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Overcoming Barriers to Mental Health Service Utilization Among Justice Involved Youth

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OVERCOMING BARRIERS TO MENTAL HEALTH SERVICE
UTILIZATION AMONG JUSTICE INVOLVED YOUTH

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

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

by
Susan Yvonne VanAllen

June 2015

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ABSTRACT

The purpose of this study is to identify the barriers to and facilitators of mental health services utilization among youth in the justice setting, and to explore ways to overcome these barriers and expand these facilitators. This qualitative study utilized focus groups as a means to extract themes among the perceptions of social workers on this topic. Results were transcribed to written form. Qualitative analysis procedures were followed to identify and label themes. A total of 473 statements are organized into 26 major themes with 18 sub-themes. Suggestions for change under the agency/organizational category of domain three received the most overall discussion with 108 statements in all. The most discussed topics in the focus groups are quality of or improvements to services, which receives a total of 114 statements total, and punitive systems of care, which receives a total of 60 statements in all. Major suggestions for change made by participants include education and outreach for the public on mental health for juveniles, training on interventions and cultural competence for providers, and a shift from punitive to restorative for systems that justice youth interact with, to include schools, courts, probation, and law enforcement.

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DEDICATION

First of all this work is dedicated to all the justice involved youth I have come in contact with who inspired this work to begin with.

Next, to my husband, daughter, friends, and extended family whom I have robbed of my time for the last few years in order to complete my educational journey; Thank you for your understanding. Particularly, to my husband for stepping in and being the everything-guy, and for loving me even when I'm grumpy and self-centered.

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CHAPTER ONE

INTRODUCTION

Social workers are in a unique position to interact with juveniles within the justice setting. These interactions can occur in group homes, juvenile detention centers, and private home settings. Since the prevalence rates of mental health issues among juveniles in the justice system are high (Whitted, Delavega, & Lennon-Dearing, 2012), services to meet the challenges faced when diagnosing, treating, and following up with these young clients are imperative. California juvenile detention centers contain a mental health component that evaluates and treats the youths they house for mental health needs and services. Additionally, community mental health facilities are available within each county in California to address mental health issues for youth on probation or in placement in the community. Still, many juvenile individuals who suffer moderate and severe mental health disorders do not get treatment even after having come in contact with the justice system. Moreover, many who begin treatment do not adhere to the recommendations of the treating clinician. Lack of treatment can have long-term and detrimental consequences for these youths and their families.

Problem Statement

In screening juveniles in the general population, research has estimated that 14% are positive for a mental health disorder (Burnett-Zeigler et al.,

2011), as compared to 81% in the juvenile justice setting (Whitted et al., 2013). Additionally, as many as 40% of justice involved juveniles suffer from a severe mental disorder (Kenny, Lennings, & Nelson, 2008; Mallett, 2009). Up to 71% are diagnosed with conduct disorder, up to 48% with attention deficit hyperactive disorder, and 9.8% with bipolar disorder (Archer, Simonds-Bisbee, Spiegel, Handel, & Elkins, 2010). In fact, Fazel, Doll, and Langstrom (2008) conducted a sizable literature review and found juveniles in the justice system to be up to 10 times more likely to be diagnosed with a psychosis as compared to juveniles in the general public setting. These numbers place a heavy burden on the juvenile justice and community mental health personnel to provide assessment and treatment for adolescents in need.

Research demonstrates that youths with mental illnesses are greatly helped when they are properly diagnosed, given counseling or treatment, and prescribed any necessary accompanying medications. Proper treatment and medication are associated with reduced recidivism (Dailey, Townsend, Dysken, & Kuskowski, 2005), reduced psychiatric hospital readmission (Semble & Dadson, 2011), and reduced occurrence of psychiatric symptoms (Hong, Reed, Novick, Haro, & Aguado, 2011).

The juvenile justice system and community mental health providers engage in collaborative efforts focused on ensuring that all juveniles in the justice system get the mental health services they need. Yet many youth do not receive needed mental health treatment, or do not continue treatment after

it is initiated. It is estimated that less than half of the youth offenders who are in need of mental health services actually receive those services (Lopez-Williams, VanderStoep, Kuo, & Stewart, 2006). This gap in effective service provision is often caused by physical and perceptual barriers, which stand between the individual and the needed services.

Policy Context

In an effort to increase accessibility of mental health services, Congress established the Substance Abuse and Mental Health Services Administration (SAMHSA) in 1992. SAMHSA replaced the Alcohol, Drug Abuse, and Mental Health Administration, for the purpose of reorganizing and restructuring service delivery to consumers. SAMHSA's main goal is "to reduce the impact of substance abuse and mental illness on America's communities" (SAMHSA, 2012, para. 9).

Working in partnership with other agencies, SAMHSA created the Federal Mental Health Action Agenda in 2005, which seeks to transform and actualize the mental health services received by all Americans (SAMHSA, 2009). The goals of the Federal Mental Health Action Agenda (FMHAA) include creating avenues to reach all Americans with mental health services, with an emphasis on underserved and isolated populations such as refugees, children, men suffering depression, homeless, and oppressed populations. The FMHAA has initiated many projects to achieve these hard to reach populations including multiple educational campaigns to serve specific

populations, creating alliances for suicide prevention, developing and promoting incentives for employers who hire and advance individuals with psychiatric illnesses, and promoting collaboration with the juvenile justice system to assist incarcerated youth transition into the arena of employment arena (SAMHSA, 2009). These are but a few of the initiatives promoted by the FMHAA.

Funded by a 1% tax on annual income in excess of \$1 million dollars, Proposition 63, the Mental Health Services Act (MHSA), is a vital piece of California legislation enacted to benefit populations living with mental health challenges. Passed in November of 2004, and activated in 2005, the MHSA received strong support from Democrats and social workers in California. The intent of the MHSA is to improve and expand county mental health programs, decrease the many barriers to accessing these services, and to enlarge preventative measures to include early intervention and educational components (Sheffler & Adams, 2005).

The enactment of these and other policies have paved the way to expanded mental health services for youth, particularly at the community level.

Practice Context

Social workers in a variety of settings will come in contact with individuals and families challenged with all types of mental illnesses. This is particularly true in the juvenile justice setting due to the high prevalence rates of mental health diagnosis found therein. Additionally, social workers play

many roles in the juvenile justice setting. There are social workers who visit youths in juvenile hall, conducting complex bio psychosocial interviews and assessments. There are social workers who visit youths on probation or in placement in their homes or group homes, maintaining contact and supporting the wellness and success of these individuals. There are social workers that are dedicated to reducing truancy among youth, working to connect these youth and their families to valuable resources within the surrounding community.

Social workers in all of these micro level settings benefit from understanding what factors block or aide youth in utilizing mental health services. On a macro level, organizations serving youth with mental health needs will be able to better meet the needs of the youth they serve by making adjustments to practices at the agency level. Last, the results of this study will assist policy makers and policy advocates to change existing policies and create new policies that are better suited to meet the needs of justice involved youth.

Purpose of the Study

The purpose of this study is to elicit the perspectives of social workers who come in contact with youth in the juvenile justice setting in order to identify and describe the barriers encountered by these youth in accessing, utilizing, and maintaining mental health treatment services both during and after incarceration. Additionally, the social workers' perspectives will be elicited

to identify and describe any facilitating factors that help youth to access and utilize services. The final purpose of this study is to identify and describe suggestions for change to overcome the barriers or augment the facilitators.

This study is important for several reasons. First, social workers as sample subjects do not possess the same biases that the clients, caregivers, and physicians who have been sampled in past barrier research might. Juvenile clients and their caregivers may not want to disclose the true reason that they did not engage in services. For example they might state that they could not get an appointment when they really did not try calling because they do not want service. Physicians and counselors may be biased in favor of themselves, their organization, or their funding sources. Social workers come in direct contact with juvenile clients and often engage in acts with the intent of connecting clients to mental health services. That is, social workers in the justice system are not responsible for performing the mental health psychotherapy, or for prescribing medications. A justice system social worker's motive is to see the client succeed and will gain or lose nothing if the client accepts services or not. In short, social workers are likely to witness the true reasons that a client does not utilize services.

Second, social workers will present a viewpoint of juvenile client's access to mental health services that has not been well represented in the literature as of this date. The majority of the research on barriers to mental health access and utilization present the viewpoints of clients, caregivers, or

mental health clinicians. Social workers, with an entirely different education and set of field experience, will have a different perspective. For example, a juvenile client and their caregiver may not be able to identify structural barriers to mental health services simply because they are not aware of the capacity at which services should be available. They may blame their own low income, not fully realizing that they are entitled to quality services. Social workers, usually keen resource experts, will be aware of what services should be available, and be competent reporters of any gaps in availability or functionality.

As presented earlier, it is estimated that less than half of juveniles entering the justice system in need of mental health services actually receive services. Therefore, the third reason that this study is important is the simple fact that all possible efforts must be undergone to increase the number of youth who receive mental health services on entering the justice system. Research has demonstrated that early mental health diagnosis and intervention for youth can lead to "...significantly reduced problems and significantly increased competencies and manifest improvements in several areas of adjustment" (US Department of Education, 2000, p. 73).

Significance of the Project for Social Work

This study will explore social workers' perceptions of the barriers to mental health service utilization among juvenile offenders. The results will potentially serve to help round out the literature on this topic, since the

perceptions of social workers have not frequently been documented and presented in the study of barriers and facilitators to mental health services. The results of this study will assist clinicians and social workers in identifying and implementing better solutions when addressing the issue of barriers when working with young clients in the justice setting. Social workers are able to improve the quality of the services they provide to juveniles in the justice system, when all the facets of barriers are understood from all angles. The perceptions of social workers, combined with the perceptions of clinicians, parents and caregivers, and juvenile clients will augment current understanding of how the barriers to mental health services for justice involved youth can be overcome, and possibly contribute to increasing facilitators to these services.

On a macro level, agencies, organizations, and communities may find the results of this study helpful in improving the accessibility and quality of mental health services for justice involved youth. This is true because social workers often serve as liaison between client and service organization, and are thereby aware of the challenges faced when connecting clients with resources. Last, this study will benefit the juveniles that come in contact with the justice system by increasing social workers' knowledge and understanding of these clients and the challenges faced by them. The goal is that this increased knowledge and understanding will lead to a reduction in barriers and

an expansion in facilitators to mental health services for juveniles in the justice setting.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter consists of an examination of the research relevant to the topic of barriers to and facilitators of mental health services among justice involved youth. The subsections will include mental health among justice-involved youth, and the barriers faced among adult, youth, and juvenile justice populations. The final subsection will examine Diathesis-Stress Theory, the Transtheoretical Model, and the Trauma-Informed Approach, which are relevant to this population.

Mental Health Needs of Justice Involved Youth

As much as 81% of the youth in the justice setting suffers from a diagnosable mental health problem (Whitted et al., 2013). Additionally, up to 40% of these juveniles suffer from a mental health condition, which would be considered severe (Kenny, Lennings, & Nelson, 2008; Mallett, 2009). Many of these diagnoses can be helped with medication, individual behavior therapy, family therapy, or a combination of these. Many factors play a role in a youth's need for these therapies. Poverty, substance abuse, racial and gender disparity, negative coping styles, and trauma are all found in the juvenile justice population.

Substance Abuse

According to SAMHSA, (2012) more than 60% of the juveniles in the justice system have a diagnosable substance use disorder. This is important to keep in mind when addressing justice involved youth, as effective mental health services must often address co-occurring substance abuse issues in order to be effective. Moreover, substance abuse and delinquency are related. Brunelle, Tremblay, Blanchette-Martin, Gendron, and Tessier (2014) sought to learn what percentage of youth presenting with substance abuse disorders might also have experienced problems with delinquency. The study sample includes the retrospective data gathered on 726 adolescents enrolled for addiction treatment in Quebec, Canada. The Addiction Severity Index is used to determine severity of each youth's substance use disorder, and only youths found to have reached a point in which treatment services are deemed necessary are included in the study. Results indicate that severity of addiction is associated with a greater incidence of delinquent activity (Brunelle, Tremblay, Blanchette-Martin, Gendron, & Tessier, 2014). Additionally, users of the more expensive drugs are found to have a greater delinquency (Brunelle et al., 2014). Greater use of alcohol and drugs is also found to be associated with a history of sexual abuse (Brunelle et al., 2014, p. 26). The authors caution that these results cannot determine cause-effect relationships. Nonetheless, this information is crucial in assessing and treating mental health in juveniles, because all of these factors impact the mental health of juveniles.

Socioeconomic, Racial and Gender Disparity

Poverty is experienced by many justice-involved youth. Boe, Overland, Lundervold, and Hysing (2012) conducted a study referred to as the Bergen Child Study, in which 5,871 Norwegian children aged 11 to 13 were studied for emotional problems, hyperactivity, conduct problems, and peer/social difficulties. Family poverty consistently and significantly predicted problems, and level of education of parents predicted externalizing such as ADHD and conduct disorder in their children (Boe, Overland, Lundervold, & Hysing, 2012).

Mennis et al. (2011) conducted a study that combined census data with juvenile records of delinquency and recidivism in Philadelphia to learn how juvenile crime rates in urban neighborhoods might be associated with the economic status of the juvenile's family. Findings indicate many aspects of socioeconomic status to be strongly related to juvenile delinquency, including the amount of vacant housing in a neighborhood, inner city locations, neighborhoods that are considered more socioeconomically disadvantaged, and neighborhoods with higher number of families on public assistance. Similarly, recidivism was associated with poverty and vacant housing. Moreover, there was a strong correlation found between recidivism rates and when the first arrest has a drug charge associated with it. Astonishingly, 90% of juvenile delinquency came from neighborhoods with the highest rates of poverty (Mennis et al., 2011).

