# OFFICE OF

## CRIMINAL JUSTICE PLANNING

# A CRY FOR HELP:

# THE MENTAL HEALTH AND SERVICE NEEDS OF HOMELESS SEXUALLY EXPLOITED YOUTH

*August 1992*

**PETE WILSON**

*Governor*

# OFFICE OF

## CRIMINAL JUSTICE PLANNING

**RAY JOHNSON**
*Executive Director*

**MARYANNE GILLIARD**
*Chief Deputy Director*

**MICHAEL BORUNDA**
*Deputy Director, Programs*

**EUGENE BALONON**
*Deputy Director, Administration*

**MIKE CARRINGTON**
*Deputy Director, Communications*

Pete Wilson
*Governor*

1130 K STREET, SUITE 300

SACRAMENTO, CA 95814

916.324.9100

# A CRY FOR HELP:

# THE MENTAL HEALTH AND SERVICE

# NEEDS OF HOMELESS SEXUALLY EXPLOITED YOUTH

Linda Ward Russell, L.C.S.W.,

Julia Pennbridge, Ph.D.,

Nikolaos Stefanidis, Ph.D.

Division of Adolescent Medicine,

Childrens Hospital Los Angeles


and


Harder+Kibbe Research, San Francisco

August, 1992

# ACKNOWLEDGMENTS

# TOO MUCH TIME IN HELL
## by : S. W.

There's only so long you can walk the road alone
and keep falling thru the cracks in a pavement of sharp stone.

Each time you think you have found someone to walk beside
you come out with a weaker heart, but a tougher hide.

The scenery never changes, though the street names always do,
the face in the mirror is never the same but it is still the reflection of you.

I can't believe in heaven, I've spent so much time in hell.
I don't believe in happy endings, I can't pretend that all is well.

When I close my eyes to sleep, I pray the lord my life to take.
I've seen so much this time around, it won't be long before I break.

So, I sit all alone in the darkness of the night
just searching for a reason not to give up on my life,
I can't seem to find an answer for my fears
I just can't see the future when my eyes are filled with tears.

I haven't found a solution behind any of the doors
My heart is way past breaking and I just can't take it anymore.

This poem was presented to one of the authors by S.W., a twenty-one year old young
woman who had no prior knowledge of this evaluation study.

# EXECUTIVE SUMMARY

## A CRY FOR HELP: THE MENTAL HEALTH AND SERVICE NEEDS OF HOMELESS SEXUALLY EXPLOITED YOUTH

*Counselors need to recognize that we are street kids and really get to know us—you can't solve our problems easily. Tell them [counselors] don't assume they know me or tell me they know me or understand. Don't say you know what I'm going through—you don't.* (17 year old African American male on his own for 2 years).

"A Cry for Help" is an evaluation of the mental health and service needs of 84 homeless sexually exploited youth age 13 to 18 representing varied ethnic backgrounds. In addition, it presents data from a survey of youth-serving agencies and from interviews with selected experts in service provision, planning and policy in relationship to the mental health and service needs of homeless youth. Youth from Latino ethnic backgrounds were oversampled in the Northern California portion of the study in an attempt to gain more information about this little studied, growing sub-population of homeless youth. The project was funded by the California State Office of Criminal Justice Planning as part of the Child Sexual Exploitation Intervention Program. It draws upon data provided by four primary sources: First, the results of a widely used standardized psychometric test, The Minnesota Multiphasic Personality Inventory (MMPI), and an accompanying demographic questionnaire administered to 84 homeless youth from two youth-serving agencies in Los Angeles and San Francisco. These youth were identified by agency staff as involved in or at high risk for involvement in survival sex/prostitution. Second, semi-structured interviews conducted with a sub-group of 34 of the youth taking the MMPI. Third, a mail survey of selected youth-serving agencies in four major California metropolitan areas and fourth, expert interviews. (Profiles of these experts appear in Appendix A of this report).

The goals of this evaluation study, which builds on previous evaluative work funded by OCJP, are as follows:

1. To document the mental health status of runaway and homeless youth involved in survival sex;
2. To understand their perceptions of and attitudes toward mental health services;
3. To learn about their experiences with the mental health service system; and
4. To obtain information about the kinds of services available to these youth.

### Key Findings: The Mental Health Problems of Homeless Sexually Exploited Youth

#### MMPI Psychometric Test Results:

Eighty-four youth took the MMPI and 66 had valid profiles.
Of the 66 youth with valid MMPI profiles:

■    84% of the youth with valid profiles suffer from a moderate to severe affective disorder, most often depression expressed in extreme apathy, aimless energy, high risk behaviors, conduct disorders and suicide attempts.

■ 36% of the youth are at high risk of suicide and 58% should be referred to a psychiatrist to assess their need for medication.

