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THE DISPROPORTIONATE IMPACTS OF CERTAIN FACTORS THAT DIFFERENTIATE THE AMOUNT OF MENTAL HEALTH REFERRALS OF SCHOOL A COMPARED TO SCHOOL B

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A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

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by

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ABSTRACT

This study explores the relationship between a variety of factors the school of attendance for two schools in the Inland Empire. This research project sought to assess if there are differing rates of exposure to parental substance use, geographical location, diagnosis of anxiety, diagnosis of depression, and exposure to traumatic events based on the high school of attendance. Secondary data was acquired from a school district in the Inland Empire. Fifty assessments from school A and fifty from school B were used; a total of 100 adolescent assessments were used. The adolescent assessment explores the location of living, questions regarding adverse childhood experiences, exposure to parental substance use, and diagnoses. The assessments were used to gather information to provide the necessities of a mental health service from this school district. A bivariate analysis was used to determine if there were statistically different rates of diagnosis and exposure to other risk factors between the two high schools. The factors that demonstrated a significantly higher rate of exposure to parental substance use, the amount of depression referrals, traumatic events in School A. School B shows a higher rate of anxiety referrals. The findings demonstrate that each school may require different types of social services, and potentially that demographic factors differing between the two schools (specifically socioeconomic status) may impact these factors.

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DEDICATION

First, I would like to thank God. Quiero dedicar este trabajo a mis padres Carmen Elicia Barcenas de Barrientos y Jose Ruiz Barrientos que me dieron el apoyo y motivation a echarle ganas en todo. El privilegio de sigirle a la escuela, siempre sera agradecido por lo que ustedes han hecho para mi, los amo. I want to thank my sister Sandra for pushing me to go to school and paving the way of the possibilities as a first generation college student. I also want to thank my sister Lorena, my brother Jose, my nieces Briana, Giselle, and Vanessa, and my nephews Cruz, Edwin, Jose (Gordo), Matthew, and Rey, who motivate me to continue to be a positive role model.

Thank you to my vecino “Joe” (Jose) for becoming a positive role model and a great friend. I want to thank the homies and loved ones who showed their love and encouragement during my educational journey. For the people who are not here anymore, that taught me to adapt, survive, and utilize the minimal resources to make it happen. Most importantly,” I got love for the place they raised me, even though times get lil’crazy, so I gotta give love back.” …. The City of Chiques.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE

PROBLEM FORMULATION

Introduction

An individual's ongoing lifestyle proceeds based on the values and morals on their journey to adulthood (Schwab, 2019). Whether living a privileged or underserved lifestyle, both can have good or bad consequences (Schwab, 2019). In some circumstances, factors are placed in an individual's path early on as adolescence due to exposure to their environment and traumatic life events (Adolescent et al., 2021). While in school, students are encouraged to strive to be greater and present themselves with excellent character as they grow. Often, there are similar expectations for students who come from different backgrounds. However, barriers affect individuals differently, which can affect them emotionally and mentally (Cecil et al., 2014).

Background of Problem

Individuals predominately in low socioeconomic communities are prone to exposure to parental substance use, community violence, and trauma, which can be harmful or life-changing and take part in the progress of an individual's life (Adolescent et al., 2021). However, some interventions can mitigate the adverse effects of harmful experiences and situations. For example, a school district in the Inland Empire offers behavioral and mental health services for students facing mental health problems. The district offers weekly school-based mental health counseling services for individuals referred to the program criteria.

Statement of Problem

The district referenced above has 28 schools with a population of over 20,000 students. To keep confidentiality, two schools in the district in the Inland Empire will be labeled school A and school B. The focus of this research is the difference in the number of anxiety and depression referrals between school A and school B. Both schools in the same district should offer the same resources and programs but display evidence of disparities in the number of mental health referrals.

Three factors are identified that contribute to the differences in identifying the amount of referrals of anxiety and depression between school A and school B. The factors include parental substance use that affects the adolescent years due to neglect and maltreatment (Children Living With Parents Who Have a Substance Use Disorder, n.d.). A hostile environment due to the geographical location that is impacted by the exposure to crimes, violence, and gangs in or around their neighborhood (Assari, 2018). Lastly, the traumatic event an individual has or is exposed to, such as but not limited to neglect in the home and disputes that create stress (Lind et al., 2020).

Examining the amount of referrals between two schools in the same district is essential to understanding the different factors impacting the students. This research highlights the appropriate resources needed in each school to create an equal opportunity for all schools and help create adequate equity (Ross et al., 2007).

Social Work Implications

The findings from this study will bring awareness to social work practice at a micro and mezzo level. At a micro level, these findings will bring attention to harmful factors that are overlooked of an adolescent. Bad behavior is an individual's reaction to the factors in their lives and environment, which becomes a misconception (Mercy, 2003). At a mezzo level, this will raise awareness amongst the district to ensure equity among underserved communities in every other city. Furthermore, the findings will highlight differences between schools, their locations, and the impacts of the different populations of students.

Purpose of the Study

Students referred to the mental health program have been impacted due to the different factors they are exposed to, with students that are predominantly at a low socioeconomic status, such as school A, and students at a higher socioeconomic level, such as school B, being the possible cause of the different amount of referral of anxiety and depression. By creating a common ground of equitable resources based on the need, school districts are to ensure the possibility of equity. The research question for this project is: Are students from School A and School B disproportionately impacted by certain factors that lead to a higher risk of developing anxiety and depression?

CHAPTER TWO

LITERATURE REVIEW

Introduction

In this chapter, the researcher will discuss two mental health disorders that are caused by the possible factors that affect adolescents. The factors include parental substance use effects on an adolescent's mental health, geographical location of a violent environment, and traumatic events that are some of many factors that harm an adolescent's mental health. The CDC describes these factors as adverse childhood experiences that occur when children are exposed to events that overwhelm their ability to manage what they experience, which becomes a long-term health issue (Trauma and Adverse Childhood Experiences (ACES) | ECLKC, 2023).

Adolescents Mental Health

Adolescence is the phase of life from 10 through 19 years of age (Adolescent Health, 2019). This age of life is an essential and unique stage of development in the journey to adulthood (Adolescent Health, 2019). Adolescents experience rapid psychosocial, cognitive, and physical growth (Adolescent Health, 2019). These changes can be affected by exposure to poverty, abuse, or violence, putting them at risk of mental health problems (Adolescent et al., 2021).

For adolescents, one in six are exposed to the barriers of poverty, violence, or trauma (Adolescent et al., 2021). One in seven (14%) adolescents in the world experience a mental health disorder (Adolescent et al., 2021). In some

areas, their mental health is overlooked and continues to be affected by it long term (Adolescent et al., 2021). Individuals with a mental health disorder are vulnerable to being socially ostracized, face a stigma of seeking help, educational difficulties, and ill health (Adolescent et al., 2021). Emotional disorders are the most common mental health disorder that affects adolescents, such as depression and anxiety, that is also the leading cause of illnesses and disabilities (Adolescent et al., 2021).

Anxiety

According to the Diagnostic and Statistical Manual of Mental Health Disorders, anxiety is described as an excessive worry that affects events or activities and difficulty controlling the worry (American Psychiatric Association, 2013). The symptoms can include being fatigued, difficulty concentrating, irritability, muscle tension, and affect sleep patterns that cause significant distress and impact mentally (American Psychiatric Association, 2013). The National Institute of Mental Health and Prevention states that, in 2012, of all adolescents in the United States, about 31.9% had an anxiety disorder (Anxiety Disorders, n.d.). This number continues to rise; as of 2019, there was a 9.4% rise in anxiety among adolescents (Centers for Disease Control and Prevention[CDC]. 2022). Factors include, as stated, high expectations and pressure to succeed, the world view of threats, and social media (Centers for Disease Control and Prevention [CDC]. 2022).

Depression

The DSM5 describes major depressive disorder or clinical depression as a consistent sadness and lack of interest or lack of enjoyment in events or activities an individual used to find enjoyable (American Psychiatric Association, 2013). The DSM5 describes the symptoms as a decline in interest, indecisiveness, an inability to concentrate, drained energy, feelings of worthlessness, and consistent suicidal ideation (American Psychiatric Association, 2013).