Significant gender and ethnic disparities are evident among justice system youth. According to the Office of Juvenile Justice and Delinquency Prevention (2012c), arrest rates in the United States for males in 2010 were approximately 6,500 per 100,000 males aged 10 to 17, and females arrest rates were approximately 3,000 per 100,000 females aged 10 to 17. Similar disparities exist among racial and ethnic juvenile populations. In 2010 among juveniles aged 10 to 17, there were approximately 9,000 per 100,000 Black juveniles arrested, 4,000 per 100,000 Caucasian juveniles, just over 3,000 arrests per 100,000 American Indian juveniles, and just over 1,000 arrests per 100,000 that were Asian (OJJDP, 2012c).

Coping Styles

Research indicates that coping style plays a role in the behavior of justice involved youth. Ireland, Boustead, and Ireland (2005) conducted a study of 203 young offenders aged 15 to 21 that utilized a tool which broke coping methods down into four styles: emotional, avoidant, detached, and rational. Results demonstrated that emotional coping predicted increased overall psychological distress, and that avoidant coping reduced psychological distress. Interestingly, avoidant coping also predicted social dysfunction, and increased rational coping was associated with decreased depression (Ireland, Boustead, & Ireland, 2005)

Trauma

A shocking number of youth in the justice system have experienced trauma. Dierkhising et al. (2013) set out to describe the trauma and mental health histories of 658 juveniles recently involved in the justice system, using secondary data from the Core Data Set of the National Child Traumatic Stress Network. Findings illustrate that 80.6% of these juveniles displayed two symptoms of post-traumatic stress disorder (PTSD), over 60% had suffered a traumatic loss, 51.7% had a caregiver with a disability, 51.6% had lived in a home where domestic violence had taken place, 49.4% reported emotional abuse, and 38.6% reported various types of physical abuse. Significant differences between genders are identified in sex related traumas. Fifteen percent of boys versus 31.8% of girls reported sexual abuse, and 8.8% of boys versus 38.7% of girls reported sexual assault/rape. Age of onset is particularly alarming in this group. Over 33% had experienced trauma before the age of one, 62.14% of the group had experienced trauma by age five, and 90% had experienced two or more types of trauma overall. These results indicate a high level of stress from trauma endured by most juveniles in the justice system.

Barrier Studies on Adult Populations

Mojtabai et al. (2011) conducted the National Comorbidity Survey Replication, which consists of 9282 face-to-face interviews of adults in the United States between 2001 and 2003. Subjects considered any

self-perceived need for mental health services within the last 12 months. Data are also included from subjects stating that within the last year they felt a need for mental health services, but did not seek out and utilize services. Subjects stating they did see a provider answered the question as to whether the clinician terminated treatment, or if the subject dropped out of treatment prior to the clinician recommending them to stop. Subject's responses are categorized by low or self-perceived need for treatment, structural barriers to treatment, and attitudinal/evaluative barriers to treatment (Mojtabai et al., 2011). Subjects are evaluated and diagnosed using DSM-IV. Diagnoses are categorized by severity levels, which include low, moderate, and high levels.

Low perceived need was the largest reported barrier across all categories of diagnoses for individuals who did not seek services. Of subjects who did perceive a need for services, 97.4% reported attitudinal/evaluative reasons such as a desire to handle the problem on one's own, perceived ineffectiveness of services, stigma, and thinking the problem might resolve on its own for not seeking out services, and 22.2% reported structural barriers such as monetary reasons, availability, transportation, and convenience as explanations for not seeking services (Mojtabai et al., 2011).

Eight hundred and fifty-one subjects reported receiving treatment services within the last 12 months, of which 10.6% dropped out of these treatment services. The top reasons for dropping out of treatment are described as a desire to handle the problem on one's own, and perceiving that

one's mental health had improved. Over 97% of subjects who perceived a need for services reported a minimum of one barrier to services. Some socio-demographic correlations are that low perceived need for services is predicted by lower educational achievement (zero to 11th grade), sex (males more so than females), and severity of diagnosis. Race and marital status are the largest predictors of structural barriers, as Hispanic and single subject experience more such barriers (Mojtabai et al., 2011).

While some of the findings of this study may be difficult to compare to the juvenile justice population, the later findings in particular, are extremely relevant when it comes to identifying and pinpointing disparity among given populations. Though no direct study could be located pointing to the number of married versus unmarried individuals serviced in the juvenile justice system at a given time, one can assume that most or all juvenile individuals are single, and thus possibly more prone to structural barriers as depicted by Mojtabai et al. Additionally, the Hispanic population is represented at much higher rates in the justice setting according the Office of Juvenile Justice and Delinquency Prevention (2011). For every 100,000 females aged zero to 17 in the United States juvenile population, the rate of incarceration in the juvenile justice setting is 46 for Hispanic females and 38 for White females (OJJDP, 2011a). A greater disparity is reported among males with 350 Hispanic males for every 100,000 total juvenile males in the United States, as compared to 182 White males for every 100,000 total juvenile males (OJJDP, 2011b). With these

statistics in mind, it may be possible that greater structural barriers to services exist among clients within the juvenile justice setting.

Studies of General Population Adolescents

Smith, Linnemeyer, Scalise, and Hamilton (2013) investigated the barriers to mental health services among 46 youth inpatient clients at acute care facilities from the perspective of the youth's parent or guardian caregiver. Each youth possessed a history of having been given a prior referral to outpatient mental health services. Of the youth subjects, some had received referrals to multiple types of service providers, including individual therapy and family therapy. Nineteen percent of these youth have a history of having been in state custody, and 6.3% have a history of past or present foster care experience. Twenty-four percent are African American, 68% are White, five percent are Hispanic, and three percent are Asian. Both qualitative and quantitative methods are used in this study, employing the use of the Barriers to Treatment Participation Scale, parent version, and open-ended questions for the purpose of capturing new possible barrier information.

Quantitative results show that the most common barriers to treatment are the parent/caregiver's perceptions that the problem had improved, that treatment caused too much stress for the caregiver, or that treatment did not work. Qualitative results fell under three main categories; "treatment did not meet expectations, access issues, and family discord/crises (Smith, Linnemeyer, Scalise, & Hamilton, 2013, p. 82). Among the 10 subjects in the

first category, most caregivers expressed concerns regarding the need for more than just medication, needing inpatient treatment instead, or feeling unsure of the ability of the clinician to provide proper services. Eight caregivers reported access issues, of which six stated these issues to be an inability to obtain timely appointments with the correct mental health professionals. These responses included statements expressing a need for a greater span of available office hours of clinicians, an overall need for more clinicians, due to available appointments being too far in the future and a need for more localized services. The later category reflects an overall difficulty in setting appointments due to constant crises, or simply due to disagreement between parental dyads (Smith et al., 2013). There were three families whose answers reflected this later barrier. One limitation to this study is that only five percent of the sample identified as Hispanic, making the results less representative of the average juvenile justice subject.

Studies Focusing on Justice Involved Youth

There is scant research that is targeted directly and specifically on youth in the juvenile justice setting and the barriers to mental health services faced among them. Therefore, this study will review research conducted on community health care for youth in general, which are most often the same mental health services utilized by justice involved youth on release. This will be followed by the one juvenile justice specific study that was located in the research.

In an exhaustive study of the state mental health plans for all 50 states, Gould, Beals-Erickson, and Roberts (2011) sought to identify gaps and barriers in services for children. The authors accomplish this by obtaining each state's mental health plan, and then eliciting the perceptions of the each state's planning committee. These planning committees are comprised of both government and community stakeholders, including legislators and representatives of government bodies, representatives of the agencies who provide and regulate community mental health care, and the consumers who use the state mental health plans (Gould, Beals-Erickson, & Roberts, 2011). For the purpose of this study, input from the planning committee is first categorized as a gap or a barrier.

Forty-two state committees identified gaps in their children's mental health plans, 37 of which specifically identified a shortage of service providers (Gould et al., 2011). Twenty-five state committees pointed out a shortage of services for specialty populations, which include "...services for co-occurring mental health and substance abuse disorders, services for those with developmental disabilities, and those within the juvenile justice system..." (Gould et al., 2011, p. 771). Additional identified gaps are services for youth in transition to adulthood by 20 states, inpatient services by 12 states, crisis services by 11 states, and both community and juvenile justice services by 11 states (Gould et al., 2011). A limitation of this study is that it cannot be ascertained if California was among the states specifically citing gaps in

services for juvenile justice youth. Nevertheless, this articulates that these gaps are nation-wide, and should be investigated as possibly existing in any setting.

Forty-five state committees identified barriers in children's mental health services. Included among these are funding shortages by 26 states, transportation shortages by 23 states, unorganized systems of care by 23 states, stigma by 18 states, and overly rigid eligibility standards by 13 states (Gould et al., 2011).

These identified gaps and barriers do appear to match up with the gaps and barriers identified through the perceptions of clients and professionals in the studies examined thus far in this review. Next, the community-based clinician's point of view will be examined, to be followed by the views of young juvenile system clients. This will provide viewpoints not expressed by the state planning committees, and will either dispute or validate those viewpoints.

Gearing, Schwalbe, and Short (2012) explore the viewpoints of clinicians serving youth in four separate outpatient community-based mental health clinics in New York, regarding the barriers and facilitators to youth adherence to psychosocial treatment plans. Thirty-four clinicians currently working in direct practice with youth to provide psychosocial services formed three focus groups which met for up to two hours each. Among the 34 subjects, four are social work interns, one is a doctoral level psychiatrist, and

29 are clinical social workers. Semi-structured interviews with open-ended questions are detailed.

Among the clientele at the four clinics, approximately 55% are involuntary, six percent of which reportedly drop out of treatment prior to completion. Forty-five percent are voluntary, 27% of which reportedly drop out of treatment prior to completion (Gearing, Schwalbe, & Short, 2012). Subjects were asked to assess barriers and facilitators to adherence in four domains: a) the adolescent, b) the caregivers/parents, c) the clinician, and d) the agency. Barriers and facilitators are then categorized within each domain, to an extent that exceeds the scope of this review.

In short, clinicians perceived more barriers and less facilitative factors within the adolescent and parental domains, and more facilitators and less barriers within the clinician and agency domains. Some highlights of the adolescent and parental domains are that client motivation for change and expectation of treatment can be both a barrier and facilitator, scheduling conflicts with adolescent's schedule can be a barrier, parental understanding and/or agreement with therapy can be both a barrier and/or a facilitator, and parental health/stress and stigma can be a barriers in the parental domain (Gearing et al., 2012).

Highlights from the clinician and agency domain are that clinicians sited specific techniques, skills, and therapeutic alliances aimed at both adolescents and parents as facilitators, financial, scheduling, procedural, and technological

barriers are cited at the agency level, and agency facilitators are identified as requiring familial participation in therapy, accessible location, and the offering of incentives to clients (Gearing et al., 2012). Clinicians reported that many clients expressed a need for extended hours or days of operation due to scheduling conflicts. Moreover, clinicians conveyed that to combine services together makes them non-reimbursable by insurance. This highlights a continually identified barrier by both caregivers and professionals of juvenile clients, and perhaps points out a needed change in community mental health care. A limitation of some of the aforementioned studies is that they commonly contain the opinions of only one member of a treatment trio, which in this realm would consist of youth patient, their caregiver, and the clinician.

In an effort to capture all three of the afore mentioned perspectives, Baker-Ericzen, Jenkins, and Haine-Schlagel (2013) conducted research involving the perspectives of 26 therapists and 14 adult caregivers, revolving around services for 10 youth clients with disruptive behavior problems (DBP). This study is highly relevant and perhaps quite generalizable to juvenile justice clientele because the subjects were gathered from publicly funded community child mental health clinics in Southern California, and the DBP's the youth were diagnosed with consist of "...oppositional defiant, aggressive, and/or delinquent behavior..." (Baker-Ericzen, Jenkins, & Haine-Schlagel, 2013, p. 856). These are the same outpatient clinics that juvenile justice clients might be referred to on release into the community. Qualitative methods are

employed, using semi-structured, open-ended questions geared towards eliciting a detailed subjective response of the subject's experience.

Participants answered questions about their experiences with community-based mental services, problems encountered, and possible methods to improve services.

The therapists' perspectives reveal three distinct categories of barriers. First, many community mental health therapists report feeling overwhelmed by the complexity of needs among many families seeking treatment. Second, therapists perceived a lack of willingness and involvement from parents. Finally, therapists reported a "...lack of formal service system support as interfering with meeting families' needs and maximizing service delivery" (Baker-Ericzen et al., 2013, p. 860).

Therapists made statements about their frustration in having to refer a parent to another therapist in order to get help for the parent, making multiple appointments and travelling for services difficult for already struggling families. Some therapists thought in-home services for the entire family would be beneficial.

Parents reported feeling often overwhelmed by their child's symptoms, perceiving a lack of support from service systems, perceiving blame or being ignored by their child's therapist, and an overall dissatisfaction with treatment services.

The most profound results are found in the answers of the youth who stated they wanted more active involvement from parents in therapy sessions, and they felt an overall dissatisfaction with services. Many youth reported their parents to be constantly over-stressed, and that helping the parents would be an important part of therapy. These findings indicate a need to investigate the possible benefits of moving toward a holistic, whole family approach for community-based mental health service providers, which may provide a better forum for addressing and treating the needs of the entire family system, rather than the child alone.