■ Over half (52%) of these youth, especially the males, are at high risk for substance abuse and only 8% are at low risk. Many seem to be "self medicating" in an attempt to control emotional pain related to feelings of hurt, isolation, anger and loss.

■ MMPI profiles indicate that 68% of these youth are predisposed to behave in sexually provocative ways including being overly seductive and using their bodies as currency to meet both survival needs and needs for simple human contact. There are strong associations between these findings and the incidence of early sexual abuse.

■ 57% of the male youth presented MMPI profiles which indicate concern about sexual identity—a finding often present in males with a history of sexual abuse by a male.

Interview and Demographic Questionnaire Results (84 youth):

■ Only 29% of these youth grew up in homes with both parents present.

■ More than half (55%) of the youth have lived in a foster home or placement for at least one night and 68% have been thrown out of their own home and/or a placement for at least one night. On average, they have been thrown out of where they were living 10 times.

■ A full two-fifths (40%) have received help for a mental health or emotional problem at some time in their lives, and 25% have stayed overnight at a hospital or other treatment program because of mental health or emotional problems. Almost one-fifth (18%) have taken psychiatric medication prescribed by a doctor.

■ Of 63 youth in the Los Angeles portion of the study, 49 (78%) had a history of child abuse. Forty-eight percent (30 youth) disclosed histories of sexual abuse, many on multiple occasions and often perpetrated by relatives and/or family members. Forty-nine percent (31 youth) had histories of physical abuse and 19% (12) had experienced both physical and sexual abuse.

Based on the data analyzed as part of this evaluation, recommendations were made in three areas: state-wide policy, training for service providers, and service needs and gaps in relationship to the mental health and related needs of homeless sexually exploited youth. Recommendations for state-wide policy changes to improve mental health services to these youth are presented first, followed by recommendations for training and research, and for better meeting service needs. A full listing and discussion of all of the recommendations drawn from this evaluation appears in Chapter 6, along with a summary of the concerns of interviewed experts.

1. OCJP should work with the State Board of Control to improve the access of homeless sexually exploited youth to the Victim Witness Assistance Fund.

2. OCJP should Work with the State Department of Social Services to designate a Youth Expert or Deputy in local welfare agencies to be available to address questions of Medi-Cal eligibility of homeless sexually exploited youth and to improve their access to Medi-Cal funding for health, mental health and related services. Similar arrangements should be made with the Social Security Administration in regard to Supplemental Security Income (SSI).

3. OCJP should work with the State Department of Insurance to maximize the access of homeless youth to use of their families' private insurance coverage to pay the cost of mental health services including residential treatment and medication, especially for youth who are victims of sexual and physical abuse.

4. OCJP should Work with appropriate state agencies to maximize the ability of homeless youth to provide consent to mental health treatment and general medical care including physical examinations and routine, non-invasive, non-surgical medical treatment. In addition, OCJP and relevant agencies should work to clarify confusion about issues relating to minor consent and other legal issues affecting youth by sponsoring the development and publication of a manual on youth law for counselors and youth workers and facilitating training of counselors and youth workers in this important advocacy area.

5. OCJP should work with the State Department of Education and other appropriate agencies to improve the access of homeless youth to educational services meeting their special needs--thus improving their chances for success in the transition to independent living as well as potentially reducing the need for later rehabilitation, unemployment and AFDC resources and incarceration due to survival related street crime.

6. OCJP should work with appropriate State agencies to amend the penal code relating to systems response to youth arrested for prostitution and solicitation, changing the focus of intervention from an emphasis on hearing such cases in juvenile or criminal court (Penal Code 602 and related adult penal codes) to handling them through dependency court (Welfare and Institutions Code 300) under the child abuse statutes or through non-judicial intervention and diversion.

7. OCJP should work with the State Department of Education and related state agencies, youth serving agencies, and business and community organizations to increase the availability of programs designed to assist homeless youth with the acquisition of independent living skills, job training and placement, and the transition to independent housing arrangements as well as working with the State Department of Education to ease access of homeless youth to work permits-- enabling multiply challenged youth to better acquire the tools necessary for transition into the community as productive young adults. This assistance, along with mental health services, is needed by most homeless youth and is especially crucial for sexually exploited homeless youth both up to age 18 and from age 18 to 24.

## FINAL RECOMMENDATIONS: Counselor Training and Research

Counselors must have experience working with youth, access to expert supervision and continuing education on a regular basis, and must receive additional training in the following areas:

A. Critical issues in child development

B. The life experience and special mental health issues of homeless sexually exploited youth.

C. Recognition and treatment of problems of substance abuse and understanding of the mental health consequences of growing up in a substance abusing environment.

D. Extensive training in the area of child abuse and neglect and issues of sexual exploitation and their impact on child/adolescent development and mental health.