The National Institute of Mental Health states that in 2020, about 4.1 million adolescents in the United States experienced a depressive episode, making it the most common mental health disorder (Depression, n.d.). In addition, some factors disclosed but not limited to traumatic events, isolation, and substance use (Depression, n.d.).

Parental Substance Use

In this section, the researcher will discuss the impacts parental substance use has on their children's mental health. About 11% of children in the U.S. are exposed to an adult in the home with a current or history of substance use (Solis et al., 2012). Substance use disorder is defined as the constant usage of a drug that is harmful to the self and becomes physically and psychologically dependent (Reid et al., 2012). Substance abuse affects the individual and their surrounding support system, such as family; this can affect the dynamics that cause emotional distress (Overholser et al., 1997). Emotional distress is linked to the transition to a mental health disorder, displaying similar symptoms of anxiety and

depression, such as helplessness, being overwhelmed, or hopelessness (Overholser et al., 1997). Children who are exposed to and affected by parental substance use are at risk of an adverse outcome in the future, and research has shown an increase in the number of diagnoses of anxiety and depression (Solis et al., 2012). Parental substance use from either parent affects their children differently. Mothers who are using substances are less likely to display compassion, interaction, and engagement with their children and display an aggressive and intrusive style of interaction compared to non-substance-using mothers (Solis et al., 2012). Fathers are less likely to display sensitivity and engagement and have a structural relationship with their children than non-substance abusive fathers (Solis et al., 2012). Overall, children who are affected by this relationship develop a less secure self due to maltreatment and neglect from both parents (Solis et al., 2012).

Research on the "Forgotten Children" is based on children who were in a household with parental alcohol abuse and analyzed the areas that were overlooked in research on children of alcoholics (Burk & Sher, 1988, pp. 285–302). Children of alcoholics are labeled as an "at-risk" population, often being overlooked by professionals who oversee alcoholism in the field; nevertheless, there has been more attention to the children in the family (Burk & Sher, 1988, pp. 285–302). Holden's (1945) study shows that 25% of juvenile delinquents that were surveyed in a specific guidance clinic were in a household with one parent with alcohol abuse and displayed common behaviors of children of alcoholics

such as truancy, aggression, nervousness, and hyperactivity. He also spoke on the vulnerability to the adverse outcomes of depression, juvenile, academic problems, and interpersonal difficulties (Burk & Sher, 1988).

A National Survey on Drug Use and Health conducted a study of children who live with parents who had substance use within the past year (Children Living With Parents Who Have a Substance Use Disorder, n.d.). The study looked at parent alcohol disorder and illicit drugs from data of 2009 through 2014. Children who are living with a parent with substance abuse were found to be of lower socioeconomic status, have difficulty in social environments, and were more likely to have a higher rate of mental health and behavioral disorders (Children Living With Parents Who Have a Substance Use Disorder, n.d.). The data showed that an average of 8.7 million (12.3%) children of 17 or younger have at least one parent who has a substance abuse (Children Living With Parents Who Have a Substance Use Disorder, n.d.). About 7.5 million (10.5%) of those children have been in a household with a parent with alcohol abuse in the last year (Children Living With Parents Who Have a Substance Use Disorder, n.d.). Also, of that average of substance abuse, 2.1 million (2.9%) are living with a parent who has abused illicit drugs in the last year (Children Living With Parents Who Have a Substance Use Disorder, n.d.). The data states that 1 in 8 children in the United States 17 or younger are in a household of at least one parent that has or had substance abuse (Children Living With Parents Who Have a Substance Use Disorder, n.d.),

Many of the children living in homes exposed to parental substance use do not experience neglect, but they are at high risk for maltreatment and child welfare being involved (Burk & Sher, 1988). There is an urgency to take note of children who are in the household with a parent or parents who have a substance use disorder and are prone to mental health and behavioral issues. The population of children of alcoholics is considered "at-risk"; this type of labeling brings awareness, making it essential to study and understand each individual that is affected by their parental substance use (Burk & Sher, 1988).

Geographical Locations

In this section, the researcher will discuss the impact of geographical location inequalities on an adolescent's mental health. The living standards are the services available regarding income, basic needs, and services of either society or location. It is essential because it is considered to be a contribution to an individual's quality of life (Weich & Lewis, 1998). The barriers to poor material living standards negatively impact an individual's mental health, including socioeconomic level and inequalities of location (Weich & Lewis, 1998). In addition, low-income communities are faced with disparities that are often normalized, such as community violence. Community violence is the potential and collective negative impact of an individual's stressor and often affects their mental health due to their geographical location (Weich & Lewis, 1998).

The geographical location is defined as an individual's living location, and the exposure to their environment will be examined. Exposure is considered an

occurrence out of an individual's control and prone to exposure to a hostile environment (Copeland-Linder et al., 2010). Community violence exposure is recognized as a global health problem (World Health Organization: WHO, 2019). The Centers for Disease Control and Prevention describe community violence as "violence that happens to an unrelated individual that is or not familiar with specifically outside the home," such as any violent acts or crimes that are exposed in the individuals' community (Centers for Disease Control and Prevention [CDC]. 2022).

Exposure to community violence is a risk factor for adolescents' mental health (Cecil et al., 2014). Mental health disorders affect 16% of adolescents in the world. Half of the cases presented state that it occurs at 14. However, the transition from adolescence to adulthood goes undetected and drags some symptoms, stating that 75% of the cases begin around the mid-20s (Durlak et al., 2011). Common mental health disorders that impact the population of individuals who face community violence are often anxiety and depression (Durlak et al., 2011). A study of adolescents exposed to violent crimes was conducted in the state of Brazil’s population. The results determined that 30% of the common mental health such as anxiety and depression, are factors that are effects of exposure (Durlak et al., 2011). The focus is that community violence for adolescents at the low socioeconomic level continues to rise and presents factors of adolescents’ decision to be outside rather than inside the home due to factors that are out of their control. A large population of adolescent deciding to

leave their home to escape their problems find the same problems that evolve into negative behaviors (Durlak et al., 2011).

The location of living affects not only the external appearance but also the internal as adolescents collect information as they develop (Bunch et al., 2018). A study was done of a sample of 504 adolescents, predominantly African American individuals, being exposed to, witnessing, or taking part in violent acts in the community (Copeland-Linder et al., 2010). Of that sample, 66% are of low socioeconomic status (Copeland-Linder et al., 2010). Factors of exposure to violence and self-worth labeled as depression were measured in this study. They indicated that 77% of the individuals were labeled as moderate to high risk of mental health issues due to being exposed to violent acts that affect their self-esteem (Copeland-Linder et al., 2010). The outcome of living in a violent community correlates with worry and concern (Bunch et al., 2018). Individuals exposed to participate in violence but do not partake in the acts are predicted to be the future in statistics rates (Bunch et al., 2018).

Community violence is not only occurring in low socioeconomic level communities but is more likely to occur due to a large number of individuals in the marginalized community. This becomes a factor in the amount of anxiety and depression that progress into adulthood if left untreated. (Smith et al., 2017). Dealing with the disparities in the community becomes a "norm"; adolescents are unable to escape their situation and acknowledge the symptoms due to their exposure and mask it with the label of "life lessons.".

City of School A and City of School B

According to the census in San Bernardino County in southern California, city A has a population of 54,285 (QuickFacts, 2021) with a median household income of $56,762, 15.1% of the population is at or below the poverty level. As stated in the City Data Crime Index, city A showed that the city's crime rate was about average in the United States cities. Nevertheless, it was at a high 79.2% of crimes reported for 2019. Although the rate has fallen by 10% compared to 2018, violent crimes have increased, and property crimes have decreased (QuickFacts, 2021).

City B has a population of 13,223 (QuickFacts, 2021). The median income for city B is $70,200, and, in the population, there is 8.7% percent at and or below the poverty line (QuickFacts, 2021). City B's crime rate in 2019 was 67.9% of crimes reported which was 1.4 times lower than the city crime rate average in the United States (QuickFacts, 2021).