One study is identified among the literature solely soliciting the perspectives of juvenile justice clients by Abram, Paskar, Washburn, and Teplin (2008), which surveyed juveniles detained in Chicago in the Cook County Juvenile Temporary Detention Center between November 1995 to June 1998. During this time period, 2275 names were randomly selected. The final sample consists of 1,829 juveniles and is stratified by race/ethnicity, age, and legal status, and consists of 1172 males and 657 females. Face-to-face, structured interviews are used, each lasting approximately two hours. Interviewers completed a month of training and are at minimum, master-level degree holders. Mental health diagnoses were made using the Diagnostic Interview Schedule for Children, version 2.3.

Results indicate that 56.3% of boys and 64.2% of girls believed that the problem will go away on its own, 31.7% of boys and 40.4% of girls feel unsure

where the right place to get help is, 19.1% of boys and 16.5% of girls feel that getting help was too difficult, 16.4% of boys and 17.8% of girls worry what others might think, and 13.2% of boys and 12.1% of girls express concern about involved costs (Abram, Paskar, Washburn, & Teplin, 2008).

These results indicate a great need to initiate comprehensive and pervasive education at the youth level, regarding mental health treatment and outcomes. Additionally, efforts to reduce stigma, overcome barriers, and provide facilitators such as increased office hours and availability of services need to be addressed in the community mental health care setting.

Theories Guiding Conceptualization

Three theories used to conceptualize the ideas in this study are the Diathesis-Stress Model, the Transtheoretical Model, and the Trauma-Informed Approach.

In the Diathesis-Stress Model, Coyne and Downey (1991) outline how stress and genetic propensity combine to increase the incidence of mental health diagnoses in certain populations. It is asserted by Coyne and Downey, that one's psychological characteristics, in combination with one's social environment, are the mediators for the impact of stressful life events on an individual's well-being. The diathesis portion of the model recognizes the role that genetic predisposition might play in mental illness, and the stress portion of the model highlights the important roles of social support, individual coping, and violence or victimization in the mental health process. As outlined in prior

sections of this paper, juvenile justice youth experience greater social pressures including economic and trauma influenced pressures, as compared to general population youth.

The Transtheoretical Model as outlined by Velicer, Prochaska, Fava, Norman, and Redding (1998), provides a framework for understanding the decision-making stages of individuals, as these decisions apply to the change process of behavior. The passage of time is a critical component of the Transtheoretical Model, and is illustrated through the use of five stages. The stages are precontemplation, contemplation, preparation, action, and maintenance (Velicer, Prochaska, Fava, Norman, & Redding, 1998). A key element to look at within each stage is an individual's level of intention to change. These stages can last for up to six months, with individuals at each stage displaying different levels of desire and ability to change. The most powerful assertion of this model is that people can be guided toward making personal decisions for meaningful change no matter what stage of change they are currently functioning at (Velicer et al., 1998).

This theory helps to frame the process that a juvenile's thinking might enter into as he or she realizes that there is a problem, which needs to be addressed with perhaps extensive action. Additionally, it increases understanding of why some juveniles are more open to mental health services than others. Coming to terms with the need for mental health services is simply a process that takes time.

Due to the high numbers of juvenile justice youth who suffer from childhood trauma, the Trauma-Informed Approach is a valuable tool in the justice setting. Under the trauma-informed approach, it is first understood that the traumatized individual's brain may have a different reaction pattern as compared to a non-traumatized individual. Griffin, Germain, and Wilkerson (2012) outline a trauma-informed approach specifically for use in the justice setting. The authors offer three elements which are crucial to utilizing this approach in the juvenile justice setting: a) for justice involved juveniles, mental health assessment must include measurement of traumatic events and symptoms, b) "evidence-based, trauma-focused treatment..." must take place whenever a juvenile in custody demonstrates trauma symptoms, and c) diagnosing clinicians involved with justice youth must first consider trauma and its impact prior to making a mental health diagnosis (Griffin, Germain, & Wilkerson, 2012, p. 277). Griffin et al. additionally posit that a trauma-informed approach is superior to the mental health model in the justice setting because of its focus on safety and self-regulatory skills, rather than labeling and medicating symptoms. While medications may be necessary for traumatized youth, trauma-informed therapy would likely involved Cognitive Behavioral Therapy (CBT) interventions with an emphasis on aiding youth to better understand what is triggering their behaviors and regularly practicing new responses (Griffin et al., 2012).

Summary

This study explored the barriers and facilitators to mental health services among juvenile justice youth as perceived by social workers serving youth in the justice system. The mental health needs of juvenile justice youth are great. There have been many policy, agency, and organizational changes to accommodate this great need. Nonetheless, there are still many justice-involved youth who do not utilize or adhere to the mental health services that are available, and the barriers and facilitators to these services have been identified in the literature. Diathesis-Stress Model, Transtheoretical Model, and Trauma-Informed Approaches help professionals in the justice setting to better understand and help this population. This study sought to add the social workers perception to the literature, and explored solutions for improved service utilization.

CHAPTER THREE

METHODS

Introduction

This study sought to describe the barriers to and facilitators of mental health services among justice involved youth, and additionally sought to identify mechanisms to overcome barriers and expand facilitators to services. This chapter contains the details of how this study was carried out. The sections discussed will be study design, sampling, data collection and instruments, procedures, protection of human subjects, and data analysis

Study Design

The objective of this study is to identify and describe the barriers to and facilitators of mental health service usage among the juvenile justice population in San Bernardino County, and to explore avenues to overcome them. This is an exploratory research project, due to the limited amount of research that addresses this topic from the perspective of social workers. Since the professional viewpoints and impressions of the social workers may unveil aspects of the topic not described in other research, this is a qualitative study, and utilizes focus groups with open-ended questions as the tool through which to collect data from subjects.

A strong point in using an exploratory, qualitative approach with focus groups is that participants are allowed to add their own personal experiences

to their answers, rather than being restricted to a limited range of answers. Since the social worker perspective has not often been solicited in prior research, this will allow participants to identify new barriers or facilitators, as well as to provide new details, observations, and insights about barriers and facilitators which have been identified by clients and therapists in past research. The focus group will allow participants to build on one another's knowledge, and provide rich, detailed explanations.

A limitation of using focus groups is that by nature, they are more intrusive and less anonymous than surveys, as each participant must give his or her answers in front of a live interviewer and other group members. This may cause participants to answer the way they feel the interviewer or peers might want them to answer, or to withhold answers they might feel uncomfortable about sharing. Another limitation is that focus groups usually require more skills and training to administer, as compared to surveys, which require little training and experience to administer. Last, it must be mentioned that qualitative data cannot be used in determining causality. Therefore the findings of this study are not intended to define any causal relationships between the themes that were unveiled and the nature of mental illness.

This study seeks to answer three basic questions regarding juvenile justice youth: 1) What are the barriers to mental health service utilization? 2) What are the facilitators of mental health service utilization? 3) What can be done to overcome these barriers and augment these facilitators?

Sampling

The purpose of this study is to gain knowledge of barriers and facilitators of mental health services for justice involved youth in San Bernardino County. Therefore this study utilized a non-random purposive sample of social work staff serving juvenile justice clients in the San Bernardino area. These social workers were from the San Bernardino County Public Defender's Office, and from the Department of Behavioral Health's Juvenile Justice Community Reentry program. Approval was sought and granted from the supervisors of each of these agencies. There were a total of 15 subjects participating in three focus groups, with three to seven participants in each focus group. Subjects consisted of four interns and eleven employees. As far as highest achieved educational level, five were bachelor degree holders, nine were master degree holders, and one subject held a doctoral degree. The sample members represent a variety of ages from 23 to 64, with the median age being 45. There were four males and 11 females. Five subjects identified as Caucasian, five as African American or Black, four as Hispanic or Latino, and one as Middle Eastern. Years of experience in current field ranged from two months to 26 years, with a median of seven years experience in current field.

Data Collection and Instruments

Qualitative data was collected via live, audio-recorded focus groups taking place in May 2014. Each focus group began with an introduction and

description of the study and its purpose. Demographic information was collected prior to the start of each focus group (see appendix D). This information consisted of age, gender identification, ethnicity identification, achieved education level, number of years in current practice/field, and whether the subject was an intern or employee.

The researcher conducted each focus group using procedures as outlined in the focus group guideline sheet in Appendix A. The focus group guideline sheet is a tool developed specifically for this study, for the purpose of eliciting the subjective experiences and unique insights of social workers. The tool and procedures were developed with the collaborative assistance of Dr. Janet Chang.

The focus group guideline breaks barriers and facilitators to mental health services down into three domains. The concept of domains were adapted from the domains used in Gearing et al. (2012). The domains are individual barriers and facilitators, community/environmental barriers and facilitators, and agency/organizational barriers and facilitators. Each of the three sections contains a list of examples of barriers and facilitators that fall under that category. Participants were asked to describe their experiences with those barriers and facilitators, and to describe any others that may fit into that domain. Themes that surface were documented on two flip charts, one for barriers and another for facilitators. Then, participants were asked for their

ideas on overcoming these barriers and expanding these facilitators. These themes were documented on another flip chart.

The researcher employed the use of additional stimulus or probing questions, and furthering responses depending on the responses given by participants. The researcher took steps during each focus group to ensure that all members' voices were heard and to keep the more dominant and vocal personalities from skewing results.

Procedures

A flier was created describing the purpose and goals of the study, as well as the need for participants. Three proposed dates and two different time slots for upcoming focus groups were posted on the flier. The researcher was granted a time slot to explain the study and to address questions of potential participants during regular staff meetings of the social workers at the public defender's office, and of social workers at the juvenile justice reentry program. Fliers were distributed at this time, as well as a sign-up sheet. Participants were asked to either use the sign-up sheet, or to RSVP their intent to attend a focus group date via email or phone call. Participants were allowed to select the focus group date and time that best suited their schedule.

Conference rooms were reserved for two of the focus groups at the One Stop Transitional Age Youth (TAY) Center in San Bernardino, and one conference room was reserved at the public defender's office for the third focus group. One focus group was set for a morning time slot and two were

set for afternoon time slots in order to allow a variety of choices. Each focus group lasted approximately one and one half hours, and consisted of three to seven participants per group. The focus groups took place on May 19, 20, and 21, 2014.

The researcher arrived thirty minutes prior to each focus group to set up equipment, refreshments, tables and chairs, and sign-in sheets. As participants arrived, each was asked to sign in and take a nametag with an assigned participant number on it. The participant number was logged on the sign-in sheet. Participants were then each given a packet containing the demographic and consent forms to read and fill out. Each participant was then given a \$10 gift card in appreciation of their contribution to this study. After a brief meet and greet, confidentiality was discussed and the signed demographic and consent forms were collected. Participants were thanked and the study was introduced. The audio recording device was then turned on and the focus groups began. At the close of each focus group, participants were again thanked and a debriefing statement was read and handed out to each.

Protection of Human Subjects

The identity of the focus group members was kept completely confidential from individuals outside of each focus group. Separate sign-in sheets were used for each group, and were kept in a locked desk. Focus groups occurred in private conference rooms behind closed doors.

Nonetheless, it was explained to participants that their confidentiality and anonymity is limited due to the nature of focus groups. Participants were instructed not to mention names, but rather to use the participant number as displayed on each person's nametag during the recorded focus group conversations. Participants each read and signed an informed consent (see Appendix B) prior to participating in the focus group, as well as consent to be audio recorded. Participants were given a debriefing statement (see Appendix C) on conclusion of each focus group. The audio recordings were stored on a USB drive and kept in a locked desk. Each participant's number was assigned a color-code which was used in transcribing the data, so that there was no information on the transcribed and printed data that could identify any participant. All sign-in sheets and the color-code key were kept in a locked desk. One year after completion of the study, the audio recordings, sign-in sheets, and color-code keys were deleted from the USB drive.

Data Analysis

All data gathered in the focus groups were analyzed with qualitative techniques. First, audio recordings of the focus groups were transcribed into written form. Individual participants were each assigned an individual code and a group code to be used while transcribing for the purpose of differentiating the comments of the various speakers. All supporting or opposing utterances and comments were documented on the transcription. One and two word statements such as "Uh hu" and "You're right" are not counted in the overall

total number of statements, but are documented in the transcription and mentioned when substantial in the findings that follow. Head nodding in agreement was also documented on the flip charts and will be described where applicable.

All statements were first sorted into either individual, environmental, or agency/organizational domains. Under each domain, statements were then categorized as being about barriers, facilitators, or suggestions for change. Major themes and sub-themes were identified under each category and assigned a code and the codes were logged onto a master code list. The researcher read, and reread transcripts to be certain of themes and sub-themes assigned. Individual statements were then assigned under their corresponding category and entered into an excel document under their assigned code. Frequencies and proportions were each ran for all comments relating to barrier, facilitator, and suggestions for change.

Summary

This study examined barriers to and facilitators of mental health services use among justice involved youth, and explored methods to overcome barriers and expand facilitators. The focus groups actively invited the subjective and unique viewpoints of social workers, and were intended to highlight the avenues toward providing mental health services to more justice involved youth. The qualitative methods used in this study best facilitated this process.

CHAPTER FOUR

RESULTS

Introduction

Included in this chapter is a presentation of the results from the transcribed and coded data derived from the focus groups. The domains and categories in which these statements are assigned are defined and outlined. Major themes and sub-themes are grouped and quantified. Direct quotes from participants are used to bring the meaning of each theme to light and to lend support and further describe the points in which participants sought to make clear.

Presentation of the Findings

The categories of barriers, facilitators, and suggestions for change are introduced with a discussion of the statements that fall under each. Major themes and sub-themes in each category are outlined. Table 1 shows the total number of statements in each domain and category. Figure 1 shows the proportion of statements by each domain.