E. Training in effective work with special populations including: gay identified youth, youth of color, undocumented and refugee youth, gang-involved youth, HIV infected youth, and pregnant and parenting youth—all of which are growing populations on the streets.

F. Training about the impact and mental health consequences of growing up in a climate of family violence.

G. Training and technical assistance in effective advocacy for homeless sexually exploited youth with service systems such as public education (enrollment, IEP's, Work Permits), Social Services (Medi-Cal, SSI), the Victim Witness Assistance Fund and other resources for which these youth may be eligible—as well as in the legal rights and responsibilities of minors.

H. Research and demonstration projects should be encouraged and financed in areas related to more effective practice with and programs for homeless sexually exploited youth and the exchange of knowledge between agencies should be encouraged.


## FINAL RECOMMENDATIONS: Service Needs and Gaps

Homeless sexually exploited youth need:

1. Access to mental health services in the community that understand their needs and problems as well as the realities/difficulties of providing effective services to this population.

2. Well trained counselors, clinical supervisors and psychological/psychiatric consultants available at shelters, drop-in centers and other youth-serving agencies providing mental health and related services to this complex, multi-problem population.

3. Access to appropriate and affordable treatment resources when they are acutely psychotic, suicidal or suffering from chronic mental health problems--especially youth needing medication or aftercare.

4. Access to affordable substance abuse treatment services including detoxification, outpatient and residential treatment programs, and aftercare.

5. Access to mental health and other needed services addressing their doubly jeopardized status as both homeless and gay youth, pregnant and parenting youth, youth of color, undocumented and refugee youth, HIV infected youth, youth heavily impacted by substance abuse or gang involved youth--all of whom are growing populations among youth on the streets.

6. Continued access to mental health, transitional and independent living, and shelter services when they reach 18 years of age and beyond. These sexually exploited youth in particular have long term problems that require long term solutions. Services should be extended to youth age 18 to 24 and this age group recognized as an extension of the youth service population with special needs that often go unmet in adult focused systems of care.

7. Access to longer shelter stays for those youth who need them to provide the intensive, multifaceted services required to assist severely troubled youth in the process of stabilization and eventual transition to more independent living.

## CONCLUSION

In our research interviews, both sexually exploited youth and experts eloquently argue the need for additional services and sensitive and well-trained counselors who are very familiar with the life issues and mental health concerns they present. Such counselors come armed with a non-judgmental acceptance of youth that allows them to treat with respect both youth and the coping strategies they employ to survive on the streets. This climate of respect, along with the techniques and approaches outlined in the body of this evaluation, allow effective counselors to work with youth to maximize their strengths, add new coping and survival skills to their repertoire, and gain a real sense of empowerment and efficacy in their lives.

The funding provided by the Child Sexual Exploitation Intervention project (CSEIP), as well as additional funding provided to youth-serving agencies by OCJP to augment services to sexually exploited homeless youth, have contributed greatly to the strengthening of mental health, case management and related services available to these troubled, multi-problem youth. In addition, these funds have facilitated extended staff training for OCJP funded agencies. In the current climate of decreased mental health and related resources, CSEIP funding has been particularly valuable and timely.

The results of this research project suggest, however, that unserved and underserved youth remain on the streets and that the mental health needs of sexually exploited youth are more diverse, severe and urgent than previously recognized. CSEIP funding has helped youth-serving agencies to begin to meet the mental health needs of many youth since it's implementation. Still, suicidal youth, psychotic and chronically mentally ill youth and youth in need of psychotropic medication often remain beyond the ability of drop-in and shelter facilities to adequately service alone--especially while maintaining the safety and meeting the

needs of less severely troubled youth. Few referral or funding resources exist for these youth and more are desperately needed. In addition, existing case management, counseling and other youth service staff need increased training and supervision to consistently and effectively meet the multiple mental health needs of homeless sexually exploited youth.

The mental health problems of homeless sexually exploited youth, as they emerge from the analysis of the four data sources used in this evaluation, are both complex and compelling. Even experts working with homeless youth were surprised at the prevalence and severity of the mental health concerns evidenced by the MMPI profiles of the homeless youth studied. The high incidence of depression and other affective disorders, suicidality, substance abuse risk and possible need for psychiatric medication suggests a population with increasingly critical needs in a climate of constricting financial resources.