Traumatic Events

In this section, the researcher will explain the impacts of traumatic events on adolescents' mental health as they go through the process of adulthood. Trauma is a wound that never fully heals, and the scars left behind are like memories, meaning they will always be there. Although negative life-changing moments are left to remember, some may choose to forget the events, and others accept them (Schrock et al., 2021). However, there are ways of controlling how the situation affects the individual. The event and thoughts often cause

negative impacts on an individual's mental health. Often, adolescents are exposed to traumatic events that impact their behavior, values, and norms based on fear that activates the flight or fight response (Schrock et al., 2021).

The National Institute of Mental Health defines traumatic events as scary, dangerous, or shocking events that can impact an individual physically and emotionally (Coping With Traumatic Events, n.d.). These acts can include natural disasters, violence, physical abuse, psychological abuse, life-changing events, the loss of a loved one, neglect, or any traumatic event (Coping With Traumatic Events, n.d.).

Often, symptoms to recognize in adolescents are individuals who feel alone, developing eating disorders, self-harming behaviors, and substance use (Larkin et al., 2013). Traumatic events are adverse exposures that are out of their control but harm the individual and affect their daily life, which becomes specified as a “part of life” (Wethington et al., 2008). The psychological harm that traumatic events have on adolescents who are taken into adulthood is often masked and hidden (Wethington et al., 2008). Specifically, maltreatment at home can affect the brain's function, such as the memory and attention span of an adolescent, and leads to mental health issues such as anxiety and depression (Wethington et al., 2008).

Maltreatment at home is a public health problem that continues to be a problem, with estimates in the United Kingdom that between 5%-15% are maltreated severely by caregivers or parents (Cecil et al., 2014). In a sample of

201 adolescents that were measured for maltreatment, only 48% were recruited and assessed. Childhood maltreatment was measured with critical quality, consisting of twenty-eight items of self-reports (Cecil et al., 2014). 58% of the participants were indicated as having "low maltreatment," 30% had moderate maltreatment, and 12% of the participants had severe maltreatment (Cecil et al., 2014). It was analyzed that each group was experiencing an event that was impacting them differently among each group. However, a mental health disorder of some type was the effect of maltreatment (Cecil et al., 2014). Negative emotions of anger were seen for all three groups; none were specified on the difference of anger (Cecil et al., 2014). Results found that maltreatment predicted the severity of the mental health disorder symptoms later in the future (Cecil et al., 2014). The maltreated adolescents who felt unsafe in their maltreated environment are more likely to affect their psychological and emotional functioning due to abuse and neglect (Cecil et al., 2014). Nevertheless, this information sets up early interventions to stop the efforts of effects on their mental health (Cecil et al., 2014).

Adolescents are often exposed to conflict and life-changing events that impact them and have a negative effect. Unfortunately, traumatic events are often overlooked and seen as everyday event occurrences that many individuals experience. As a result, traumatic events have long-term impacts on mental health that progress into adulthood, often masked and removed from the linkage of emotions.

Theories Guiding Conceptualization

A theory that is used to conceptualize ideas for this study is the ecological systems theory. The ecological systems theory developed by Urie Bronfenbrenner (1974) implements a framework for the relationship of an individual's interaction with five ecological levels of the surrounding environment (Eriksson et al., 2018). The five levels of ecological systems include microsystems, mesosystems, exosystems, macrosystems, and chronosystems (Eriksson et al., 2018). The microsystem is the first level, the relationship of their immediate environment: parents, teachers, siblings, and school peers (Eriksson et al., 2018). The mesosystem is the second level, the interconnection between the first level, such as teachers communicating with parents (Eriksson et al., 2018). The third level, exosystem, is the social structures that are not part of the individual but are an indirect influence, such as their neighborhood (Eriksson et al., 2018). The fourth level, the macrosystem, focuses on cultural elements such as socioeconomic status, beliefs, and morals (Eriksson et al., 2018).

Finally, the fifth level of the chronosystem is the environmental changes that influence development, such as life-changing events like starting school (Eriksson et al., 2018).

The theory explains that individuals are the "product of their environment" and are influenced by their multiple social circles. Each ecological level plays a role in structuring and developing the individual and gives an understanding of each level, which becomes an obstacle in the individual's life. The outside factors

in the social circles correspond to the outcome of an individual’s ecological factors, such as education, socioeconomic status, and social change, that influence mental health. Education is dictated by the illiteracy of risk factors for mental health disorders (Singh et al., n.d.). Low socioeconomic status is a prevalent factor in mental health. Individuals face economic burdens and inadequate resources, which impact their mental health (Singh et al., n.d.). Negative social change affects the mental health of adolescents, which becomes a barrier to reaching their potential (Singh et al., n.d.). The rapid social change experienced through the time of ascent to adulthood impacts their insecurity and hopelessness (Singh et al., n.d.).

The ecological framework's impacts correspond to an individual's outcome and molding. For example, the microsystem is the daily life in an immediate home setting with consistent behavior exposed to the individual. Microsystems are connected to the mesosystem that correlates to the experiences in the different social circles, such as family and school, that contribute as factors to the individual's behavior and attitude. This behavior is linked to the exosystem and macrosystem of the individual. Both of these categories are the exposure to different role models in the individual's life. The chronosystem is the life-changing events with a domino effect that continues to impact the individuals in the social circles, such as traumatic events.

Summary

Adolescents face many factors that affect their mental health. Assessing the factors that individuals are affected by their parental substance use, environment, and exposure to negative impact is essential when it comes to providing services that are appropriate for their needs. The factors discussed correlate with the ecological model in that each influences each individual differently, and part takes in the number differences of depression and anxiety referrals in both schools.

CHAPTER THREE

METHODS

Introduction

This study will describe the differences in the amount of anxiety and depression diagnoses in a district in the Inland Empire between the students at school A and school B. The student referrals that are important for this study are the recorded referrals for diagnosis of anxiety and depression between both high schools. This chapter contains how this study will be conducted and sections that will be discussed. These will be the study design, sampling, data collection and instrument, procedures, protection of human subjects, and data analysis.

Study Design

The purpose of this study is to identify the amounts difference in anxiety and depression diagnoses between School A and School B in a district in the Inland Empire. The study explores both schools in the same district to identify the differences between the schools and the students that attend. This study is comparative research, which compares the amount of depression referrals and anxiety referrals between the schools and the supporting factors that impact the student’s need to seek mental health support. The data that will be explored will bring attention to the differences in both schools' populations and give a better understanding of differences from a social work perspective. The data utilizes a

mixed methods study; it will utilize questions from student referrals and diagnoses to collect secondary data from each student.

A positive aspect of using secondary data is the accessibility of the information for both schools. With this secondary data, the district has a quantitative study of the referrals, describing the questions and a number to examine two types of referrals, given the circumstances of the mental health program at the district in the Inland Empire that began in 2018.

The negative aspect of using secondary data is that clarifying some questions is impossible when looking at the data. However, it is necessary to rely on the answers from the assessments and referrals. Approval is needed to use the Inland Empire School District data in the secondary data. Another conflict is using secondary data being able to interpret answers into questions that are needed to support the differences.

This study will answer questions regarding the differences in mental health disorders in the high school setting, such as: 1) What barriers impact the mental health of students between these high schools? 2) Why is there a higher amount of referrals of depression and anxiety in School A than in School B? 3)Why is there a significant difference in the amount of anxiety and depression diagnoses if they are under the same district?

Sampling

This study will use convenience sampling; the data being collected is secondary data from the Behavioral Mental Health Southern California district,

specifically referrals from School A and School B. This data is collected through the district's Behavioral Mental Health service. The director will approve, and the director and supervisors will explain what the researcher can use on the referrals or any other secondary data that will help with the research. The data set will be used from 2019 through the 2021 school year.

Data Collection

Data will be collected from referrals and assessments (Appendix). The researcher will pay attention to and determine the study group based on the diagnosis given by their clinician (Appendix). Data entered from referrals and assessments will be coded to ensure confidentiality.

Nevertheless, the diagnosis will ultimately determine the section in which they belong in the data retrieval process. The questions that are to be looked at are the location of the city, parental substance use, and trauma exposures. These questions will be coded, renamed, and generalized to specific subgroups to set up frequencies. Once the researcher has the population, the researcher will look at their assessment to collect data needed for the research.