Table 1. Statements by Domain and Category

Category	Domain #1: Individual Factors	Domain #2: Environmental Factors	Domain #3 Agency/ Organization Factors	Totals
Barriers	60	75	102	237
Facilitators	8	33	35	76
Suggestions for Change	28	45	87	160
Totals	96	153	224	473

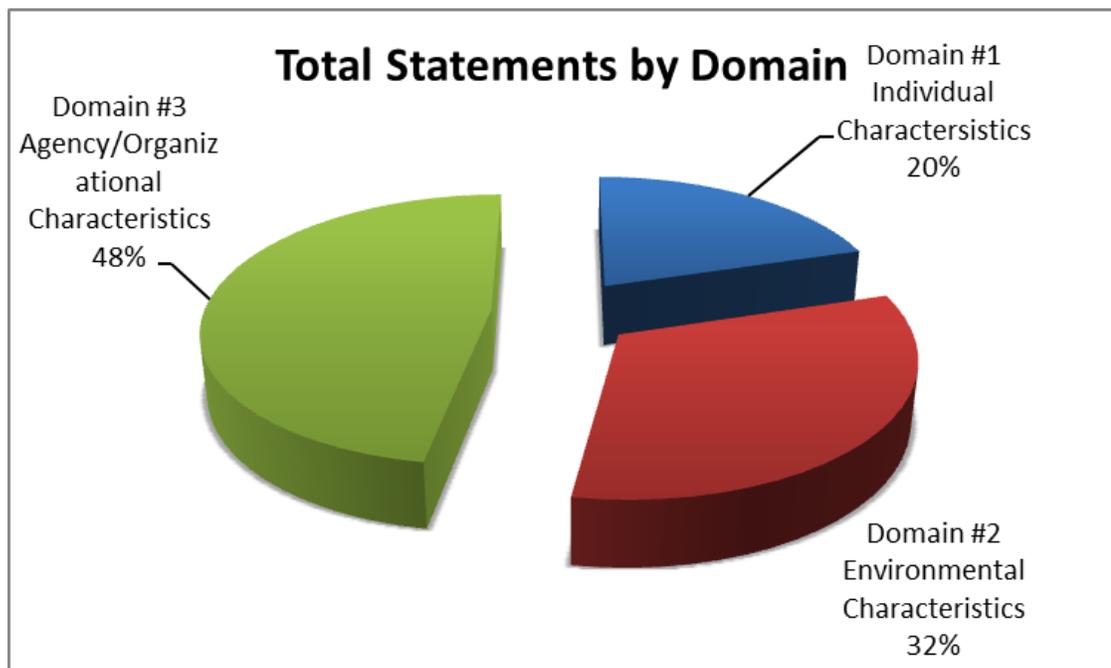


Figure 1. Proportion of Total Statements by Domain

Table 2. Barriers by Domain, Theme, and Sub-Themes:

Domain #1: Individual Barriers (60 total)	
Stigma	(17)
Denial/Low Motivation	(17)
Don't Trust System	(18)
Drug Use	(8)
Domain #2: Environmental Barriers (75 total)	
Gang Involvement	(5)
Severe Poverty	(25)
Familial Resistance	(32)
Cultural/Religious Beliefs	(13)
Domain #3: Agency/Organizational Barriers (102 total)	
Quality of service (59)	
Untrained Staff	(12)
Impacted Services	(17)
Lack of Collaboration	(4)
Lack of Follow-up/Extended treatment	(21)
Too Much Red Tape	(5)
Punitive Systems (29)	
Punitive Schools	(12)
Probation/Law Enforcement/Courts	(17)
Services Controlled by Funding & Target Pops	(14)
Barrier Totals	237

Barriers

Barriers are anything that impedes a justice youth in seeking or using mental health services. Two hundred and thirty-seven statements were

identified as barriers. Barrier statements were then sorted into the three domains as follows: Domain #1, individual barriers (n = 60); Domain #2, environmental barriers (n = 75); Domain #3, agency/organizational barriers (n = 102). Table 2 shows the barriers by domain, theme, and sub-theme.

Domain #1: Individual Barriers

Individual barriers are characteristics or beliefs of the youth that impede them from seeking or using mental health services. Four major themes emerge under the domain of individual barriers. They are stigma (n = 17 statements), denial/low motivation (n = 17), lack of trust in the system (n = 18), and drug use (n = 8).

Many statements under the theme of stigma cited labeling as a major concern of justice involved youth, such as Participant 2, who stated, “I think that youth admitting they have some type of mental health issue is...can be embarrassing. They can get picked on” (Focus Group, May 2014). Or as described by Participant 12, “They don’t want to be perceived as weak or vulnerable or needy” (Focus Group, May 2014).

Also under the theme of stigma, four statements are made indicating how youth tend to ascribe blame of normal emotions to their mental health diagnosis out of misunderstanding of what symptoms might belong to the diagnosis, and what symptoms might belong to any normal human being. An example of this is made by Participant 8, who stated:

Well, why do you do this? I'm bipolar. Its not that they are looking for an excuse, but someone has...a lot of people have labeled them, so they just kind of accept that label, and it is utilized to kind of, but not really to excuse the behavior. (Focus Group, May 2014)

These types of statements represent a general lack of understanding of what a mental health diagnosis means and illustrate from the consumer's standpoint, two major issues: 1) Fear of being diagnosed, and 2) What to do with a diagnosis once one is given. Four statements are made regarding reluctance/avoidance of medications due to stigma, such as "No, I don't want to go to group because all they'll want to do is put me on medication" (Participant 10, Focus Group, May 2014).

A total of 17 statements focused on denial or low motivation on the part of justice youth. As one participant states, "They really don't want to deal with it, like, nothing is wrong with me kind of attitude" (Participant 15, Focus Group, May 2014), or "Yeah, most kids think they don't have issues, like they are indestructible" (Participant 8, Focus Group, May 2014). Another participant stated, [speaking of youth]"...just not motivated because they really just don't want to do the work" (Participant 2, Focus Group, May 2014). Low motivation appeared as a common theme in all three focus groups, as one participant put it, "Just being a teenager is a barrier in itself" (Participant 8, Focus Group, May 2014).

Another theme was lack of trust in systems of care (n = 18 statements), with discussion occurring in all three focus groups. There were two types of these statements. First, there were six statements that infer a lack of trust in the system from juveniles who have not directly had contact with the system. Some may have had a sibling or other family member who has had negative contact with systems of care, which is made clear in Participant 14's statement, "Let's say a family that has brothers in prison, the minute an officer approaches a younger kid they are going to think, 'oh they are going to send me to prison too'" (Focus Group, May 2014).

There were 13 of the second type of statement that indicate lack of trust in the system due to youth having directly had a negative experience with systems of care. This was illustrated well by Participant 4 who stated:

And I think (inaudible) you know, you'll have that kind of history of having bad experiences in the system. So the parents kind of continue that...the...I don't know how to describe it. Like they just fight with the schools, they fight with the...so, they're in an adversarial relationship with most of the systems. (Focus Group, May 2014).

Also Participant 3 stated "They've had experiences with many service providers, like too many, too many people coming and going from their lives" (Focus Group, May 2014). Participant 2 directly added to this, "And they keep repeating the same story again and again, over and over..." (Focus Group, May 2014). Many focus group members nodded and commented during these

statements, indicating agreement. Participant 11 stated virtually the same thing in another focus group, “A lot of these kids have been in the mental health system and they’ve seen so many different therapists, or so many helpers that they are done at that point. Nobody has helped me” (Focus Group, May 2014).

The final theme under individual barriers was drug usage (n = 8 statements). Some statements indicated the belief that drugs are not a problem such as indicated in this comment about marijuana, “I’m gonna put that out there as the main [barrier] because there is pretty much a perception that it is not a problem” (Participant 4, Focus Group, May 2014). Participant 5 added to this, “Well, especially with the push for legalization” (Focus Group, May 2014). Five statements reflect that youth feel drugs work better than medications to reduce symptoms, as illustrated by, “...their experience may even be that marijuana works better for their anxiety than the pills they have been given” (Participant 4, Focus Group, May 2014), and “Yeah, drugs work for them. Uh, some of our kids with PTSD, but they need those symptoms to stay alive...it works for them in terms of survival” (Participant 8, Focus Group, May 2014).

Domain #2: Environmental Barriers

Environmental barriers were defined as characteristics or aspects of the justice youth’s surroundings that impede the youth in seeking or using mental health services. There were 75 comments in which four major themes were

identified. The four major themes were: gang involvement (n = 5 statements), severe poverty (n = 25), familial resistance (n = 32), and cultural/religious belief systems (n = 13).

There were six comments from one focus group identifying gang involvement as being a barrier to mental health utilization among justice youth. Participant 6 stated, “Sometimes they are gang members, then their environment does not allow them to exit...it’s gonna be hard for them to leave the gang because maybe their brother or sister or father are members too” (Focus Group, May 2014).

Twenty-five statements across all three focus groups identified poverty as a major challenge for justice youth and their families. As one focus group participant put it, “You cannot address mental health issues when families are in poverty and don’t have their basic needs being met” (Participant 8, Focus Group, May 2014), another participant added, “And if you look at poverty, I mean there are so many things with that. They don’t have transportation or insurance” (Participant 11, Focus Group, May 2014). Another focus group member described why mental health issues are often not addressed when families are living in poverty:

So like there’s a hierarchy of needs, and treatment is last. It’s not a priority when you can’t feed your kids. And it goes back to your crisis, and so often families that are like this are in constant crisis, so treatment is not a priority. (Participant 4, Focus Group, May 2014)

Four statements cited community poverty as contributing to individual and familial poverty as well.

Thirty-two statements across all three focus groups identified familial/parental resistance as barriers. Some statements focus on parents not wanting services to come into their home as exemplified by Participant 2 stating “Or that parents don’t want them to get treatment cause they might...someone might find out what’s going on in the home” (Focus Group, May 2014). Participant 5 added to this, “Well, sometimes they’re using, sometimes they’re dealing” (Focus Group, May 2014). Another statement reflects lack of involvement from parents, “...parents don’t wanna do the work that they need to do” (Participant 4, Focus Group, May 2014).

Other statements reflected extreme familial dysfunction, as exemplified by, “...they can be incarcerated in the hall, get services, maybe become stabilized, but then go back to the same environment. So you are always playing catch-up or starting over” (Participant 7, Focus Group, May 2014). Participant 8 put it into further perspective:

If you look at it with systems perspective they like homeostasis, so everybody has their place. You have the identified patient, you have...you know if everybody’s got their roles, and then somebody tries to step out of it by becoming sober or getting mental health it throws the whole family off. (Focus Group, May 2014).

These statements reflected a challenge in providing mental health services focused on the youth only, as well as focused on treating the whole family.

The final theme identified under environmental barriers was cultural/religious belief systems in which there were 13 statements across all three focus groups. Three statements spoke of how religion can interfere with willingness to take medications as indicated by Participant 15 who stated, “Some religious groups, they don’t believe in medications and stuff” (Focus Group, May 2014). Ten comments focused on cultural aspects such as “In some cultures they don’t really recognize certain things as mental health issues” (Participant 15, Focus Group, May 2014). Speaking of culture Participant 10 stated, “...So they may not say I’m depressed, they might say I have a tummy ache or I have a head ache” (Focus Group, May 2014). Another participant talked about how some cultures have a tendency to attribute symptoms to other things, “I’ve seen a number of times with Asians too, there is no admission or acknowledgement of mental illness. Oh they are just acting out...anything but to admit” (Participant 7, Focus Group, May 2014).

Domain #3: Agency/Organizational Barriers

Agency or organizational barriers are characteristics that impede service usage by juvenile justice clients that can be attributed to agencies and organizations. Three major themes emerged within the 102 barriers statements. The first major theme was quality of services (n = 59 statements),

the second was overly punitive systems (n = 29), and the third was services controlled by funding (n = 14).

Five sub-themes were identified under the major theme quality of services. The first sub-theme contained 12 statements and concentrated on lack of training among clinicians and other workers.

Five statements cited cultural competence or racial bias as a barrier to treatment, as Participant 8 stated, "...young kids who are African American get more severe mental health diagnoses. Yes, it's true if you look at the research. So they are disproportionately given more severe mental health diagnoses" (Focus Group, May 2014). Other participants were quick to add to this statement about how these severe diagnoses can then get a youth locked out of certain services later on. The other seven statements in this sub-theme concentrated on lack of training on current clinical interventions and lack of training on trauma and its symptoms. Participant 8 summed up all statements in this sub-theme well in these next two statements, "From a clinical standpoint, is we're not provided enough training on up to date clinical interventions and new research. You know, new evidence-based...we don't get a lot of that" (Focus Group, May 2014). This participant goes on to say:

Like the whole trauma thing is starting to come around. Focusing on trauma and treatment like TICBT [Trauma Informed Cognitive-Behavioral Therapy] and so now here we are starting to do

this a little more cause all our families are traumatized. All of them. All our kids, all our families. (Participant 8, Focus Group, May 2014).

Another sub-theme identified under quality of services was impacted, overburdened service systems, which includes 17 statements. All three focus groups contributed statements to this sub-theme. Twelve statements in this sub-theme concentrated on the effect of impacted systems on the consumer. Participant 10 talked about the challenges of getting an appointment, “I want to look at client caseloads, cause that’s a huge issue in receiving mental health services...they can’t see their clients regularly enough” (Focus Group, May 2014). Another participant added to this, “I’ve seen it if the client is not in immediate crisis, then they are not really a priority and they are not going to get the services they need” (Participant 11, Focus Group, May 2014). Another focus group talked about the frustration of getting an appointment, “You can also be on a wait list for several months” (Participant 2, Focus Group, May 2014), and another appointment related comment, “...evening hours are non-existent at this point for most programs. Most things shut off at 5:00” (Participant 4, Focus Group, May 2014). Another participant spoke of how bad waiting lists can be for youth, “I had a homeless kid have to call TAY every two weeks just to remain on the waiting list...without services. Meanwhile they’re living in a ditch” (Participant 12, Focus Group, May 2014). In two focus groups there was multiple heads nodding, commenting, and elevated conversation when the topic of appointment availability arose.