Action taken now to increase specialized assistance to homeless sexually exploited youth can help to break the cycle of abuse and exploitation. By providing increased access to comprehensive and flexible mental health and related services and tailoring them to the needs of sexually exploited youth, we can help these youth gradually develop the skills and build the emotional foundation necessary to establish stable and self supporting lives. Early attention to the mental health and related needs of these youth will improve their chances of avoiding more serious psychiatric problems, long term unemployment and financial dependence, and incarceration for street crime-- representing a considerable savings to the public and the State. In addition, youth interviewed in this evaluation document the prevalence of family violence, child abuse, substance abuse, depression and suicidality in their lives. Interviewed youth have also spoken eloquently about their needs for both additional shelter, drop-in and transitional living services and sensitive, well trained, counselors and youth workers coming from the many cultural and ethnic backgrounds increasingly represented by California's homeless youth. Addressing the issues raised by youth and experts in this evaluation will move forward the process of developing a comprehensive state policy to respond to the dire needs of California's homeless youth. Let us answer their "cry for help."

## Chapter I.   INTRODUCTION AND EVALUATION METHODS

## Chapter II.   MENTAL HEALTH PROBLEMS OF HOMELESS YOUTH INVOLVED IN SURVIVAL SEX

## Chapter III.   YOUTH'S EXPERIENCE AND PERCEPTIONS OF MENTAL HEALTH SERVICES

# Tables: Survey of Youth Serving Agencies

# CHAPTER I:  INTRODUCTION AND EVALUATION METHODS

## A.  INTRODUCTION

Recent research suggests that the population of runaway and homeless youth is getting younger, more troubled, more diverse, and more likely to present with multiple problems than their counterparts in earlier years (Robertson, 1991; Rothman & David, 1985; Senate Hearing, 1988; Yates et al, 1988).  Many of the homeless youth found living on city streets and in abandoned buildings, as well as many of those who engage the services of youth shelters and drop-in centers, are running from chaotic home environments plagued by family conflict, and often by substance abuse.  These youth are often running from homes where they have been victims of physical, sexual and/or emotional abuse and neglect (Robertson, 1991; Rothman & David, 1985; Yates et al, 1988; Yates et al, 1991).  Some youth have been abandoned or thrown away by families who can no longer cope.  Other youth end up on the streets as a result of residential instability and overwhelming socioeconomic challenges.  Additional research indicates that a significant number of homeless youth land on the streets of American cities due to failed foster care and institutional placements or as a result of inadequate aftercare and transitional living arrangements (Digre, 1991; Housing Committee Staff, 1992; Robertson, 1991; Rothman & David, 1985; Senate Hearing, 1988).

Many runaway and homeless youth who find their way to the streets of urban centers fall prey to adults who sexually exploit them.  Child sexual exploitation is defined as any form of sexual interaction between an adult and a youth or child under the age of 18.  This definition is based on recognition that adults, by virtue of their age and experience, are in a position to manipulate children and youth for their own sexual satisfaction or economic benefit.  Examples of child sexual exploitation include child molestation, child pornography, and youth involvement in survival sex and prostitution.  The longer these youth are on the streets, the more likely it becomes that the struggle for survival will lead them in the direction of survival sex and other sexual exploitation.  In this report, survival sex is defined as any situation in which a young person trades sex for a place to stay, for food, drugs, money or other commodities as well as for simple human contact.  Research has shown that many youth who engage in survival sex also bring with them past histories of sexual abuse earlier in their

1

childhood, especially abuse by family members (Burgess 1984; Janus 1984; Silbert & Pines 1981).

Out of concern for these sexually exploited youth, the Office of Criminal Justice Planning's (OCJP) Child Sexual Exploitation Intervention Program was created to target services toward youth who either have been sexually exploited or are at great risk of being exploited. The program initially provided three years of funding to three youth-serving agencies in Los Angeles, San Diego and San Francisco. When fourth year funding was made available, a Santa Clara site was added to the program. OJCP, in conjunction with the State Technical Advisory Committee, developed the funding requirements and implemented the program. In addition, they have overseen the program evaluation.

In the first three years, San Diego Youth and Community Services (SDYCS) and Harder + Kibbe Research (H+K), documented the implementation of the three projects. In the second and third years of the program, H+K also conducted exploratory research among youth who, in the course of living away from their parents and/or guardians, had engaged in survival sex. The results of this evaluation were published in an OCJP report titled: "Confronting Sexual Exploitation of Homeless Youth: California's Juvenile Prostitution Intervention Projects."

A second report was also produced by H+K which more fully describes the results of the research conducted among a cohort group of youth who engaged in survival sex. The report is titled: "Growing Up Too Fast: An Ethnography of Sexually Exploited Youth in San Francisco." This exploration into the lives of 20 sexually exploited youth pointed to the wide range of mental health issues faced by many runaway and homeless youth. The following quotation from "Growing Up Too Fast " illustrates some of these issues:

> Many of the youth in the cohort had serious psychological issues. Eleven of them had attempted suicide at some point in their lives. The suicide attempt rate ranged from once to five times, averaging 2.3 times. Nine of the youth had spent time in mental institutions. The staff (who worked closely with these youth) expressed concern with the lack of conscience exhibited by two of the cohort youth. Two additional youth engaged in self-mutilation, another in head-banging. One youth sucked her thumb. Another sometimes comforted herself by drinking milk from a baby bottle. Other cohort youth suffered from bulimia, insomnia, nightmares, and chronic headaches. In addition, most of the youth had been sexually abused. Many had also been beaten, raped, or both in their tenure on the street. All of the youth were coming to terms with their sexuality. For many, the experience of being stigmatized for their survival sex activities was an issue of great concern (Harder and Kibbe, 1991, p. 32).