Procedures

Before the assessments of each client are collected, there is a process of confidentiality and mandated reporting. During that process, the client and parent are advised that the information is being taken and signed for approval by both

parent and student. In accepting the services, both the parent and client agree to the services and the data that is being collected.

Protection of Human Subjects

The client and the client's parents are informed of the program offered by the district. During approval, confidentiality, and mandated reporting, permission is signed to gather data and provide services to the client, which will remain nameless. The sole purpose is to collect the amount of anxiety and depression between school A and school B. No name will be disclosed while gathering information from the assessments. Nevertheless, data will be separated from school A and B students. As mentioned in the early processes of assessing a child, the data collected will solely be used for research and information to educate and inform. Data will be collected from schools A and B, specifically depression and anxiety diagnoses. Data will be extracted from the assessment forms that clients and client's parents fill out.

Data Analysis

All data collected from the referrals and assessments will be analyzed with content analysis, as before going through the referrals and the assessments, the data collected will each be coded. Diagnosis of depression and anxiety will take part in the data collection to see the significance of the schools. The researcher will run a descriptive statistic on SPSS and a Chi-Square analysis to examine differences between critical variables.

Independent variables are school A and school B; the researcher will run statistics to look for differences in the dependent variables, parental substance use, geographical location of the students, number of traumatic events experienced, and diagnosis or reason for referral. The data responses were analyzed using bivariate analysis.

Summary

This study will examine the difference between School A and School B. The data will provide an overview of both schools, showing different numbers and types of referrals in the same district. The possible results will bring awareness of possibilities and unforeseen barriers and the social work perspective of understanding the reasoning behind the outcomes playing a part in students at each school. This study best utilized the quantitative approach to obtain the necessary data. The researcher abided by ethical and social work principles to make sure the students in the assessments were protected.

CHAPTER FOUR

RESULTS

Introduction

This chapter will discuss the study's general findings. A sample of 100 students was acquired from a district in the Inland Empire assessments from 2019 through 2021. First, the researcher reviews the study's descriptive statistics. Second, the researcher reviews the data analyzed. Lastly, the researcher discusses the study's results.

Demographics

In the study, there were a total of 100 participants. Table 1 shows the characteristics of all students in the study. Of the 100 students in the study, 50% are from School A, and 50% are from School B. From the study, 33% live in the city near School A, 52% live in the city near School B, and 15% are from a different city. Students asked if they had witnessed trauma, and 37% checked off no, and 63% checked off yes. The students were to check off the number of different traumas 37% checked off none, 20% only checked off 1, 14% checked off two boxes, 15% checked off three boxes, and 14% checked off four or more boxes were checked off. Additionally, they were asked if the student was exposed to parental substance use in the home 52% said no, and 48% said yes. Also, considering their diagnosis, 48% were diagnosed with depression and were not diagnosed with depression, 58% were diagnosed with anxiety, and 42% were

not diagnosed with anxiety. Also, 81% had a different diagnosis, and 19% had z-codes. Finally, of the z-codes, 42% did not have z-codes, 42 % had one z-code, and 16% had two z-codes.

Table 1. Demographics

Variable	Frequency (N)	Percentage (%)
School		
A	50	50.0
B	50	50.0
Location		
A	52	52.0
B	33	33.0
Different location	15	15.0
Trauma		
Yes	63	63.0
No	37	37.0
Trauma Boxes		
none	37	37.0
1 box checked off	20	20.0
2 boxes checked off	14	14.0
3 boxes checked off	15	15.0
4 boxes checked off	14	14.0
Parental Substance Use		
Yes	48	48.0
No	52	52.0
Depression		
Yes	49	49.0
No	51	51.0
Anxiety		
Yes	58	58.0
No	42	42.0
Different Diagnosis		
Different Diagnosis	81	81.0
Z-codes	19	19.0
Z-codes		
No z-code	42	42.0
1 z-code	42	42.0
2 z-codes	16	16.0

Presentation of Findings

Analysis was completed to determine if there were differences between rates of diagnosis of depression, anxiety, exposure to substance use and trauma exposure based on the high school of attendance. Based on the data, a Chi-square test was appropriate. A Chi-square test was performed to determine if there was a significant difference between rates of depression diagnosis and high school location. This test (χ=21.17, p<.001) is significant, with students from School A showing higher rates of depression diagnosis than School B. Please see Figure 1. below for details.

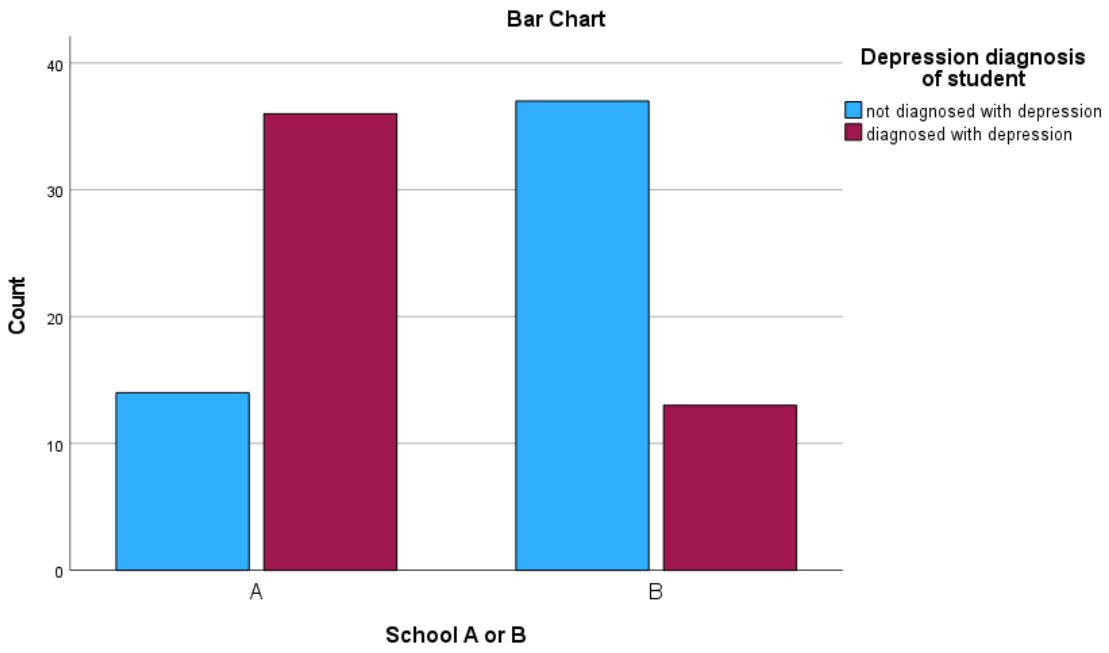

Figure 1. Depression

A Chi-square test was performed to determine if there was a significant difference between rates of anxiety diagnosis based on high school location. This test (χ=4.11, p>.043) is significant, with students from School A showing higher rates of anxiety diagnosis than School B. Please see Figure 2. below for details.