The other five statements in this sub-theme focused on how impacted systems affect clinicians, leading to burnout. Participant 14 pointed out, “Service providers are burned out by caseloads, long hours, and bad relationships with managers or coworkers” (Focus Group, May 2014). In another focus group it was stated, “With all the limitations and the constant kind of changes and stuff, there’s also employee burnout. And the burnout factor is pretty big” (Participant 7, Focus Group, May 2014). Another participant added, “The therapist could offer better quality when he is not stressed than if he is overloaded” (Participant 6, Focus Group, May 2014).

The third sub-theme under the theme of quality of resources was lack of interagency collaboration, in which there were four comments occurring in two different focus groups. Participant 13 spoke on lack of collaboration between agencies, “The reason you don’t see any results is because you have one doing this, and the other doing this, and if they were just to come together it would be much better” (Focus Group, May 2014), another participant added here, “Everyone has their own goal” (Participant 14, Focus Group, May 2014).

Another sub-theme in the theme of quality of services was about lack of follow up and the dependence upon short-term treatment models. This conversation occurred in one focus group, but received exuberant participation from almost all members, making up 21 statements in all. As one participant pointed out, “We get kids outside juvenile hall phase 2 and really don’t follow the kids to see what he is doing, is he getting better, or is he back to crime”

(Participant 6, Focus Group, May 2014). This statement spurred several comments about lack of outcome reporting and follow-up for juvenile justice clients. Short-term treatment models were seen as a barrier, as depicted by Participant 4:

Short-term treatment models are like a barrier. So you have lack of consistency, for somebody who is a really high need of mental health issue, rather than being able to say 'we are going to hold onto this kid and help for a while. We do three to six months and if they still need help, which most likely they do, we are going to refer them to another program. (Focus Group, May 2014)

The final sub-theme in the major theme quality of services was too much red tape, which received five statements. This sub-theme occurred in one focus group. Participant 4 summed it up well:

Too many different referral streams, and everybody has a point in which they can say "no". Certain providers don't like...they don't like kids on probation, or don't like kids with criminal behavior. So there's a lot of referral points, and at any point they can be turned down because of their criminal history. (Focus Group, May 2014)

After this comment, another participant asserted, "Yeah, they are very contradictory" (Participant 7, Focus Group, May 2014).

The second major theme under the domain three barriers category was punitive systems, which received n = 29 comments spanning across all three

focus groups. There were two sub-themes identified in this theme. They were punitive schools (n = 12), punitive law enforcement, probation, and court systems (n = 17).

Conversations occurred in two focus groups in the sub-theme of punitive schools. Participant 14 stated, “Well I think one thing with schools too, that instead of dealing with the problem, they will just suspend the student” (Focus Group, May 2014). Another participant added, “Some clients...we’ve had suspensions and then find out they have some mental health problems that haven’t been addressed that result in acting out or anger” (Participant 13, Focus Group, May 2014). Another participant inserted here, “I think also that the fact is, the schools, they stigmatize the children” (Participant 15, Focus Group, May 2014). In another focus group, participants talked about regulations that local schools may not be following. Participant 11 described it well:

The schools are very punitive. Nobody really knows this, but there was a law that went into effect in January for middle and high schoolers, you need to...that is the school needs to provide three interventions before they can suspend. They do not do that. These kids get suspended every day. (Focus Group, May 2014)

While this statement was being made, Participant 9 (Focus Group, May 2014) was chiming in with “Yes” and “Daily!” Participant 8 inserted, “They should at least follow federal regulations” (Focus Group, May 2014), which Participant

11 corrected to, “They should follow the laws exactly!” (Focus Group, May 2014).

The second sub-theme under the major theme of punitive systems was punitive probation, law enforcement, and courts, with $n = 17$ statements in two different focus groups. Participant 6 brought up the topic of probation officers who are too punitive to juvenile hall clients stating, “Like one employee, he’s rough on the kids and he gives them penalty and he is literally mean. He is making it harder for the kids to move to phase 2” (Focus Group, May 2014).

Participant 5 explained it in more detail:

The kids can only do what the PO will pay for and let them do. I can refer them, I can link them, but there’s only one person who can approve it and that’s the PO. Some of them are marvelous, and others are just punitive. I mean probation by its very nature is punitive. Do this or else. (Focus Group, May 2014)

Lots of head nodding and multiple comments were made as this group spoke of the punitive culture of probation officers who deal with youth.

Focus group two spoke of punitive law enforcement and court systems with $n = 6$ comments. Participant 8 explained:

There’s a lot of kids with mental health issues who are being put in juvenile hall as criminals. Like who threw a chair at a special ed teacher, and they’re arrested and booked at juvenile hall. I had an eight

year old who actually got booked and put into a little jump suit. (Focus Group, May 2014)

Participant 10 asserted here, “That’s like an organizational...I want to say norm, we’ll just place them in juvenile hall until we can find a solution” (Focus Group, May 2014). Multiple supportive commentary occurred during these statements, as four participants voiced their feelings on why the youngest of youth with mental health issues should be diverted from juvenile hall. One participant pointed out, “It’s a revolving door, the younger they become involved in the juvenile justice system, the longer they stay” (Participant 8, Focus Group, May 2014).

The final major theme under the domain three barrier category was services controlled by funding and target populations, with 14 statements across all three focus groups. Some focus group members felt it to be a barrier when funders only allow services for severe clients as exemplified by Participant 15 who stated, “They are too quick to turn them down because of the criteria they use. It’s too strict. If they are not severe, they are not gonna take you. Like to qualify for services” (Focus Group, May 2014). Two of the three focus groups talked about competition for funding dollars. This is made clear in this comment from Participant 8, “Cause everyone is competing for the same dollars. Unfortunately, you know, community agencies trying to get contracts from the county. So it kind of gets in the way of collaborating” (Focus Group, May 2014). Similar statements were made in focus group 1 about

competition for funds as well. Two focus groups also mentioned how certain populations can be targeted for funding, causing agencies to focus more on these funded populations than on others. Participant 2, stated, “An it depends on what the target population is-the focus of the department at that time” (Focus Group, May 2014). Participant 5 interjected here:

The political cause de jour or crisis de jour. You know, its like it depends on what the focus of admin is, or what grant you have, or what article came out in the paper as to how the powers that be are going to go after that population. So, well, that was important last week, but we’re not gonna do that anymore. Now we are gonna focus over here.

(Focus Group, May 2014)

All three focus groups spoke about billing being associated with diagnosis as being a barrier. One participant stated, “The system only pays for certain things, services, certain diagnoses, so it kind of limits who you are providing services to and what kind of services. It does not allow you to individualize anything” (Participant 8, Focus Group, May 2014). Another participant summed it up well, “It’s a cookie cutter system. If you fit a certain mold then you can get services. If you don’t, you can’t” (Participant 2, Focus Group, May 2014). In focus groups one and two there were a large amount of heads nodding and one and two word commenting during discussion of this sub-theme.

Facilitators

Facilitators are described as anything that aids a justice youth in accessing and utilizing mental health services. A total of 76 statements were identified as facilitators. Table 3 shows a breakdown of the facilitators by domain and theme.

Table 3. Facilitators by Domain and Theme

Domain #1: Individual Facilitators (8 total)	
Internal Motivation	(6)
Spirituality	(2)
Domain #2: Environmental Facilitators (33 total)	
Supportive Family or Network	(11)
Mentors	(12)
Socioeconomic Status	(7)
Resource Rich Community	(3)
Domain #3: Agency/Organizational Facilitators (35 Total)	
Service method	(19)
Trust and Consistency with a Provider	(11)
Collaboration	(5)
Facilitator Totals	76

Domain #1: Individual Facilitators

Individual facilitators are aspects of the individual youth that may aid them in seeking or using mental health services. Eight comments were identified as individual facilitators. Some statements focused on general

internal motivations (n = 6), and others focused on spirituality as a facilitative factor (n = 2).

An example of a general internal motivation was evident in Participant 9's statement, "Like when you have a go getter attitude. I'm going to get the services I need to get better. But we don't serve a lot of them, but we do have those ones that say, you know, I'm gonna do what's necessary" (Focus Group, May 2014). Another participant described another general motivation stating, "Sometimes circumstances get to a place where they can't, that is they don't want to keep doing it again and again, enough detentions, or enough trouble with home or school, and their motivation changes" (Participant 4, Focus Group, May 2014). As one participant was talking about bible study for youth in detention, two other participants mention, "Spirituality is a motivator" (Participant 2, Focus Group, May 2014), and another participant chimed in, "Ah a connection!" (Participant 3, Focus Group, May 2014).

Domain #2: Environmental Facilitators

Environmental facilitators are elements surrounding the youth that may aid them in seeking or using mental health services. There were 33 total statements that were assigned under the category of facilitators in domain two. Four major themes emerged. The themes were supportive family network (n = 11 statements), mentors (n = 12), socioeconomic status (n = 7), and a resource rich community (n = 3).

Participants voiced strongly the importance of a family/caregiver support network for justice youth. Family can be whomever is important to the youth, as one participant stated, “Having supportive parents or supportive family, not necessarily parents-whoever it is-their family group or guardian. And parents who are advocates-that learn how to navigate the system” (Participant 2, Focus Group, May 2014). Five statements pointed toward general support from family in the home. Other statements focused on extended family and friends such as, “I think families who have a lot of support, outside support-other family outside of their home, whether its friends, or family, or whatever, just a really large network of support” (Participant 2, Focus Group, May 2014).

All three focus groups commented on how important mentors are to justice involved youth. Some participants felt it important for mentors to be professionals in the system such as social workers or law enforcement officers. Participant 14 talked about professionals as mentors, “Cause I know some programs, some mentorship programs connect you with a cop, like a mentorship thing,” and “Like with a social worker or counselor at school that explains to them the benefits of services or it willing to talk with them regularly.” Other participants felt that mentors should be, “...people who look like them, have walked the walk, have come out on the other side and are coming back to give back to their community will have the most impact on the kids” (Participant 8, Focus Group, May 2014). Another participant voiced the

effect this kind of mentor will have on justice youth, "...and they think maybe I can be like him" (Participant 6, Focus Group, May 2014).

A total of seven statements in two focus groups cited socioeconomic status as an environmental facilitator. Some statements focused on basic needs of families as being very important, "Families who have all their basic needs met, who have transportation-that have a house, and have a job. I mean they might just be getting by, but they have all those basic things" (Participant 2, Focus Group, May 2014). Some participant pointed out how low socioeconomic status is concentrated in certain communities, "Systems change with higher economic status" (Participant 13, Focus Group, May 2014). Another participant expanded on this comment stating, "And if they are from higher socioeconomic status their schools might be a little bit better too" (Participant 14, Focus Group, May 2014).

Three statements voiced, one in each focus group, how important a resource rich community is to justice youth. Participant 4 stated, "...Positive schools, positive communities-support so that they have all those things that help increase motivation...if they don't have a sense of involvement that gets in the way" (Focus Group, May 2014). Another participant stated, "I'm thinking about faith-based agencies. I don't know what...young visionaries and just different people that's kind of trying to help keep these young people motivated and on the right track" (Participant 9, Focus Group, May 2014). Resource rich communities have many attributes that are beneficial to youth,

as Participant 14 stated, “Having a good non-profit in the community, a good community park, resource center, or activity center that youth can go to after school” (Focus Group, May 2014).

Domain #3: Agency/Organizational Facilitators

There were a total of $n = 35$ statements assigned to the domain three facilitators category, and three themes were identified: interagency collaboration ($n = 5$ statements), trust and consistency with provider ($n = 11$), and service method ($n = 19$).

All three focus groups mentioned the value of interagency collaboration. As Participant 15 (Focus Group 3) stated plainly, “I think agency collaboration is very necessary between agencies.” Participant 5 described in detail:

You can't put a price on that. That you can call up someone you know and say, 'help me, how do I make this happen for this kid?' And, 'okay let me make a call.' And Done! Whereas if the kid gets a referral they wait two to five months to get something done. (Focus Group, May 2014)

The second major theme identified in domain three facilitators was trust and consistency with a provider, which received 11 statements from discussions occurring in all three focus groups. Two statements mentioned past success with a provider as a facilitator. Other statements described how success with a client can take place. Participant 7 stated, “I think developing trust and credibility with them and also their families” (Focus Group, May

2014). Participant 12, stated, “Consistency with a provider. Not like consistency for a week. I mean consistency, thorough consistent service for however long it takes” (Focus Group, May 2014). Three statements cited the level of investment on the part of the clinician or worker, as with comment from Participant 8, “And we do have people that are very invested in these kids” (Focus Group, May 2014).

The third major theme identified in the domain three facilitators category was service method (n = 19 statements). For the purpose of this study, service method is defined as the methods and style by which the clinician or agency delivers services to the client. In one focus group, n = 5 statements focused on alternatives to detention, mentioning youth court, mental health court, and drug court as examples. Three comments focused on how cultural sensitivity is important, as Participant 3 states, “Culturally sensitive or trained staff to work with them so that, you know, you’re not afraid of environmental things that they might stumble across or whatever” (Focus Group, May 2014). Another participant added to this, “And not just the client, but like cultural competence to what the families are going through, and cultural competence to the culture of poverty and those issues” (Participant 4, Focus Group, May 2014). Two comments mentioned how important one-stop-shops are to juvenile clients. Four comments talked about using a team approach and empowering clients, as evidenced by Participant 2, “...an agency that has more of a team approach-not just helping the family, but the family and you

are working together” (Focus Group, May 2014). Participant 4 chimed in here, “You know, going along with that, empowering our families rather than enabling them. Think of them as being capable” (Focus Group, May 2014). Six comments in one focus group talked about the value of viewing juvenile clients holistically. Participant 12 says, “Looking at...um holistically, I mean, not just what we can do to a person, but like building on skills in a holistic, strength-based approach.” Participant 8 added, “So you look at the whole person and family” (Focus Group, May 2014) and Participant 10 then adds, “It’s not just we are going to put you on medication, we’re going to have a holistic approach. You may want to go to Zumba or do poem writing” (Focus Group, May 2014). Overall participants felt that there is much that the therapist can do to facilitate client interest in mental health services.