Given the extent and severity of mental health problems found among these youth, in the fourth year of the project, OCJP, in conjunction with the State Advisory Committee, identified mental health as an issue warranting closer examination. As a result, an evaluation grant was awarded to the Division of Adolescent Medicine (DAM), Childrens Hospital Los Angeles to undertake the current assessment of the mental health needs of runaway and homeless youth who engage in survival sex. Research staff from DAM and H+K worked together on most aspects of this evaluation project. Researchers from DAM conducted the MMPI and interview portions of the evaluation in Los Angeles, supervised the clinical aspects of the project and conducted the expert provider and policy interviews. The DAM subcontracted with Harder and Kibbe Research to conduct the MMPI and Interview portions of the study in the San Francisco area and to develop, administer and analyze data for the Youth-Serving Agency Survey. This evaluation study, which builds on findings from the previous evaluations, has four main goals:

- To document the mental health status of runaway and homeless youth involved in survival sex;
- To understand their perceptions of and attitudes toward mental health services;
- To learn about their experiences with the mental health service system; and
- To obtain information about the kinds of services available these youth.

" A Cry for Help: The Mental Health and Service Needs of Homeless Sexually Exploited Youth" is the product of the fourth year evaluation. In the remaining sections of this chapter, the investigators describe the research methods used in this evaluation.

## B.    EVALUATION METHODS

The methods utilized in this study were designed to provide insight into issues related to the provision of mental health services to homeless sexually exploited youth from the perspectives of: 1) the youth themselves, 2) service providers who have worked closely with them, and  3) representatives from the youth-serving agencies in four metropolitan areas in California.

The evaluation design consisted of four distinct methods of data collection. The first method involved the administration of a standardized psychometric measure, the Minnesota

Multiphasic Personality Inventory (MMPI). The second method used a series of open ended interviews with homeless youth who had engaged in survival sex. The third method employed a mail survey of youth-serving agencies. The fourth and final method was a semi-structured interview conducted with long term service providers to sexually exploited youth. In the following sections, each method more fully described.


### 1.    Minnesota Multiphasic Personality Inventory (MMPI)

In order to gain insight into the mental health status of sexually exploited, runaway and homeless youth, a standardized psychometric instrument, the Minnesota Multiphasic Personality Inventory (MMPI) was administered to a convenience sample of 84 homeless and runaway youth between the ages of 13 and 18 years. Each of these youth also provided the investigators with basic demographic information through a self-administered questionnaire. While OCJP currently funds Child Sexual Exploitation Intervention Programs in San Francisco, Santa Clara, Los Angeles and San Diego, the youth involved in this phase of the study were recruited from two OCJP funded agencies, one in Los Angeles and the other in San Francisco. The youth who participated in the study were all identified by agency staff as having a history of sexual exploitation/survival sex. Many also had histories of child sexual molestation, often at the hands of family members.

The MMPI was developed by Hathaway and McKinley in Minnesota in the 1930s. It is a self-administered inventory consisting of 566 self-reference statements. The examinee is instructed to provide a "true," "false" or "cannot say" response to each statement and is told that there are no right or wrong responses. The accuracy of a particular statement to the respondents' current experience is indicated by her or his "true" or "false" response.

Since its development, the MMPI has undergone a number of revisions to improve the validity, normative data base and the language of the test. The MMPI is one of the most widely used objective personality tests. Although it was originally developed to assess psychiatric disorders, extensive research on the MMPI has strongly suggested that it can be a useful tool for screening purposes in a variety of settings. Over the years, several forms of the MMPI have been developed which accommodate the specific needs of different populations. For example, there is a tape-recorded version for group administration and for individuals with specific learning disabilities or impairments. In addition, an abbreviated version is available where only the first 399 items are administered (Dahlstrom et al., 1982).