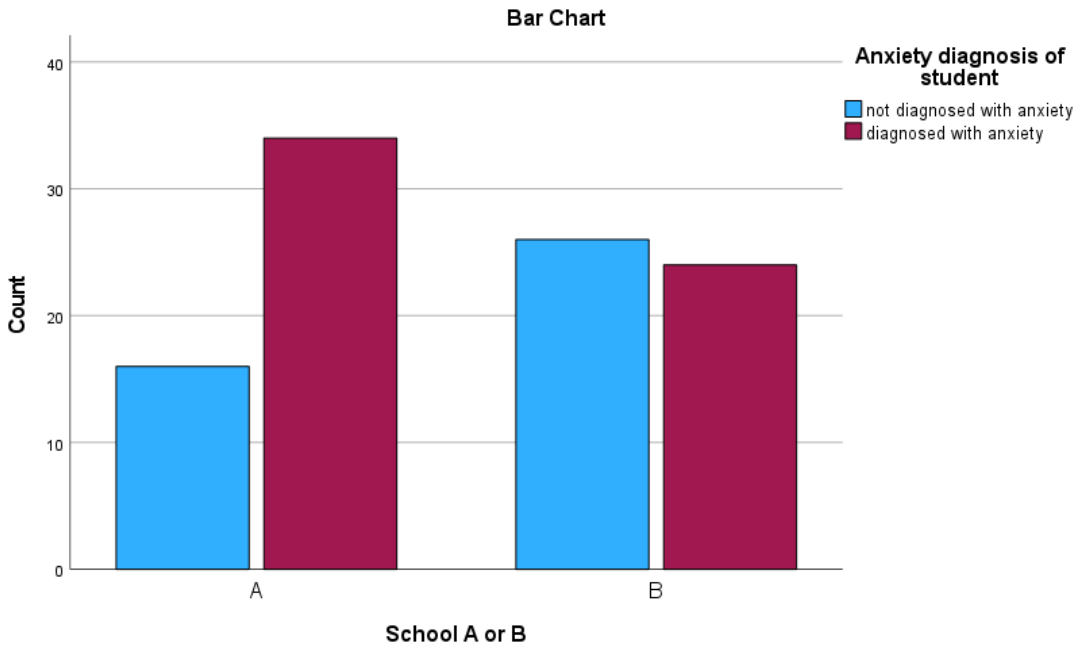

Figure 2. Anxiety

A Chi-square test was performed to determine if there was a significant difference between rates of students being exposed to parental substance use based on high school location. This test (χ=16.03, p<.001) is significant, with School A students showing exposure to parental substance use rates than School B. Please see Figure 3. below for details.

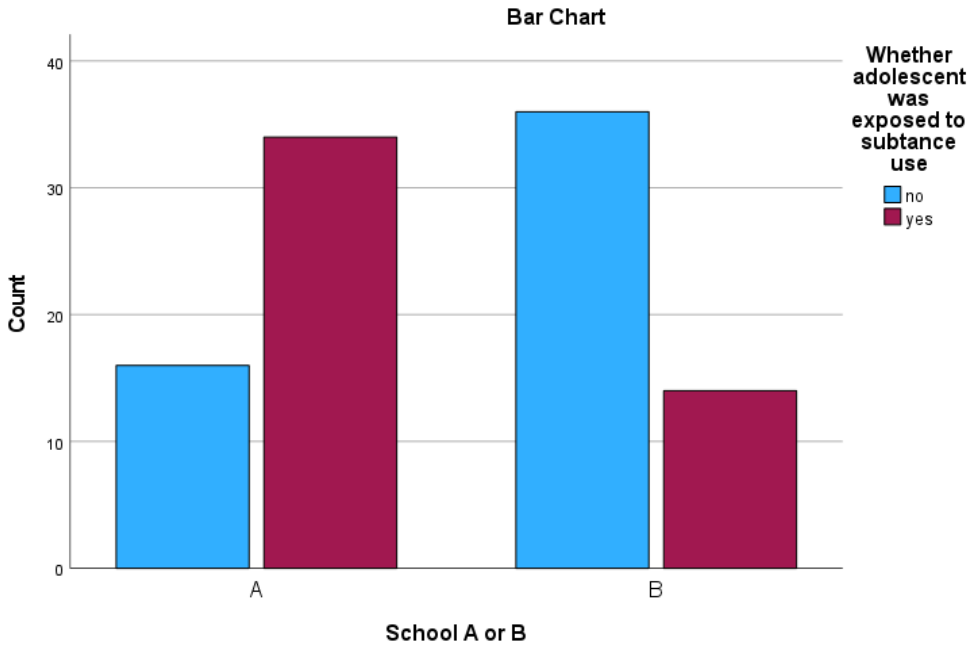

Figure 3. Parental Substance Use

A Chi-square test was performed to determine if there was a significant difference between rates of trauma based on high school location. This test (χ=18.92, p<.001) is significant, with students from school A showing higher rates of trauma exposure than school B. Please see Figure 4. below for details.

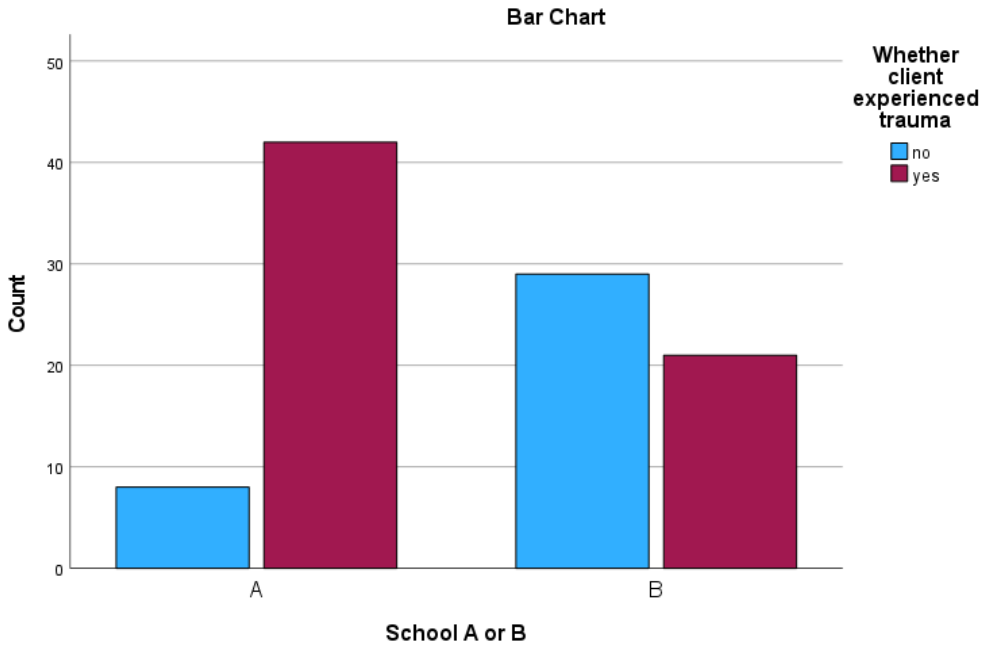

Figure 4. Traumatic Events

Conclusion

This chapter reported the demographic characteristics of the secondary data collected and the significant findings from the analysis. The findings show that students attending school A or B found significance in relation to the factors that influence the reasoning of different mental health referrals.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter will present an overview of the data collected from the assessments of students from schools A and B. This section will further explain the study's findings and how they relate to the existing literature and symptoms checklist, such as the Adverse Childhood Experiences that measures traumatic experiences linked to the risk increase of health, social and emotional problems. Additionally, this chapter will discuss the study's limitations, recommendations for future research, and how the findings can be used to improve the services being provided and encourage other districts to implement the importance of mental health.

Discussion

The literature shows that certain factors discussed by the researcher do impact the students negatively towards their mental health, which leads to the amount of referrals of anxiety and depression. Individuals who are often exposed to parental substance use are neglected, have been affected by their parents, and have shown emotional distress that is linked to depression and anxiety (Overholser et al., 1997).

Also, the location's demographics show the number of crime rates reported as being prone to low socioeconomic communities in the city of school

A. The inequalities of one city play a part in the student's mental health due to exposure to a violent community (Cecil et al., 2014). Another finding was traumatic events evidence has shown long-term effects, as mentioned by Adverse Childhood Experiences. The scoring method of adverse childhood experiences explains that the more different types of trauma an individual is exposed to, the more likely the high-risk problem is to their mental health (Trauma and Adverse Childhood Experiences (ACES) | ECLKC, 2023). The three factors support that they contribute to differentiating the amount of referrals of anxiety and depression. This research focused on the students in a school district in the Inland Empire, not all students in every school, which does not represent every student in the district. Further research into the traumas that affect each student and the individuals at risk from these factors is needed to better understand their experiences.

Limitations

Secondary data was acquired for this research to support the factors that present the limitations that affect students differently of either school. Secondary data was used from a district in the Inland Empire to do this research. This caused the researcher to have data from years before and present. Files were chosen based on random sampling. Another limitation would be the time frames of the assessments from both schools. Additionally, the chosen files had at least one diagnosis on file. Lastly, the study is based on the students referred to the program, not all students in the school.

