties in the state of California are also surveyed and mandated to provide treatment. The questions on the survey needs to be answered so the state can see what is going on, and if all is occurring like it should be, then measures can be taken to correct them. This information is needed by the state in order for them to fund these treatment programs. All future surveys will need to have been answered for the programs to progress, and in order to determine the needs of each county's population as far as what programs to provide to their respective populations. Ongoing evaluation of program effectiveness is recommended.

Counties in other parts of California conduct a survey for the family/caregivers of the adolescents in the programs. The instrument used is the YSS-F (Family) and could be conducted alongside the one for the YSS and the results could be compared to see if their data is along the response rate of other counties. It appears that it would be helpful to see if the parents/caregivers are reporting responses that are similar to the adolescents, or if they have different needs for the adolescents and their families, and how this could be coordinated into the planning of the programs for the adolescents.

There needs to be more reports of research projects like this one conducted in the other counties in the state and reported, to see what is occurring in those locations. The surveys need to be answered on all questions for a true picture of what is occurring in the counties treatment programs. With the appearance of adolescents picking and choosing what survey questions to answer is not helping the programs provide treatment, or will not help the adolescents get the treatment they need to really make a difference in their

future lives. Throughout the state, especially in the larger counties like Los Angeles, San Diego, San Francisco, Sacramento, and also the smaller rural counties. The larger counties you may find different race/culture mixes, this is also true of the rural counties, where you may find only one or two races/cultures. These research projects can help the state to find out what is occurring in the various counties, a) they can see if the programs are working as designed, b) they can find out where to make change when they are not working, c) they can add to the treatment what is identified in the surveys that the adolescents say they need to help them to stay out of trouble, d) and these programs can help these adolescents grow up to lead a productive life. California has a very large population of people in prison, approximately 170,000, if we can stop these young adolescents and to turn their lives around, we can save the state money, have a more lawful citizenry, and have hope for all of California.

This study is an important step in the direction of understanding adolescents perceptions of mental health services provided to them by county mental health agencies. Key differences were observed in some variables such as age and length of time in treatment while no meaningful difference was observed in race/ethnic groups, gender and certain problems with the legal system. The results of this study points to the importance of continued evaluation of the perceptions of services received by adolescents when faced with mental health challenges.



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## APPENDIX A

### YSS DOMAINS AND SCORING INSTRUCTIONS

Domain	Survey Items	Scoring Mean
General Satisfaction	1. I like the services I received here. 2. If I had other choices, I would still get services from this agency. 3. I would recommend this agency to a friend or family member.	
Perception of Access	4. The location of services was convenient. 5. Staff were willing to see me as often as I felt was necessary. 6. Staff returned my calls within 24 hours. 7. Services were available at times that were good for me. 8. I was able to get all the services I thought I needed. 9. I was able to see a psychiatrist when I wanted to.	
Perception of Cultural Sensitivity	10. Staff here believe that I can grow, change and recover. 12. I felt free to complain. 13. I was given information about my rights. 14. Staff encouraged me to take responsibility for how I live my life. 15. Staff told me what side effects to watch. 16. Staff respected my wish about who is, and is not to be given my info. 18. Staff were sensitive to my cultural/ethnic background. 19. Staff helped me get the info needed so that I can take charge of illness. 20. I was encouraged to use consumer-run programs ( i.e. support groups).	
Treatment Planning	11. I felt comfortable asking about my medications and treatment. 17. I not staff, decided my treatment goals.	
Outcome of Services	21. I deal more effectively with daily problems. 22. I am better able to control my life. 23. I am better able to deal with crisis. 24. I am getting along better with my family. 25. I do better in social situations. 26. I do better in school and/or work. 27. My housing situation has improved. 28. My symptoms are not bothering me as much.	

Perception of Functioning 29. I do things that are more meaningful to me.  
30. I am better able to take care of my needs.  
31. I am better able to handle things when they go wrong.  
32. I am better able to do things that I want to do.  
28. My symptoms are not bothering me as much.