The test can be given to anyone who has at least a 6th grade reading ability or has a full scale IQ of 80 and above as measured by the Wechsler Intelligence Tests (Dahlstrom et al., 1982, p.21). Typically, the test takes between fifty minutes and two hours to complete. Information about the examinee is obtained from the MMPI's three validity scales and ten clinical scales. Additional information can be derived from a number of special scales. Examination of the validity scales provides information on the respondents' test taking attitude. The three validity scales (L, F, and K) are designed to detect naivete (L), eccentricity or "fake bad" (F), and defensiveness or "fake good" (K). A test is considered invalid if the respondent answered the test from an all "True" or all "False" response set. Respondents may inflate or underreport problems depending on their desired goals. Naive attempts to present oneself in a good light are also detected by the validity scales. The ten clinical scales assess problems in the following areas:

1. **Hypochondrasis (Hs)**: Somatic complaints, cynicism, self-centered tendencies.
2. **Depression (D)**: Dissatisfaction with *status quo*, pessimism, self-criticalness.
3. **Hysteria (Hy)**: Immaturity, neediness, childishness, egocentrism.
4. **Psychopathic Deviance (Pd)**: Antisocial amoral behavior, impulsivity, anger, substance abuse tendencies.
5. **Masculinity - Femininity (Mf)**: Stereotypical masculine/feminine interests, sexual identity.
6. **Paranoia (Pa)**: Hostility, hypervigilance, suspiciousness, blaming others, psychoticism.
7. **Psychasthenia (Pt)**: Anxiety, phobic tendency, rumination, obsessive-compulsive problems.
8. **Schizophrenia (Sc)**: Alienation, idiosyncratic thinking, withdrawal, thought disturbance.
9. **Mania (Ma)**: Excessive activity, unmodulated energy, impulsivity, restlessness, inflated ego.
0. **Social Introversion (Si)**: Shyness, timidity, loneliness.

While the MMPI has been used as a research and assessment tool with both adult and adolescent populations for over four decades (Capwell, 1945), the adolescent norms were created in the 1970's. Marks et al., (1974) in their study of more than two thousand adolescents (both "normal" adolescents and those receiving psychological services) developed a data base for adolescent normative and clinical correlate information. In addition, Marks and

his colleagues (1974) were the forerunners in developing age appropriate norms for 13 to 18 year old males and females. Archer (1987) and others support the notion of using adolescent norms with adolescent respondents since the adult norms tend to overpathologize the adolescent.

The present evaluation used both the abbreviated and the Spanish translation versions of the MMPI. Each subject gave his/her informed consent in writing. Under the supervision of a psychologist, interns and the investigators administered the MMPI to youth who first completed the demographic questionnaire. When necessary, MMPI questions were read to youth in addition to them reading the material themselves. The youth were given five dollars in fast-food coupons for completing the measure. Debriefing was available upon completion of the study on an individual basis. Test results were used to provide a tailored treatment plan for each of the participating youth.

2.      Mental Health Experiences Interview

Face-to-face interviews were conducted with thirty five youth by one of three interviewers. These interviews were conducted in a private setting in one of two host agencies in either Spanish or English. The interviewing process took from 45 minutes to two and a half hours with most taking one hour and a half. Youth were given eight dollars in fast-food coupons for being interviewed and kept them whether or not they completed the interview. One youth was found to be over 18 years of age and hence dropped from the study. Three youth did not complete the interview and two declined the interview.

Analysis of the interview data showed that the information could be easily collapsed into 4 major areas for presentation. These areas include: 1) Youths' experience of personal, family and friends counseling, 2) Youths' views of the meaning of counseling, 3) Youths' ideas about effective counseling strategies and behaviors, and 4) Youths' access to counseling services and recommendations for service improvement.

3.      Youth-Serving Agency Survey

The third evaluation method consisted of a mail survey sent to 201 youth-serving agencies in the San Francisco, Santa Clara, Los Angeles and San Diego metropolitan areas.

The survey was designed to focus on mental health services available to homeless and runaway youth in larger urban areas of California. The survey asked respondents to describe some of their agency's characteristics, the characteristics of clients, services offered, staffing patterns, and criteria for access and payment. Overall, 58 agencies (29% of those surveyed) responded. In order to enhance the value of the information gathered through the mail survey, five service providers with expertise in working with homeless and runaway youth were interviewed. Combined, these data provide insight into trends in the service system addressing the needs of homeless and runaway youth in California.

## 4. Expert Provider and Policy Interviews

In the fourth and final area of data collection, face to face or phone interviews were conducted by one of the investigators with experts involved in service provision and policy regarding runaway and homeless sexually exploited youth. These interview lasted from forty five minutes to two hours and covered the experts views in the following areas: 1) State-wide policy issues related to the mental health and service needs of homeless sexually exploited youth, 2) Training needs of counselors and youth workers, and 3) Service Needs and Gaps in relationship to homeless sexually exploited youth. The experts interview for this evaluation are profiled in Appendix A.