Despite the limitations, the study had strengths. First, the researcher had access to the secondary data that had been collected. Also, the researcher got an equal sample size with the support of a district in the Inland Empire.

Implications

This study can be informative and help improve policies in the district's program when it comes to providing services for students. The findings of this study will bring awareness to students exposed to harmful factors that often affect them negatively more than others. Individuals exposed to harmful factors in their environment are not limited to what was discussed but show significant differences that indicate the hardships of students' everyday lives and improve the services for many schools to promote equity. Additionally, the study would indicate the importance of other districts implementing mental health services and creating student wellness centers. The results can expand the services offered by the behavioral mental health departments in school districts, utilizing the assessment and improving the necessities that families and children need beyond mental health services.

Conclusion

The intended purpose of this study is to investigate two schools in the district to determine the possible factors that impact and differentiate the amount of anxiety and depression referrals. The research results showed that the factors from school A are significantly different from those from school B. The research

included students who were assessed as being exposed to parental substance use, geographical location of living, and traumatic events that differentiate the amount of referrals from each school. School A, located in a low socioeconomic city, continues to face inequalities in needs and services. The study's results align with the literature as the three identified factors mentioned by the researcher are, but are not limited to, harmful to the student’s mental health. The researcher suggests further studies be conducted with other school districts to study other possible factors and exposures that students experience.

APPENDIX A:

IRB APPROVAL

Date: 1-28-2024

IRB #: IRB-FY2023-123
Title: The Disproportionate Impacts of Certain Factors that Differentiate the Amount of Mental Health Referrals of school A Compared to School B
Creation Date: 11-16-2022
End Date:
Status: Approved
Principal Investigator: Carolyn McAllister
Review Board: Main IRB Designated Reviewers for School of Social Work
Sponsor:

Study History

Submission Type Initial	**Review Type** Exempt	**Decision** Exempt

Key Study Contacts

Member Carolyn McAllister	**Role** Principal Investigator	**Contact** cmcallis@csusb.edu
Member Carolyn McAllister	**Role** Primary Contact	**Contact** cmcallis@csusb.edu
Member Jesus Barrientos	**Role** Co-Principal Investigator	**Contact** jesus.barrientos4854@coyote.csusb.e

APPENDIX B:

ADOLESCENT ASSESSMENT

General Information **Assessment Date:** _____

Client Name: _____ **DOB:** _____ ☐ **M** ☐ **F**
Parent/Guardian Name(s): _____
Referred by: _____
Address: _____ **City:** _____ **Zip:** _____
Home Phone: ( ) _____ **Work Phone: ( )** _____ **Message/Cell Phone: ( )** _____
Primary Language: _____ **Language Spoken in the Home:** _____
Parent's Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Sep

Presenting Concerns (*from referral source, client. Summary of the concern as presented by all parties involved*):

Client Resides with: _____

Current Living Arrangements: ☐Apartment ☐ House ☐ Motel ☐ Homeless

Family Source of Income ☐ Employed FT ☐ Employed PT ☐ Unemployed
☐ Retired ☐ On Worker Disability ☐ Seasonal/Intermittent

Occupation: _____

Education History:

Parents: Highest grade completed: **Mother**: _____ **Father**: _____

Client: Highest grade completed: _____ Currently Attending School: ☐ Yes ☐ No
School Attending: _____

Previous School(s): _____

Relavent School Issues (*school behavior, learning difficulties, problems with homework, habits, attendance, grades, significant relationships with school staff, peer functioning, activities related to school*):

Number of year's client has been in this country: _____

Client: ☐All his/her life **Parents:** ☐ All their lives

_____

_____

Is a member of the family currently serving in the United States Armed Forces: ☐ Yes ☐ No

<u>Social History/ Family Dynamics</u> (*background information, family dynamics, describe marital relationship/s (including reasons for dissolution when appropriate, sibling relationships, parent-child relationships, peer relationships, other relationships, living arrangements)*:

Genogram (optional)

Client was raised in: ☐ Intact home ☐ Blended family ☐Adoptive home

☐Single parent family ☐ Relatives' home ☐ Foster home

No. of siblings: _____ **Birth Order:** _____ **Adoption:** _____

If parents are deceased, what age was the client at the time and describe the circumstances of the death:

Was there parental substance abuse in the home? ☐Yes ☐ No *If yes, explain:*

Was there domestic violence and/or physical abuse in the home? ☐Yes ☐ No *If yes, explain*:

Family Legal History (*including immigration issues*): ☐ Never Arrested

☐ History of Arrests

Comments:

Strengths and Support Systems:

Importance of Religion/Spiritually for client: ☐ Not important ☐ Important

Have the caregiver list 3 of the client's strengths:

Extracurricular activities (*hobbies, sports, spare time activities*):

Media use/duration (TV, *online gaming, social media, YouTube*):

Family's strengths:

Family's support system (*who would the client/family go to if in need of help*):

Peer relationships/support system (*does the client have similarly aged friends that offer support or influence, are they in a romantic relationship that has affected them positively or negatively, and/or has the client experienced bullying*):

Medical History:
Sleep patterns: ☐ Normal ☐ Increased ☐ Decreased

What time does client go to bed and wake up? _____

Is bedtime a challenge or does client easily comply with set bedtime? _____

Does client have trouble staying asleep? _____

Appetite: ☐Normal ☐ Increased ☐ Decrease *If yes, explain* _____

Has the client experienced any changes in weight or appetite? ☐Yes ☐ No
If yes explain:

Body Image Concerns: ☐Yes ☐ No *If yes, explain:*

General Health: ☐ Good ☐ Fair ☐ Poor

Any current or past health problems? ☐Yes ☐ No **Date of last physical exam**: _____
If yes, please explain:

Medications and/or Holistic Approaches: ☐Yes ☐ No
Type/Reason: _____
Cultural Healing Practices: ☐Yes ☐ No
Type/Reason: _____

Developmental History:
Prenatal History: Birth Complication? ☐Yes ☐ No Pregnancy Complications? ☐Yes ☐ No
Drug/Alcohol Impact? ☐Yes ☐ No Premature Birth? ☐ Yes ☐ No
If yes, explain:

Current or Past Developmental Delays or Problems? ☐ Yes ☐ No

If yes, please explain:

Parents' attitude about having child: _____

Milestones:

Age when: Crawled? Walked? Spoke single word? Spoke sentences? Toilet Trained?

_____ _____ _____ _____ _____

<u>Mental Health History</u> (Client & Family):

Prior Counseling ☐ Yes ☐ No *If yes, when and where:*

Hospitalization for Emotional Problems? ☐ Yes ☐ No *If yes, when and where:*

Mental Health Issues? ☐ Yes ☐ No *If yes, who and reasons:*

Medications for Mental Health Issues? ☐ Yes ☐ No *If yes, type and reason*:

APPENDIX C:

ADOLESCENT ASSESSMENT (SPANISH)

I. Información General
Nombre del Padre/Tutor: _____ Remitido por: _____44cuela_____

Fecha de Evaluación: _____ Nombre del Cliente: _____ Fec. Nac.:___/___/__ ☐M ☐F

Genero: ☐ Otra identidad de género ☐ Declina responder ☐ Mujer ☐ Hombre ☐ Gente Queer ☐ Cuestionando/Inseguro de su identidad de género ☐ Transexual

Remitido por: _____
Domicilio: _____Ciudad_____ Zona Postal_____
Números Telefónicos de Casa: (___)_____ Trabajo: (___)_____
Mensajes/Celular: (___)_____ Idioma Principal:_____Idioma que se habla en casa: _____ tado civil de los padres: ☐ S ☐ M ☐ D ☐ W ☐ Sep Edad al divorcio de los padres: _____

II.Inquietudes Planteadas: (*por quien remite, padre, cliente. Resumen de las inquietudes divulgadas por todos los involucrados*):

Problemas de comportamiento: ☐ Sí ☐ No, (Explicación): Temperamento/Violencia/Daño a los Animales/Propiedad: ☐ Sí ☐ No, (Explicación): Arrestos en el pasado/actuales y problemas legales: ☐ Sí ☐ No, (Explicación): Cuestiona su Orientación Sexual; ☐ Sí ☐ No, (Explicación):