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Perception of Social Connectedness 33. I am happy with the friendships I have.  
34. I have people with whom I can do enjoyable things.  
35. I feel I belong in my community.  
36. In a crisis, I would have the support I need from family or friends.

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Scoring:

Step 1. Recode ratings of “not applicable” as missing values.

Step 2. Exclude respondents with more than 1/3 of the items in that domain missing.

Step 3. calculate the mean of the items for each respondent.

Note: SAMHSA’s Center for Mental Health Services (CMHS) also recommends calculating the percent of scores greater than 3.5 (percent agree and strongly agree).

Numerator: Total number of respondents with an average scale score >3.5.

Denominator: Total number of respondents.

**APPENDIX B**  
**MENTAL HEALTH**

YOUTH SERVICES SURVEY FOR YOUTH (YSS)

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Please answer the following questions based on the **last 6 months** OR if services have not been received for 6 months, just give answers based on the services that have been received so far. Indicate if you **Strongly Disagree, Disagree, are Undecided, Agree, or, Strongly Agree** with each of the statements below. If the question is about something you have not experienced, fill in the circle for **Not Applicable** to indicate that this item does not apply.

---

**Strongly Disagree Undecided Agree Strongly Not**  
**Disagree Disagree Agree Applicable**

---

1. Overall, I am satisfied with the services I received.
2. I helped to choose my services.
3. I helped to choose my treatment goals
4. The people helping me stuck with me no matter what.
5. I felt I had someone to talk to when I was troubled.
6. I participated in my own treatment.
7. I received services that were right for me.
8. The location of services was convenient for me.
9. Services were available at times that were convenient for me.
10. I got the help I wanted.
11. I got as much help as I needed.
12. 12. Staff treated me with respect.
13. Staff respected my religious/spiritual beliefs.
14. Staff spoke with me in a way that I understood.
15. Staff were sensitive to my cultural/ethnic background.

**As a result of the services I received:**

16. I am better at handling daily life.
17. I get along better with family members.
18. 18. I get along better with friends and other people.
19. I am doing better in school and/or work.
20. I am better able to cope when things go wrong.
21. I am satisfied with my family life right now.
22. I am better able to do things I want to do.

**As a result of the services I received:**



- 23. I know people who will listen and understand me when I need to talk.
  - 24. I have people that I am comfortable talking with about my problems.
  - 25. In a crisis, I would have the support I need from family or friends.
  - 26. I have people with whom I can do enjoyable things.
- 

**Please answer Questions #5-9 if you have been receiving mental health services for ONE YEAR OR LESS.**

- 5. Were you arrested since beginning to receive mental health services? Yes No
  - 6. Were you arrested during the 12 months prior to that? Yes No
  - 7. Since you began to receive mental health services, have your encounters with the police:
    - been reduced (for example, you have not been arrested, hassled by police, taken Police to a shelter or crisis program).
    - stayed the same
    - increased
    - not applicable (you had no police encounters this year or last year)
  - 8. Were you expelled or suspended since beginning services? Yes No
  - 9. Were you expelled or suspended during the 12 months prior to that? Yes No
- 

**Please answer Questions #11-15 only if you have been receiving mental health services for MORE THAN ONE YEAR.**

- 11. Were you arrested during the last 12 months? Yes No
  - 12. Were you arrested during the 12 months prior to that? Yes No
  - 13. Over the last year, have our encounters with the police:
    - been reduced (for example, you have not been arrested, hassled by police, taken to a shelter or crisis program)
    - stayed the same
    - increased
    - not applicable (you had no police encounters this year or last year)
  - 14. Were you expelled or suspended during the last 12 months? Yes No
  - 15. Were you expelled or suspended during the 12 months prior to that? Yes No
- 

**Please answer the following questions to let us know a little about you.**

- 17. What is your gender? Female Male Other
- 18. Are you of Mexican/Hispanic/Latino origin? Yes No Unknown
- 19. What is your race? **(Mark all that apply.)**
  - American Indian/Alaskan Native
  - Native Hawaiian/Other Pacific Islander

- Asian
  - Black/African American
  - White/Caucasian
  - Other/Mixed
  - Unknown
- 

**Thank you for taking the time to answer these questions!**