Suggestions for Change

Suggestions for change are defined as comments made by participants that express their opinions about what can be done to decrease or eliminate barriers and increase facilitators to mental health service usage among justice youth. A total of 160 statements were identified as suggestions for change. Statements were sorted into the three domains as follows: Domain #1, suggestions to help individuals (n = 28); Domain #2, suggestions to help the environmental systems around the individual youth (n = 45); and Domain #3, suggestions for agencies and organizations (n = 87). Table 4 shows the suggestions for change by domain, theme, and sub-theme.

Table 4. Suggestions for Change by Domain, Theme, and Sub-Theme

Domain #1: Individual Suggestions for Change (28 total)	
Education/Outreach	(16)
Cultural Competence	(4)
More Substance Abuse Treatment	(8)
Domain #2: Environmental Suggestion for Change (45 total)	
Improve Services at Schools	(16)
Improve/Grow Community Resources	(16)
Work with Whole Family	(13)
Domain #3: Agency/Organizational Suggestions (87 Total)	
Service Delivery (54)	
Treatment Approach	(12)
Streamline the Process	(11)
Increase Collaboration	(10)
Workforce Related (23)	
Training & Cultural Competence	(12)
General Staffing	(11)
Philosophy Change (31)	
For Parole Officers	(7)
For Court Systems	(5)
More Prevention services	(6)
Punitive to Restorative Statements	(13)
Total Suggestions for Change	160

Domain #1: Suggestions for Change to Aid Individuals

Statements sorted into this category focused on the opinions of participants on how to improve access to mental health services for justice

youth. There were 28 statements in all within the individual domain in this category, in which three themes were identified: Education/outreach (n = 16); cultural competence (n = 4); and need for more substance-abuse treatment (n = 8).

Sixteen suggestion statements were general and spoke of methods in which to perform education and outreach in the community. Participant 1 spoke about how mental health education should take place at local schools:

Also maybe more education at...where the kids are spending most of their time-at school. That way its one location, its closer to the community, and transportation issues wouldn't really be a factor. Maybe like with a mental health expert. (Focus Group, May 2014)

Other participants thought that there should be more support to organizations that already provide outreach as evidenced by this statement, "Well, I think too, like organizations like NAMI, where the families can go and they can get support to understand they are not unique, they are not alone" (Participant 7, Focus Group, May 2014). Another participant spoke about how law enforcement and mental health agencies need to target communities needing services the most, "Outreach, transparency, community involvement, like go straight to the communities where there is a lot of crime...to the underserved" (Participant 14, Focus Group, May 2014).

There were four statements that spoke of the importance of culture to outreach. One participant talked about street teams composed of people that

justice youth would perceive as being like themselves stating, “Being members of the community though, not coming from a mental health clinic, like whoa! Let me speak to you about mental health! Like can you translate that for me? But actual community members participating” (Participant 8, Focus Group, May 2014). This same participant went on to speak of the LGBTQ community, “There should be LGBT people going to the LBGT community, cause there’s a huge stigma in the LGBT community” (Participant 8, Focus Group, May 2014). Another participant talked about how important a cultural match is for the Hispanic population, “That’s true because like with the Hispanic population with mental health, I mean there is so much mis-education and they are a very closed community, very closed. They stick with one another” (Participant 11, Focus Group, May 2014). There were a multitude of head nods and comments of agreement when participants spoke of culture.

Under the substance-abuse theme, participants in one focus group voiced how important it is to address substance abuse in therapy with juvenile justice clients. One participant stated, “Substance abuse is primary. I mean at least in this population, you don’t get many who aren’t using something” (Participant 4, Focus Group, May 2014). Participant 5 adds here, “Especially with the push for legalization of marijuana” (Focus Group, May 2014). Heads were nodding and multiple commentary followed as Participant 4 shared, “you need more of something that’s gonna counter-act some of the culture that we’ve got in terms of the marijuana” (Focus Group, May 2014).

Domain #2: Suggestions for Changing the Environment

There were a total of 45 statements and three major themes that emerged under domain #2 of this category. The themes were: Improve services at the schools (n = 16), improve/grow resources in the communities (n = 16), and work with the whole family (n = 13).

All three focus groups felt that services improvements at schools were important to the success of justice youth. Focus group 1 felt that teachers and other school professionals should have mental health and trauma training, as evidenced by this statement, "...so other than ADHD, cause they tend to pinpoint that one quickly, but other issues, or trauma-based issues that are impacting the youth too. They don't talk about trauma and its relationship to mental health" (Participant 4, Focus Group, May 2014), and another participant pointed out, "Sometimes hyperactivity disorder is not a student problem. It's a teacher problem. Cause the teacher who knows how to manage [hyperactivity] can teach the child" (Participant 6, Focus Group, May 2014). Participant 4 summed it up well, "Schools need to be better trained to notice the difference between a mental health illness and a behavior problem" (Focus Group, May 2014). Participants from focus group 2 felt that social workers should be employed in the schools, as evidenced by this statement, "Do you remember when there used to be social workers in schools?" (Participant 8, Focus Group, May 2014). Another participant replied, "Yes, they actually did counseling" (Participant 10, Focus Group, May 2014). These

statements suggest a need for mental health knowledge to be present at schools on some level.

All three focus groups contributed to the 16 suggestions for change statements about improvements to community resources. Two sub-themes emerged. The first was to provide more basic needs (n = 5 statements), and the second was to target more community-based services such as libraries and community centers in the communities that need them (n = 11).

The five statements about providing basic needs concentrated on housing, medical, and transportation, as one participant pointed out, “Provide housing and medical care for everyone in the county. I believe that is a basic right” (Participant 8, Focus Group, May 2014). Participant 12 added to this, “It’s hard to deal with mental health when you don’t have a home” (Focus Group, May 2014). Two basic needs statements in 2 different focus groups concentrated on transportation, which led other members to mention the importance of targeting services in communities in need, which is the second sub-theme. Participant 5 made this point, “You know, in some communities everybody’s walking because few people have cars. So you’ve got to focus on the communities that have nothing, and outstation the services a little bit closer and make them more user-friendly” (Focus Group, May 2014). Five of the eleven statements in the second sub-theme were about physically targeting general mental health services to the communities that need them. The other six statements describe how these communities need more holistic

services such as Participant 2 suggested, “Have more community centers in the communities-not just like mental health, but like holistic campuses” (Focus Group, May 2014). Participant 7 adds to this, “Where they can access yoga, there’s aerobics, computer learning classes. There’s just a lot of wonderful things for the families as a whole” (Focus Group, May 2014). Multiple participants nodded and commented on the importance of targeting communities from a holistic standpoint, versus solely meeting the psychiatric needs of juveniles.

The final sub-theme under domain #2 suggestions for change was work with the whole family, which received 12 statements from two focus groups. Four statements in two focus groups speak of the importance of providing services in the client’s home, as with Participant 9 who stated, “Just getting in the homes and seeing what’s going on because it can say a lot and help us think outside of the box more” (Focus Group, May 2014). Most statements in this sub-theme concentrated on viewing the client as part of a larger system such as Participant 4 who stated, “You can’t...it’s hard to treat the mental illness when you have so much poverty. So you need to do things that are going to address the whole system” (Focus Group, May 2014). Eight statements specifically mention that when treating justice youth, the whole family should be worked with, as with this statement, “I think one thing is to work with the whole family-not just looking at the kid, but anybody that he feels

or she feels are important in their lives” (Participant 8, Focus Group, May 2014).

Domain #3: Suggestions for Agency/Organizational Change

Agency and organizational suggestions for change received 87 statements. There were three major themes and 9 sub-themes identified. The major themes were: service delivery (n = 33 statements), workforce related (n = 23), and philosophy change (n = 31).

The first theme was service delivery, which had three sub-themes within it. They were: Treatment approach-other (n = 12), streamline the process (n = 11), and increase collaboration (n = 10).

Statements in the sub-theme of treatment approach-other were general statements involving service delivery. Four statements speak of how the use of one-stop-shops should be expanded upon. Several statements talked about the manner in which the clinician views and assists the young client.

Participant 2 stated, “Agencies that think outside the box” (Focus Group, May 2014) as a suggestion for change. Another participant expanded upon this by saying, “The tendency can be that if they don’t like the therapist we tell them they are resistant rather than seeing how we can change the delivery or offer a new provider that matches” (Participant 4, Focus Group, May 2014).

Participant 2 replied stating:

How about meeting the kid where they’re at? Cause sometimes those professionals...we come in and there’s things we would...that they

need to change and they are not there yet, but there's certain aspects that they want to work on. (Focus Group, May 2014)

Participant 12 made a similar statement in a different focus group, "Ask the client what do you need? Get them involved in their own treatment" (Focus Group, May 2014).

Eleven statements suggested streamlining the process and reducing the red tape. Participant 5 stated, "Well I think a big piece of that is streamlining the process that governmental agencies go through before they implement the services. Sometimes it takes so darn long that...." (Focus Group, May 2014) Participant 2 finished the sentence with, "They give up" (Focus Group, May 2014). Another participant brought up the idea of using technology better, which resulted in three other comments and a multitude of head nodding and supportive one-word comments. Participant 12 stated:

I think we...agencies and organizations have to use technology better, more efficiently.[...] Sometimes I spend the same...so much time documenting the same information in several different places, when it seems technology can be used to streamline it. (Focus Group, May 2014)

Statements following this spoke on how technology could be used to coordinate services better, and to direct clients to services via internet.

The third sub-theme under service delivery was to increase interagency collaboration, which receives 10 statements from discussions which occurred

in two focus groups. Several statements spoke of collaboration between agencies as with Participant 15 who stated, “So if we have that collaboration between agencies it would make services seamless. That Transition. I know that CFS is teaming up with DBH to make it quicker for our clients to get services” (Focus Group, May 2014). This same participant continued to speak of how agencies should educate one another on the services they provide. Several statements spoke of collaboration within agencies, as with this statement from Participant 12, “Often there is a disconnect between management or whatever, and the ones who are out there in the homes every day. So like collaboration between them” (Focus Group, May 2014).

The second theme under the domain three category of suggestions for change was workforce related statements, which receives 23 statements and has two sub-themes: Training and cultural competence, and general staffing.

The sub-theme of training and cultural competence received 12 comments with discussions occurring in all three focus groups. Ten statements mentioned training, nine of which were focused on staff, and one on management. Focusing on management, Participant 6 states, “We need training for the manager just to show different way of managing people, which is healthy way” (Focus Group, May 2014). This statement seems to touch back on the earlier discussion about the gap between management and line staff. Other comments on training specifically mentioned a need for training on working with non-compliant clients (n = 3) and cognitive behavioral therapy

(n = 1). Three comments specifically mention a need for cultural competency training, as Participant 15 stated, “We can also promote cultural competence for our service providers, so we can reach this generation-speak the way they will understand what we are saying” (Focus Group, May 2014)

The second sub-theme under that theme of workforce related items was general staffing statements, which received 11 statements and discussions occurring in all three focus groups. Six statements in this sub-theme were directed at suggestions for administration. Two statements talked about how a supportive supervisor can make a great difference in a department. Four others focused on replacing administration as a suggestion, as exemplified by this statement, “Some line staff, some supervisors, some agencies do need a shake up if you have the philosophical...” (Participant 5, Focus Group, May 2014). Participant 2 finished Participant 5’s statement, “that aren’t treatment focused” (Focus Group, May 2014). Some participants felt that negative workers should be identified and removed. Three statements suggested adding more treatment staff and reducing caseloads. Two statements suggest nurturing the workforce, as evidenced in Participant 12 statement, “About the workers who are very invested, I think organizations need to acknowledge those workers who put out the effort, take care of them, or provide an atmosphere of...or some care” (Focus Group, May 2014).

The final theme in the domain three category of suggestions for change was philosophical change, which receives 31 statements with discussions that

occurred in all three focus groups. There were four sub-themes in this theme: philosophy change for parole officers (n = 7), philosophy change for the courts (n = 5), more prevention services (n = 6), and overall punitive to restorative philosophy change for all systems of care (n = 13).

Seven statements reflected a suggestion that probation officers should receive training that would shift the philosophy and culture of probation. This conversation tied in with the discussion that occurred in the barriers category about parole officers as a barrier to mental health for youth. Here participants made suggestions as participant 7 explained:

Well I think that kind of goes along too with the fact that it would be nice for probation to employ PO's to have more education about mental health. So there is...maybe it just depends on the PO, which of course is life anyway, who you get, but sometimes there's maybe more education or more um, interface with mental health, behavioral health, they might...uuh some of the judgementals or the ignorants might be eliminated. And that could open things up. (Focus Group, May 2014)

Most participants felt that training might help and that changing the culture of probation may help as well, as with Participant 6 who suggested, "We might need to change the meaning of probation officer job. Like need to have different description, different meaning. Your job is just not to give penalty" (Focus Group, May 2014).