Cliente reside con: _____

Vivienda: ☐ Apartamento ☐ Casa ☐ M44el ☐ Sin hogar

FuentedeIngresodeFamilia: ☐Trabajotiempo-completo ☐Trabajamedio-tiempo ☐Desempleado ☐Retirado ☐DiscapacitadoLaboral ☐TrabajoIntermitente

Ocupacion: _____

III.Historial colar:

Padres: Mayorgradocompleto:___ Madre:_____ Padre:_____
Cliente:Mayorgradocompleto:___ Asistiendoala45cuela:_____

cuelas previas_____

IV. cuela/Relaciones con los compañeros

Problemas actuales con: ☐ Nadie ☐ Profesores ☐ Grados ☐ Compañeros ☐ Suspensiones/Expulsiones ☐ Ausencia ☐ Se resiste a ir a la escuela ☐ Problemas para separarse del hogar/padres
☐ Caída reciente de los grados ☐ Recibe servicios de educación especial

Problemas con compañeros:

2

_____

☐ Ninguno ☐ Se aísla ☐ Tímido ☐ Normalmente un seguidor ☐ Provoca/molesta

☐ Pérdidas frecuentes amigos ☐ Normalmente un líder ☐ Llora mucho ☐ Pocos amigos ☐ Abusadores ☐ Peleas

☐ Hace amigos fácilmente

Asuntos escolares relevantes (*comportamiento escolar, dificultades de aprendizaje, problemas con tarea, hábitos, asistencia, n45as, relaciones importantes con la plantilla escolar, ncionamiento con compañeros, actividades relacionadas con la escuela, etc.)*

V. DIVERSIDAD CULTURAL

Idioma preferido para recibir servicios: ☐ Inglés ☐ Otro_____Explique: _____ Los servicios y del personal asignado tendrá que estar relacionado significativamente con la cultura del cliente: ☐ No ☐ Sí (si su respuesta es "si", complete todos los elementos de esta sección)
Si las respuestas a los puntos mencionados son "Inglés" y "No", respectivamente, el resto de esta sección es opcional.

País de origen de la madre: _____ País de origen del padre: _____ Número de años que el cliente y los padres han estado en este país: Padres: _____ Cliente: _____ Cual es la Cultura con la que el cliente se identifica más :
¿Ha tenido problemas debido a su origen cultural: ☐ Sí ☐ No, (Explicación)

Prácticas de curación relacionadas con la cultura que usa: ☐ Sí ☐ No, (Explicación) Importancia de la religión/espiritualidad : ☐ Sí ☐ No, (Explicación)

tá un miembro de la familia sirviendo en las erzas armadas de los estados unidos: Si ☐ No ☐
VI. Historial Social/Dinámicas Familiares:**(*antecedentes, dinámica de familia, describa la relación entre los padres, ras relaciones, arreglos de vivienda*):**

_____

Evaluar los aspectos únicos del cliente, incluidos los antecedentes culturales y la orientación sexual, que son importantes para la

comprensión y la participación del cliente y para la planificación de la atención.

_____

Número de hermanos: ___ Orden de nacimiento: _____ Adopción: _____
Problemas con los hermanos: ☐ Sí ☐ No, (Explicación):
Problemas con los padres: ☐ Sí ☐ No, (Explicación):
Cuestiones culturales o de crianza relacionadas con la aculturación en USA: ☐ Sí ☐ No, (Explicación):

El cliente creció en: ☐ hogar intacto ☐ hogar de crianza ☐ familia compuesta ☐ hogar adoptivo ☐ familia monoparental ☐ hogar de parientes

Si los padres han fallecido, que edad tenia el cliente en el momento y describir las circunstancias de la muerte:

Hubo abuso de sustancias de los padres en el hogar? Si ☐ No ☐ *Si contesta sí, por favor explique:*

¿Huboviolenciadomésticaymaltratofísicoenelhogar?Si☐ No☐ *Sicontestasí,porfavorexplique:*

Historial Legal de Familia (*incluyendo asuntos migratorios*): ☐ Nunca Arrestados ☐ Historial de Arrestos: *Comentario:*

VII. Fortalezas y sistemas de apoyo:

☐ **Fortalezas familiares presentes** ☐ **Apoyos naturales presentes** ☐ **Permanencia en la relación** ☐ **Entorno educativo apoya presentes** ☐ **piritual/Religiosa** ☐ **Identidad cultural** ☐ **Participación comunitaria** ☐ **Participación en el tratamiento**
☐ **Interpersonal** ☐ **Recursos** ☐ **Resiliencia** ☐ **Bienestar** ☐ **Optimismo** ☐ **Talentos/intereses**

Pedir que el padre liste 3 puntos ertes del cliente:
_____ Actividades E48racurriculares (*aficiones, deportes, pasatiempos*):
_____ Uso/duración de los medios (TV, juegos en línea, redes sociales, YouTube):
_____

Family Solutions/OMSD School District Confidential Client Information – See W & I Code 5328

Fortalezas de la familia:

Sistema de apoyo para la familia (a quien acude la familia cuando necesitan ayuda):

4

Sistema de apoyo entre los compañeros/amigos ***(¿el cliente tiene amigos de la misma edad que ofrecen apoyo o influencia, están en una relación que los ha afectado de manera positiva o negativa, ha experimentado intimidación el cliente):***

VIII. Historial médico:

Problemas de salud actuales: ☐ Sí ☐ No, Explíquelo si:_____ Condiciones de salud actuales que ponen al cliente en un riesgo especial: ☐ Sí ☐ No, Si la repuesta es "Si" Explíquelo:_____ tá embarazada: ☐ Sí ☐ No ☐ Desconocido
Tiene alergias a medicamentos u ras sustancias: ☐ Sí ☐ No, Explique las alergias: _____ Medicamentos actuales:_____

Exposición a sustancias:

Cafeína: Tabaco: Alcohol:
Otros fármacos:

☐ Sí
☐ Sí
☐ Sí
☐ Sí ☐ No ☐ Uso actual, explicación/lista:

☐ No ☐ No

☐ Uso actual ☐ Uso actual ☐ Uso actual

☐ No

Marihuana:

☐ No

☐ Uso actual

☐ Sí
¿Se le complica dormirse al cliente o no cumple fácilmente con la hora de dormir?_____

Patrón de sueño: ☐Normal ☐Aumentado ☐Disminuido
¿Tiene problemas el cliente para mantenerse dormido?_____

Apetito:☐Normal ☐Aumentado☐Disminuido
El Cliente ha experimentado cambios en el peso o el apetito: Si ☐ No ☐
Comentario:

Preocupaciones sobre su imagen/apariencia física: Salud General:

¿Algún problema de salud actual o anterior? Si ☐ No ☐

IX.Historial de Desarrollo:

Historial Prenatal: ¿Embarazo planificado? ¿Impacto de alcohol/drogas?

¿Complicaciones de Parto? ¿Retrasos o problemas de desarrollo actuales o previos?

Si ☐ No ☐
☐ Buena ☐ Aceptable ☐ Mala

Fecha del último examen médico: _____*Si contesta sí, explique*:

5

Si ☐ Si ☐ Si ☐ Si ☐

No ☐ No ☐ No☐ No ☐

¿Complicaciones del embarazo? Si ☐ No ☐ ¿Nacimiento prematuro? Si ☐ No ☐

Comentario:

Actitud de los padres sobre su nacimiento:
_____

Hitos:
Edad cuando: ¿Gateó? __ ¿Habló solo palabras? ___ ¿Habló oraciones? ___ ¿Aprendió a usar baño?___

IX. TRAUMA:

_____

☐ Abuso sexual ☐ Abuso físico ☐ Abuso emocional ☐ Abandono ☐ Trauma médico ☐ Resistencia de violencia familiar
☐ Testigo de violencia comunitaria/escolar ☐ Desastres naturales o provocados por el hombre ☐ Guerra/terrorismo afectados
☐ Testigo de actividad delictiva ☐ Perturbación en la prestación de cuidados/el apego ☐ Pérdidas Conductas delictivas de los padres ☐ Acoso por terceros *Comentarios:*

X. Historial de Salud Mental de Familia (*del cliente y la familia):* Consejería previa Si ☐ No ☐ *Si contesta sí, ¿Cuándo y dónde?*:

_____

¿Hospitalizado por problemas emocionales?