## 5. Subject Descriptions

A self-administered demographic questionnaire was completed by all youth who participated in the evaluation and the following data were obtained. Just over half (54%) of the youth involved in this evaluation were male. The average and median ages of the group were 16 years, and the modal age was 17. Youth from Latino ethnic backgrounds were over sampled in the San Francisco, sample due to their growing numbers at local shelters and the lack of research data available for this group. While youth in the evaluation were predominantly Latino, all major ethnic groups were represented including African American (12%), American Indian (6%), Asian/Pacific (3%), Caucasian (20%), Latino (42%), and Mixed (two or more minorities--17%). Over three-fourths of the youth (79%) described themselves as heterosexual, 6% as homosexual, 13% as bisexual and 1% reported being unsure of their sexual orientation.

These youth had grown up in a variety of family configurations; 29% had grown up with both parents, 32% with mothers alone, 16% with mothers and others, 7% with their fathers, either alone or with others and 13% with grandparents or other relatives. They also had extensive experience with social service and treatment institutions. Almost one-quarter (23%) had received special education at some time in their lives. More than half (55%) had lived in a foster home or group home and, on average, they had run away from their homes 14 times. Sixty-eight percent had been thrown out of their families' homes, a foster home, group home or other placement for at least one night. On average, they have been thrown out of where they were living 10 times. The result was that 25% had been on their own for less than 2 months, 44% had been alone for 2 to 12 months and 31% had been alone for a year or more.

A full two-fifths (40%) of these youth had received help for a mental or emotional problem at some time in their lives, and one-quarter had stayed overnight at a hospital or other treatment program because of mental health or emotional problems. The average age of first hospital admission was 12.7 years. Almost one-fifth (18%) have taken doctor prescribed medications for mental health or emotional problems.

Alcohol, cigarettes and many other drugs were used by these young people. Eighty-three percent have used alcohol and almost as many have smoked cigarettes (64%) as have used marijuana (62%). Psychedelics (acid, mushrooms, peyote, mescaline, ecstasy) were the next most commonly used (29%). Other drug use included powder cocaine (23%), crack (17%), amphetamines (17%), inhalants (16%), pain killers (14%) and heroin (11%). Less than 10% used tranquilizers, barbiturates, PCP, or other narcotics (codeine, morphine, opium). Forty-four percent of those using alcohol or other drugs thought they had, or have had, a problem with these substances.

An estimate of the prevalence of child abuse among these youth was obtained through the direct face to face interviews with youth in the Los Angeles area sample and augmented by an examination of their agency intake records (similar data was not available for San Francisco). Of the 63 youth who provided information about issues related to child abuse, 30 (48%) stated they had been victims of child sexual abuse. This included 18 females and 12 males. Thirty one of the 63 youth stated they were victims of physical child abuse, 15 females and 16 males. Twelve youth stated they were victims of both sexual and physical abuse. Altogether, 77% (49) of the youth in the Los Angeles area sample have experienced abuse earlier in childhood, many have been victimized repeatedly.

## 6. Limitations of the Evaluation

The runaway and homeless youth who participated in this evaluation became involved on a voluntary basis at the two agencies serving them. In Los Angeles, all of the youth meeting evaluation criteria for age and sexually exploited status who were willing to participate were included in the MMPI sample and about one in three youth were included in the interviews. In San Francisco, the decision was made to over-sample Latino clients identified as involved in survival sex due to their increasing numbers in the population of homeless youth. The sampling method used was opportunistic. If the youth assented, a formal informed consent procedure was initiated and their participation in the evaluation began. As such, these youth are not necessarily representative of the larger population of homeless and runaway youth or of those youth utilizing shelter and drop-in services. The information they provide, however, moves beyond the anecdotal, suggesting important trends in the lives of runaway and homeless youth living on the streets of metropolitan areas.

The use of the Minnesota Multiphasic Personality Inventory, (MMPI), as the psychometric test instrument for this evaluation also brought with it several limitations. The first limitation involved the versions of the instrument available for use. Ideally, the adolescent version of the MMPI, currently in development, would have been used with this youth population. Since that version was not available at the time of the evaluation, the adult version was used and interpreted according to adolescent norms to create youth profiles. While this is a common practice in the use of the MMPI with adolescent populations and minimizes resulting errors in interpretation, the adolescent version is being designed to further limit errors with youth populations.

The administration of the MMPI in this evaluation is also subject to expectation bias and other confounding variables due to administration of the measure by more than one investigator, a procedural decision necessitated by the fact that testing was done in both Los Angeles and San Francisco. In addition, the inclusion of monolingual Spanish-speaking youth in our sample necessitated the use of the Spanish version of the MMPI which varied slightly from the version administered to English speaking youth. Finally, the issue of ethnic group membership and its effects on performance on the MMPI has been studied recently by many researchers (Archer, 1987; Dahlstrom, et al., 1987; Green, 1987; Montgomery & Orozco, 1985). While historically this research has consistently produced mixed results, recent research suggests that variables such as social class, intelligence and education have a stronger

9

effect than culture on MMPI performance (Archer, 1987; Dahlstrom et al., 1987; Green, 1987; Montgomery & Orozco, 1985). The investigators attempts to accurately evaluate the effects of ethnicity and cultural issues on MMPI test results in this evaluation were also limited by the small size of our sample. Green (1987) suggests that "at least 130 subjects are needed for each ethnic group to examine differences in performance on the standard validity and clinical [MMPI] scales" (p.499). Additional information related to this issue is presented in Appendix B.