The next sub-theme was to change the philosophy of the courts, which received five suggestions. Two suggestions talked about connecting kids to services prior to putting a youth on formal probation. Participant 8 suggested, “Kids who are on informal probation, so they are not seen. That is where we should kind of begin and get them services. So actually intervening when they are on informal probation” (Focus Group, May 2014). Two participants felt that there should be mental health professionals in the court systems as asserted by Participant 2, “Cause you guys just deal with the public defender clients...there’s all the other cl[ients]...they need a mental health professionals” (Focus Group, May 2014).

The sub-theme of more prevention services received six comments in two focus groups. One participant stated, “Take some of the probation enforcement money and shift it towards preventative services” (Participant 5, Focus Group, May 2014). Most other suggestions in this sub-theme briefly point to a need for greater preventative services in the county.

The final sub-theme in domain three suggestions category was to make a fundamental shift in philosophy from punitive to restorative, which received 13 statements in one focus group. This topic stirred many comments, as Participant 8 introduced the suggestion:

Yeah, there’s a pilot...I mean programs all over the country that deal with this, and their money is focused outside of juvenile hall. The kids never see the inside of juvenile hall. And we are not of that mentality.

They have centers where the kids would go and check in, and get services, instead of taking them out of the home and putting them into the hall. And they have probation officers at these centers, so the kids still check in with an authority figure. (Focus Group, May 2014)

This spurred much conversation among the participants, as some of them had heard of restorative justice and some had not. Participants who were familiar with the topic filled in those who were not. The philosophy of restorative justice requires a different mindset at the level of juvenile courts, probation, law enforcement, and all involved in the juvenile justice system. Participant 11 jumped in, “It’s funny that you mention that, because I’ve been to conferences where they talk about how they are doing that in another state. But they just don’t know how to incorporate that here” (Focus Group, May 2014). All participants agreed that this kind of change would benefit San Bernardino County. Multiple heads were nodding and multiple one and two word supportive commentary were made during this conversation.

Summary

This chapter summarized the 473 statements made by the 15 focus group participants. Statements were divided first into the categories of barriers, facilitators, and suggestions for change. Next statements were sorted as individual aspects (Domain 1), environmental aspects (Domain 2), or agency/organizational aspects (Domain 3). Twenty-six major themes were identified, and 18 additional sub-themes emerged. Suggestions for change

under the agency/organizational category of domain three received the most overall discussion with 108 statements in all. The most discussed topics in the focus groups were quality of or improvements to services, which received a total of 114 statements total, and punitive systems of care, which received a total of 60 statements in all.

CHAPTER FIVE

DISCUSSION

Introduction

Chapter five contains a discussion on the results of the study, which were outlined in the previous chapter. Study limitations are presented, and recommendations for social work practice are introduced and discussed for future research, policy, and practice with justice youth.

Discussion

The purpose of this study was to identify the barriers that keep justice involved youth from accessing and using mental health services when needed, and the facilitators that help them to do so, as well as to brainstorm suggestions for future change. This discussion will begin with an examination of the findings among the barrier statements, facilitator statements, and finally the suggestions for change.

Barriers Category

The themes of stigma, denial, low motivation, and lack of trust identified under the individual domain are similar to that of which has been identified as being common when treating youth, as found in research that elicited the perceptions of clinicians (see Gearing et al., 2012). The barriers of familial resistance under the environmental domain, such as lack of involvement by parents and lack of trust in the system by parents, have also been identified in other research. Baker-Ericzen, Jenkins, and Haine-Schlagel (2013) caution

that when examining clinician perspectives on familial resistance that one should be careful to value this information as one sided. Baker-Ericzen et al. (2013) find similar results among clinicians in their study. However, their study also interviewed the parents, and finds that parents feel blamed, excluded, and disappointed with services (p. 860).

Severe poverty is a theme that received a large number of statements, yet appears to be infrequently cited in barrier research. Often clinicians questions why mental health services do not appear to be important among the parents of some clients, when in reality as the findings of this study point out, parents often face challenges such as lack of housing, physical illness, and family crisis that can take greater immediate priority over mental health needs of their children.

The topic of culture and cultural competence was brought up consistently throughout conversations in all three focus groups, as being a barrier or a suggestion for change. Participants felt that in order to work with San Bernardino County justice youth, that workers and agencies should be knowledgeable on the culture of poverty and the culture of justice involved youth-specifically to be capable of relating to justice youth. Race was the less frequently mentioned aspect of cultural competency in this study. Clearly culture is a valuable topic for San Bernardino County social workers, and clinicians and agencies should actively seek ways to increase their knowledge of the cultures of the communities they serve.

Agency/organizational barriers receives the most statements of all the categories. Quality of services is the most discussed theme in this category with the main focus of these statements being that participants feel services are impacted, while at the same time, clients need longer treatment and more follow-up. Participants also felt that clinics needed greater staffing and more training. This is an interesting finding of this study, as similar past research has reported clinicians to state that there are more barriers on the adolescent and family domains, than in the clinician or agency domain (Gearing et al., 2012). The participants of this study, primarily social workers, consistently cited significantly more barriers within agency structures than within any other domain.

This finding supports the researcher's original hypothesis about why the opinions of social workers are valuable to barrier research. That is, that the social worker who handles basic support and community linkage services for justice youth will have less bias and more insight as to what aids or impedes youths who need mental health services, in comparison to the clinicians working at community clinics who have been interviewed in past research. It is clear that participants in this study were quick and thorough to constructively cite fault and make suggestions for change within their own agencies and other agencies, and were less vocal in finding shortcomings on the part of individuals and families than in some past research.

Another topic that spurred enthusiastic conversation among participants is the domain #3 barrier theme of punitive systems. In the barrier category, punitive systems are mentioned in 29 statements, but this theme is brought up in in two other categories with discussions occurring in all three focus groups. Participants feel strongly that punitive probation officers, schools, and legal systems are a barrier to mental health service seeking behavior for justice youth. Often justice youth are raised in environments where power is used as a tool to oppress, and then are thrust into a society where social and structural entities force justice youth and their families into situations which repeat and reinforce this same power disparity. The current culture of the juvenile justice system in San Bernardino County is one that will mimic this same dilemma for youth, utilizing a philosophy of power 'over' rather than power 'with' the clients it serves.

One last theme among the barriers that must be discussed is that of services being controlled by funding sources. This is an important topic for service providers to look at. As monies are appointed to counties and agencies by government and other funders for specific populations, and new funds become available for new populations, over time a maze of services are created which can be difficult to navigate for consumers and providers alike. Possibly some of these funding obstacles have been remedied with recent changes to healthcare. However, more research to probe this area is warranted.

Facilitator Category

The facilitator category receives the fewest statements from all three domains. One theme of interest in the facilitator category was that of mentors. Youth, by their very nature, have a tendency to feel that adults cannot understand them. Participants in this study point out the importance of having mentors who look like them, talk like them, and have experienced in their past the things that justice youth are experiencing. These kinds of mentors are people who can create a positive connection with justice youth. This summarization of the value of mentorship is in line with another theme in the facilitator category of trust with a provider, which receives 11 statements. To further add gravity to this, is the fact that the theme service method in the facilitator category contains several statements that talk about using a team approach and empowering justice youth. Forming a relationship of power with, rather than power over, which is in line with the ideas of Mary Parker Follett (Follett, 1940 as cited in Mele, 2006), seems to be a dynamic and important aspect of working with justice youth. Follett asserts that true power cannot be delegated, and that people must be given opportunities to develop their own power (Follett, 1940 as cited in Mele, 2006).

The challenge, then, in working with justice youth with mental health diagnoses, is that service providers should view and treat them as being individuals whose opinions and feelings are just as important as their own, as who are deserving of self-determination. This idea is an overarching theme

within the facilitator category, subtly laced into many of its statements, indicating how vitally important it is to treat justice youth using egalitarian principles.

Suggestions for Change Category

The final category is suggestions for change which receives $n = 160$ statements from all three categories. Many barrier/facilitator studies do not ask for the opinions of participants in making suggestions for change. This category is the heart of this study, as when considering change there are no opinions more important than those of the professionals working the front lines with justice youth.

Education and outreach are the main suggestions to confront the individual barriers identified in this study. Education and outreach conducted in the community can help to overcome the stigma associated with mental health diagnoses and battle misconceptions about such diagnoses. Many counties offer education, outreach, and engagement services through their department of mental or behavior health. Los Angeles County Department of Mental Health and Orange Counties department of Behavioral Health Services offer outreach services that are conducted at local schools and other community settings (see Los Angeles County Department of Mental Health, n.d., and Orange County Department of Behavioral Health, n.d.).

An important theme in the category of suggestions for change is the importance of working with the whole family. In his strength-based perspective

Saleebey (2006) asserts, "Family support programs see that the best and most effective way to foster resilience in youth is to foster it in the family caregivers" (p. 213, par. 4). San Bernardino County has been moving toward working with families instead of individuals where youth are concerned, with wraparound services and other in-home and whole family services. As discussed earlier in this paper, findings from another study that elicited the opinions of caregivers who had been described as resistant by clinicians, were found to feel that the clinicians were blaming them or not including them in services. San Bernardino County mental health clinicians working with justice youth must be certain that this is not the case in their practices. Participants of this study also cited the importance of recognizing non-blood individuals that the youth might consider to be his or her family, and include those individuals in treatment.

Improving services in the community is another important theme, with 16 statements about improving services at schools, and 16 statements about community services. San Bernardino County has pockets of extremely rural areas, and pockets of urban poverty within its boundaries. These are the areas that services need to be targeted. Anakwenze and Zuberi (2013) assert that a cyclic relationship exists between intense urban poverty and mental illness, in that each contributes to the other. The authors assert:

In order to interrupt the cycle and achieve progress, social workers need to work with community stakeholders to implement a

comprehensive mental health care system that crosses traditional health care provision boundaries by mobilizing a variety of community institutions (including schools, churches, and law enforcement) and professionals (including social workers, teachers, pastors, and police) to overcome barriers to accessing mental health care services.

(Anakwenze & Zuberi, 2013, p. 155, par. 5)

Great disparities in mental health outcomes for youth are also found to occur in rural areas as well (Moore & Walton, 2013). Again, this goes back to the importance of the education and outreach that was cited previously in this discussion.

Participants in this study highlight the importance of improving services at local schools. Focusing on making the suggested improvements at schools is appropriate, as some of the suggestions are to follow laws that are already in place. Additionally, schools are an ideal place in which to conduct comprehensive prevention, education and outreach, and the fact that all rural and urban communities in San Bernardino County have elementary schools, makes this the ideal place to start.

The final domain to discuss in the category of suggestions for change is the agency/organizational domain with 87 statements in all. Participants focused many of the service delivery suggestions on increasing communication between agencies and within agencies. This is important to look at because larger organizations can become compartmentalized over

time, and may need management to take action to bridge the gaps between departments and between line workers and management. Collaborating and networking with outside agencies was mentioned in 10 statements in this category, but was also mentioned many times in other categories and across all three focus groups. Managers and staff should dedicate time each week or month on this important but often neglected task. Streamlining the process is an important topic to participants in this study. San Bernardino County Department of Behavioral Health is in the process of installing a new system called SABER, which is supposed to make paperwork, record keeping, and billing more efficient. Time will tell if SABER does as predicted, as it is not fully up and running yet.

There are 23 workforce related statements, 12 of which mention cultural competence as a suggestion for improving services. As mentioned earlier in this section, participants feel cultural competence is a crucial component of providing services to juveniles in the San Bernardino area, which can be achieved by providing training, experience, and supervision for clinicians and other staff. Participants also feel that training is needed in many areas. For example, it was stated that some managers or supervisors need training or need to be replaced. This is important because the manager or supervisor can set the tone for the departments they run. Quality of and improvements to service are the single most discussed topic in this study, and will be further

discussed in the Recommendations for Social Work Practice section that follows.

The final major theme in the suggestions for change category is that participants feel it important for San Bernardino County juvenile justice helpers to change from a punitive and punishing philosophy to one of preventative and restorative. The theme of punitive systems is discussed at length in the barrier category with 29 statements, and again in the suggestions for change category with 31 statements. There is much research on this topic in the literature. However, as mentioned earlier, this theme has not been identified in other barrier research known to this researcher. This is the second most mentioned topic in this study, and will be expanded upon in the section: Recommendations for Social Work Practice section which follows.

Limitations

This study has limitations that are important for the reader to understand and be aware of. One limitation of this study is that data was analyzed and coded by one researcher alone. When analyzing, organizing, and coding qualitative data into themes and sub-themes, multiple researchers are commonly used to confirm and validate the sorting and coding process. This may cause the results to be more subjective and less objective than if there had been multiple coders.

Another limitation is that the researcher conducted the focus groups alone. It would have been more conducive to have one person to note

participant statements on the flip charts, while the second person led the focus groups. The researcher found it difficult at times to listen, write, and probe participants to expand on statements they made. Additionally, the researcher has no specific training or experience in conducting focus groups. Whereas an experienced focus group leader may have been more successful in engaging, probing, and directing the groups.

Additionally, it became clear during the two larger focus groups that the time constrictions were a limitation. Each focus group was allotted 90 minutes, 30 of which were used for signing in, greeting, explaining confidentiality, etc. This left 60 minutes for the discussion section, which breaks down to 20 minutes per domain. It was clear that some participants felt energized to talk further about some themes and topics, than others. Therefore, a looser format without time restrictions would have been more conducive to free flowing conversation.

Furthermore, by using focus groups as the data collection method, the number of themes and statements may have been affected. This can happen when participants neglect to bring up a topic because it has already been mentioned, or when a more charismatic participant brings up a topic, more participants respond with statements. Also, some participants may have felt inhibited to respond with their true feelings and perceptions with other participants present.