¿Problemas de salud mental?

¿Medicinas para problemas emocionales

☐ Si ☐ No; ***Si contesta sí, ¿Cuándo y dónde?:***

Si ☐ No ☐ ; ***Si contesta sí, ¿Quién y razones?***:

?Si ☐ No ☐ No; ***Si contesta sí, tipo y razón:***

6. **XI. Evaluación de Riesgos:** (*reporte del padre/ tutor*)
¿Tiene el cliente IDEAS SUICIDAS ahora? ☐ Si ☐ No Si contesta sí, responda lo siguiente:¿Tiene un plan?

Descríbalo:

¿Tienen los medios? _____ ¿Como? _____ ¿Cuándo? _____

¿Tiene el cliente antecedentes de intentos previos de suicidio? cuando sucedió? *describa la situación:*

If yes, answer the following questions: **Do they have a plan and what is it?**

VÍNCULO PARA FORMULARIOS DE PROTOCOLO DE EVALUACIÓN DEL RI52GO DE SUICIDIO

https://drive.google.com/file/d/1bvOXj-3W1R8JUWIKX8eIxk8758QwuKm_/view

¿Tiene actualmente **IDEAS HOMICIDAS**? ☐ Si ☐ No *Si contesta sí, explique*:

_____

¿Ha intentado el cliente hacerle daño a alguien gravemente en el pasado? Si contesta sí, (*¿Quién, como, donde?*) *Explique*:

Client Section

(*Questions to be asked separately from caregiver*)

I.Nombre del Cliente: _____ Fec. Nac.:___/___/__ ☐M ☐F Genero: : ☐ Otra identidad de género ☐ Declina responder ☐ Mujer ☐ Hombre ☐ Gente Queer ☐ Cuestionando/Inseguro de su identidad de género ☐ Transexual

Inquietudes planteadas desde la perspectiva del cliente (*¿Cuál el testimonio de porqué él/ella está recibiendo consejería?)*

II.Fortalezas y Sistemas de Apoyo:

Pedir que el cliente liste 3 de sus puntos fuertes:

Actividades extracurriculares (pasatiempos, deportes, actividades de tiempo libre):
_____
_____
_____

Uso / duración de los medios (TV, juegos en línea, redes sociales, YouTube):
_____
_____
_____

Sistema de apoyo de parte de compañeros y amigos (¿el cliente tiene amigos de la misma edad que ofrecen apoyo o influencia, están en una relación que los ha afectado de manera positiva o negativa, ha experimentado intimidación el cliente):

8.Fortalezas de la Familia (*de acuerdo a la perspectiva del cliente*):

"¿Que te gustaría hacer cuando crezcas?"
_____ "**Si fueras un animal, ¿Qué animal serías?" ¿Por qué?**

"Si pudieras pedir tres deseos, ¿Qué pedirías?"

"¿Qué es lo que más te gusta de ti mismo?"

III. Historial Médico:

VIII. Historial médico:

Problemas de salud actuales: ☐ Sí ☐ No, Explíquelo si:
Condiciones de salud actuales que ponen al cliente en un riesgo especial: ☐ Sí ☐ No, Si la repuesta es "Si" Explíquelo:: ta embarazada: ☐ Sí ☐ No ☐ No se sabe
Tiene alergias a medicamentos u ras sustancias: ☐ Sí ☐ No, Explique las alergias:
Medicamentos actuales:

Exposición a sustancias:

Cafeína: ☐ Sí ☐ No ☐ Uso actual
Tabaco: ☐ Sí ☐ No ☐ Uso actual
Alcohol: ☐ Sí ☐ No ☐ Uso actual Marihuana: ☐ Sí ☐ No ☐ Uso actual Otros fármacos: ☐ Sí ☐ No ☐ Uso actual, explicación/lista:

Patrón de sueño: ☐Normal ☐Aumentado ☐Disminuido
¿A qué hora se acuesta el cliente? _____ ¿Cuantas horas por noche duerme el cliente?_____
¿Se le complica dormirse al cliente o no cumple fácilmente con la hora de dormir?_____ ¿Tiene problemas el cliente para mantenerse dormido?_____ ¿A qué hora se levanta el
cliente?_____
Apetito: ☐Normal ☐Aumentado ☐ Disminuido
El Cliente ha experimentado cambios en el peso o el apetito: Si ☐ No ☐

Comentario:

Preocupaciones sobre su imagen/apariencia física: Si ☐ No ☐ Salud General: ☐ Buena ☐ Aceptable ☐ Mala

¿Algún problema de salud presente o pasada? Si ☐ No ☐ Fecha del último examen médico: _____
Si contesta sí, explica:

IV. TRAUMA:

_____

☐ Abuso sexual ☐ Abuso físico ☐ Abuso emocional ☐ Abandono ☐ Trauma médico ☐ Resistencia de violencia familiar
☐ Testigo de violencia comunitaria/escolar ☐ Desastres naturales o provocados por el hombre ☐ Guerra/terrorismo afectados
☐ Testigo de actividad delictiva ☐ Perturbación en la prestación de cuidados/el apego ☐ Pérdidas Conductas delictivas de los padres ☐ Acoso por terceros
Comentarios:

LINK TO CHILD ABUSE REPORTING FORM - DCFS SB CO Ph# 1-800-827-8724 - Fx # 909-891-3545
https://oag.ca.gov/sites/all/files/agweb/pdfs/childabuse/ss_8572.pdf?

V, Evaluación de Riesgo:
Evaluación Ideas de Suicidio/Homicidio (*conforme al informe del cliente*)

¿Tienes **IDEAS SUICIDAS** actuales? Si ☐ No ☐ ***Si contesta sí, responde lo siguiente:***
¿Tienes un plan? Descríbelo:

¿Tienes los medios? _____ ¿Cómo? _____ ¿Cuándo? _____

¿Tienes antecedentes de intentos de suicidio? Y en ese caso, indica cuando y describe la situación:
_____

APPENDIX D

REFERRAL

CJUSD Mental Health Counseling Services Referral

Does the student have an IEP? No☐ Yes☐

Today's Date_____ Student ID_____ Teacher_____ Referrals source/School_____
Student Name_____ DOB_____ Age_____ Grade_____

Ethnicity_____ Primary Language_____ Home Phone:_____ Cell #:_____
Address:_____ City_____ Zip Code_____ Leave Msg? Y ☐ N☐

Mother Name_____ Father Name_____
Employed? Y☐ N☐ HS Diploma? Y☐ N ☐ Employed? Y☐ N☐ HS Diploma? Y☐ N ☐ Marital Status:_____
Primary Language:_____ Primary Language:_____

Holder of Legal Custody_____ **Type:** Sole☐ Joint ☐ Relationship to Legal Documentation of Custody?
Foster Child?☐ Ward of the Court☐ Child_____ Y ☐ N☐

List the number of children in the home **# of Family members in the home_____**

Name:_____ Age____ School_____ Name:_____ Age___ School_____
Name:_____ Age____ School_____ Name:_____ Age___ School_____
Name:_____ Age____ School_____ Name:_____ Age___ School_____
Name:_____ Age____ School_____ Name:_____ Age___ School_____

Presenting Behaviors/Concerns (Please check all that applies to students)

Anger
☐Irritability ☐Lack of self-control ☐Aggressive behavior

Conduct Issues

☐ Taking things that don't belong to him/her

Difficulties at School

☐ No friends/unable to make friends

Grief/Loss

☐Loss of significant person by death, divorce, and/or separation.

Medical/Health Issue

High Risk Behaviors

Seeing things that others cannot see

☐ Cutting/other self-harm

Mood Disturbances

☐ Giving away prized possessions

Social

Additional Comments: _____
_____
_____
_____

Physical Disabilities

99= unknown

Who Completed the Referral? Name: _____ **Phone number** _____ **Extension**_____

Additional Information Required:

Private Health Insurance☐ Provider name: _____ ☐ **Medi-Cal Yes☐ No☐ County** _____

Date: _____ **Triage Date:** _____ **Agency Triage Date:** _____

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