One last limitation is that this study's data are limited to the opinions and perceptions of social workers only, and does not include the opinions and perceptions of the clients, clients caregivers, or other professionals and paraprofessionals that justice youth are involved with in systems of care, and therefore presents only the viewpoints of social workers and other staff who have done case management and community reintegration work with the youth.

Recommendations for Social Work Practice, Policy and Research

By far the most discussed topic among participants, which subtly found its way into many of the themes, is quality and type of services and the aspects that affect these services. Many feasible suggestions for change come from participants in this study. Agencies must move away from outdated intervention models and educate themselves on newer, more comprehensive models. It is highly suggested that all providers serving justice youth to be educated on trauma informed approaches, such as Trauma Focused Cognitive Behavioral Therapy (TFCBT). This is vitally important, as such a high percentage of youth in the justice system have suffered trauma as part of their history. The results of this study indicate that this is likely true of their family members as well. Information on TFCBT is available at no cost through the Department of Health and Human Services, Administration for Children and Families (See Child Welfare Information Gateway, 2012).

Another important finding of this study and others is the importance of working with the whole family. When attempting to intervene with a juvenile justice client with a mental health diagnosis, the whole person must be helped from a person-in-environment perspective. This requires assisting the youth and all systems that come in contact with that youth

Another important barrier to address is stigma. Education and outreach are excellent avenues in which to combat stigma and demystify mental health topics for youth. The ideas of education and outreach go hand in hand with early intervention and prevention, which are also topics discussed by participants in this study. A suggestion made in this study is that education and outreach should occur in schools. In order to reach youth who are at risk of becoming involved in the justice system, this should begin at the elementary school age. While San Bernardino County does offer some prevention, outreach, and education, there are counties that far exceed what is currently in place in San Bernardino County. The Mental Health Services Act (MHSA) includes funds for services that target prevention and early intervention, and can take the form of education and outreach. Currently Los Angeles County and Orange County have begun to use these funds to incorporate comprehensive community outreach and engagement components into their mental health services. Both of these counties include local schools in their outreach programs (See Los Angeles County Department of Mental Health, n.d. and Orange County Behavioral Health, n.d.). If San Bernardino County

were to follow suit, it would be advisable to make every attempt to employ individuals on the outreach team that justice youth can identify with as pointed out by participants in this study. Another important component pointed out by this study's participants, is that law enforcement should play an integral part in outreach for justice youth, so as to diminish the barrier and change the culture between law enforcement and at risk youth.

A final topic that receives much conversation from participants in this study is the idea of initiating and sustaining a paradigm shift from punitive to restorative within San Bernardino County's juvenile justice system. As cited earlier in this work, early contact with juvenile justice systems is associated with adult offending later on. The concept of Restorative Justice is a topic that participants of this study feel would be of great benefit to the San Bernardino County juvenile justice system.

Restorative Justice is a broad theme with several models used. Counties in Florida, Minnesota, and Pennsylvania have successfully employed the use of restorative models in their juvenile justice systems for quite some time (OJJDP, 1998), and there are pilot programs being conducted in other places across the country (Restorative Justice for Oakland Youth, n.d.), and all across Europe and the United Kingdom (Restorative Justice for All, 2014). The idea of restorative practice originates with the Maori culture of New Zealand in an approach called Family Group Conferencing (FGC), which began to reduce the number of children ending up in systems of care (Ross, 2000). FGC has

been used in child protective services settings, juvenile justice, and other settings. An FGC proceeding usually takes place outside of a courtroom at a location the family chooses, and a family's culture and rituals can be incorporated. For more information in FGC as a restorative justice process in New Zealand, see Ministry of Social Development (n.d.).

In the justice setting, the term Restorative Justice is the term generally used to describe a model that seeks to avoid incarceration and increase community involvement for non-violent, status type offenders. Restorative justice accomplishes this with the FGC model by using conferencing that includes not only the offender and the offender's family and support, but also the victim and victim's family and support. Rather than the main goal being to denote punishment only for wrongdoing, restorative practices seeks to assign responsibility to the responsible party, allow the wounded party a voice, and bring community together to find the appropriate solutions.

Restorative justice has been found to be cost effective in comparison to the standard criminal justice model (Coalition for Juvenile Justice, 2013; Sherman & Strang, 2007), and to reduce recidivism (Sherman & Strang, 2007; Baffour, 2006).

In 2011 California enacted Governor Jerry Brown's AB109 and AB117, known as Public Safety Realignment, which sought to reduce crowding in California's state prisons. The National Council on Crime and Delinquency (NCCD) is advocating for and currently assisting multiple counties in California

to implement restorative justice practices in their juvenile justice divisions. Community leaders in the juvenile justice field are encouraged to contact the NCCD to learn about implementing restorative practices in their community (for more information see National Council on Crime and Delinquency, 2015).

As a further measure to protect vulnerable juvenile from incarceration, currently Senate Bill 2999 seeks to reauthorize the Juvenile Justice Delinquency Prevention Act and provide additional safe guards for youth in the justice system. Individuals, groups, and community leaders are encouraged to advocate for this measure to pass, as it protects youths from being incarcerated with adults, and prohibits youths from becoming incarcerated for status offenses (for more information on SB 2999, see Coalition for Juvenile Justice, n.d.).

Conclusions

This chapter discusses and interprets the barriers, facilitators, and suggestions for change identified by participants of this study, as well as discusses the limitations and suggestions for social work practices, policy and research. Participants of this study consistently identified more barriers and suggestions for change as being attributable in the agency domain, in comparison to the individual or environmental domains. Suggestions for change include improved education and outreach, clinical models that include the whole family approach, improvements at the school level, increased collaboration between and within agencies, increased cultural competency

among practitioners, and a paradigm shift from punitive to restorative justice models. Limitations of this study include the fact that only one researcher coded the themes, lack of expertise on the part of the researcher as a focus group leader, time constraints during the focus groups, and limitations which are due to the nature of focus groups.

Recommendations for social work practice include incorporating the trauma informed approach, working with the whole family, creating more effective community education and outreach that includes law enforcement, and working aggressively to execute a paradigm shift in San Bernardino County from punitive to restorative justice models. The avenues to executing this paradigm shift are discussed in detail from a policy and social work perspective.

APPENDIX A
FOCUS GROUP GUIDELINES

Focus Group Leader Sheet

At sign-in desk: Have everyone fill out confidential sign in sheet. Assign each person a number and put that number on their name tag. Hand each person a demographics, confidentiality, and debriefing form.

- 1) Welcome, introduce self, and thank you to all.
- 2) Explain study - this study seeks to obtain your opinions on what the present barriers and facilitators to mental health service utilization are among juvenile justice youth. You have been invited because your personal opinions and experiences with justice youth are relevant and valuable to this study.
- 3) Confidentiality - please say everything that you want to say during this discussion. Your views are very important. This session will be audio recorded for the purposes of capturing all of your comments accurately. All information shared in this discussion will be kept confidential. Your comments will not be traceable back to your identity. The audio recording will be deleted within one year of completion of this study.
- 4) Any questions?
- 5) Focus group rules
 - a) Please speak one at a time, and say what comes to your mind, and feel free to build upon what others have said.
 - b) When someone is speaking, please do not have side discussions with the person sitting next to you.
 - c) Please speak your mind and do not hold back. Even if you feel your experience to be trivial-try sharing it anyway
 - d) I may direct a question to, or directly ask the opinion of individuals who have not had a chance to share. This is not do point anyone out, so feel free to say “no comment” if you like. This is only done to allow the less verbally dominant individuals a turn to share.
 - e) If directing a comment toward a certain individual, please use their group member number and not their name.
- 6) Any questions?
- 7) Have everyone fill out the demographics and confidentiality forms.
- 8) Have participants introduce themselves (#) and answer their ice-breaker question.
- 9) Thank you again for your participation. I will now turn on (or not) the audio recording device and we will begin this focus group.

Begin Focus Group

1) Facilitate an open discussion for domain one barriers and facilitators among participants. 2) Facilitate an open discussion on what can be done to overcome barriers and increase facilitators for that domain. 3) Repeat for domains two and three.

Domain One: Individual Characteristics. Characteristics within the individual that impede or aid service utilization among juvenile justice clients. (examples: attitudes, feelings, beliefs, level of acceptance of MH diagnosis, perception of service efficacy, perceived stigma, personal motivation for change, and substance abuse or other comorbid issues). Elements that exist within the individual.

- 1) Can you please share your feelings and experiences about what individual characteristics have blocked, deterred, or slowed youth from utilizing mental health services?
- 2) Can you please share your experiences where individual characteristics that have aided or quickened a youth in utilizing mental health services?
- 3) What do you feel that agencies, organizations, communities, or you as individuals can do to eliminate or reduce individual barriers, and/or increase facilitators to mental health service usage among JJ youth?

Domain Two: Environmental Characteristics. Elements surrounding the individual that impede or aid in service utilization among juvenile justice clients. (Family dynamics, family addiction, family crisis or crises, community dynamics, availability of resources in community, distance to resources, socioeconomic status, and parental or caregiver support). Elements that exists around the individual.

- 1) What are your experiences and feelings with familial, community, or environmental barriers that slow, frustrate, or impede a youth from accessing or using mental health services?
- 2) Can you please share your experiences about the aspects of a youth's familial, community, or environmental systems that help them in utilizing, or quicken the process of accessing mental health services?
- 3) What do you feel that agencies, organizations, communities, or you as individuals can do to reduce these familial and community barriers, or increase these facilitators to mental health service usage for JJ youth?

Domain Three: Agency/Organizational Characteristics Elements within the agencies and organizations that impede or aid help seeking behavior in juvenile justice clients. (examples: availability of appointments, hours of operation, quality of services, client caseloads, collaboration between agencies, etc).

- 1) Please share your experiences and thoughts on how elements within agencies and organizations can slow, frustrate, impede, or deter a justice youth from utilizing mental health services?
- 2) What are your experiences about elements within agencies and organizations that facilitate a justice youth in accessing and using mental health services...or perhaps that quicken process, or make the process less stressful?
- 3) What are your ideas on what can be done at the agency level to reduce these agency/organizational barriers and increase these facilitators to mental health services for JJ youth?
- 4) Does anyone have any final thoughts to share or add to today's conversation?

This concludes today's focus group. Thank you for your participation. You have provided me with some wonderful information that will help me to meet the research requirement for my MSW degree at CSUSB.

Are there any questions?

Pass out debriefing statement

Shut off audio-recording

Pass out gift cards.

Developed by Susan VanAllen in collaboration with Dr. Janet Chang.

APPENDIX B
INFORMED CONSENT

Social Worker Informed Consent

This study is designed to investigate the barriers and facilitators to mental health service use among juvenile justice youth. This study is conducted by Susan Y. VanAllen under the supervision of Janet C. Chang, Ph.D., Professor of Social Work, California State University San Bernardino. This study is approved by the Institutional Review Board, Social Work Subcommittee of California State University, San Bernardino.

Purpose: The purpose of this study is to elicit social worker perspectives of the barriers and facilitators of mental health service usage among juveniles in the justice setting.

Description: The focus group you are asked to participate in will consist of an open discussion of the barriers and facilitators to mental health service use among juvenile justice clients in three separate domains. Participants will be asked to rank the barriers and facilitators in order of importance, and to suggest solutions.

Participation: Your participation in this study is completely voluntary. You will be allowed to participate at whatever level you choose, and you may withdraw your participation at any time.

Confidentiality: Individual identity of participants will be kept completely confidential by the researcher(s). However, confidentiality is limited to due to the nature of focus groups. All focus group members are asked to keep the information given by other focus group members confidential.

Duration: Each focus group will last approximately an hour and a half.

Risks and Benefits: There are no foreseeable risks or benefits to participants of this study. Participation may lead to improved services for juvenile justice youth.

Contact: If you have questions about your rights as they apply to this study, contact: Dr. Janet C. Chang, Professor of Social Work, California State University San Bernardino. Email: jchang@csusb.edu. Phone: (909) 537-5184.

Results: Study results can be obtained after October 2015 at the John M. Pfau Library, located at 5500 University Parkway, San Bernardino, CA 92407. Phone: (909) 537-5000

I have read the information above and agree to participate in this study.

Mark _____ Date _____

(to maintain confidentiality, sign with an X instead of your full signature)

Audio Recording: I hereby give my permission to be audio recorded during the focus group

_____ Yes _____ No Mark _____ (sign with an "X" for confidentiality)

APPENDIX C
DEBRIEFING STATEMENT

Debriefing Statement

The purpose of the study you are participating in is to explore avenues to overcoming barriers and expanding facilitators of mental health service utilization among juvenile justice youth. All data collected in focus groups will be kept confidential and will be stored in a locked desk, and destroyed within one year of completion of this study. If you have any questions or concerns about your participation in this study, please contact Dr. Chang, Ph.D., M.S.W., Professor of Social Work at CSUSB at (909) 537-5184 or email her at jchang@csusb.edu. Results of this study can be obtained after June 2015 at the John M. Pfau Library, 3rd floor, thesis room, located at 5500 University Parkway, San Bernardino, CA 92407. Phone: (909) 537-5000

APPENDIX D
DEMOGRAPHICS

Focus Group Participant Information Sheet

Demographics:

- 1) Are you an employee_____ or intern_____? (Mark one please)
- 2) Level of education completed:
___AA ___Bachelor ___Masters ___Doctorate ___Other (type:_____)
- 3) Specific licensure (ex: MFT, AOD, etc.):

- 4) Age:_____
- 5) Gender Identity: ___Male ___Female ___Other
- 6) Years of experience in current field of practice:_____
- 7) Ethnicity, race, or cultural identity:_____

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