The agency survey conducted for this evaluation did not rely on a random sample design. Agencies were selected from a number of different sources including the California Child Youth and Family Coalition Runaway Hotline resource bank, United Way Social Service Directories, the Runaway and Homeless Youth Directory of the Los Angeles County Department of Children's Services, agency resource and referral lists, and the recommendations of other direct service providers. The investigators worked with the data that was available and used their own judgment about the appropriateness of the sample. The survey sample therefore, is not necessarily statistically representative of a larger population. In addition, a mail survey brings with it the limitations of a self-selection bias. Those agencies which responded to the survey are probably not representative of youth-serving mental health providers in California.

Overall, the combination of data sources has enabled the investigators to find points of internal consistency in the data gathered. The data collected for this study is rich and provides insight into mental health issues facing homeless and runaway youth in urban areas, their attitudes and perceptions of mental health services and the service system's response to their needs.

Chapter II addresses the mental health problems found among homeless youth involved in survival sex. It presents the interpretive results of the MMPI, a standard psychometric measure, and discusses the diagnostic categories represented in the evaluation population. Also considered are potential treatment issues and obstacles as well as youths' readiness for counseling. Chapter III and IV discuss the youth's experience in seeking psychological help, their attitudes and perceptions of mental health services and their suggestions for service improvement; Chapter V provides the research findings from the survey of youth-serving agencies. Finally, Chapter VI presents the results of expert provider and policy interviews, discusses key research findings, and presents the recommendations resulting from this evaluation.

# CHAPTER II.    MENTAL HEALTH PROBLEMS OF HOMELESS YOUTH INVOLVED IN SURVIVAL SEX

## A.    MMPI DATA: INTRODUCTION

The MMPIs in the present study were hand scored and interpreted by one of the investigators.  Before interpreting an MMPI protocol, the results are plotted on a profile form.  Two sample MMPI profiles are presented in Appendix B.  The validity scales are examined to determine whether or not the protocol is valid.  In valid protocols the points which fall outside the "normal" band are considered for interpretation.  The highest points of the profile make up the code-type of the individual to be analyzed.  Interpretation of the MMPI profile is a multilevel process which involves comparing and contrasting the relationships between the highest and lowest points of the profile and between these points and the validity scales.

In interpreting an adolescent's MMPI profile, gender, age, and ethnicity must be considered.  Archer (1987) in reviewing the adolescent MMPI literature concludes that there are age, gender and ethnic differences in MMPI responses.  Gender differences are most obvious in the Male-female (Mf) clinical scale.  This scale measures stereotypical masculine and feminine interests.  In regards to age, Marks et al. (1974) state that " item endorsement differences [are] a function of age known to occur for adolescents" (cited in Archer, 1987, p.116).  They suggest age can best be considered in interpreting results by combining adolescents into three age groups:  (a) 17 and 18, (b) 15 and 16, (c) 14 and below.

As previously mentioned, research on the impact of ethnicity on an adolescent's MMPI results has produced mixed results.  More recent research, however, suggests that variables such as social class, intelligence and education have a stronger effect than culture on MMPI performance (Archer, 1987; Dahlstrom et al., 1987; Green, 1987; Montgomery & Orozco, 1985).  Further information on this issue is presented in Appendix B.

## B. GENDER, AGE AND ETHNIC DIFFERENCES

In this study, gender, age and ethnic differences were found and are best presented in terms of the "response set," that is, the way the adolescents approached the test. Eighteen of the total 84 (21%) MMPI profiles were invalid. In Los Angeles, 60% of the invalid female profiles were from young (modal age 15 years) minority women. While 100% of the invalid male profiles were from older (modal age 17 years) Latino men. In San Francisco, the modal age for invalid female profiles was 16 and 50% were minority. Northern area invalid male profiles were 67% minority (primarily Latino) with a modal age of 17 years.

Overall, 84% of the profiles from the South were valid compared with only 62% from the North. More males (13%) produced invalid profiles than females (8%). The female profiles were invalid because they over-exaggerated their problems. The male profiles were invalid because problems were denied. Most (71%) of the invalid male profiles were from monolingual, foreign born, Spanish speaking youth in San Francisco. These young men did not want to identify themselves as having problems and needing help.

Perhaps females are more likely to admit to having problems because societal norms generally expect women to be weaker and more in need of assistance than men. Such norms may exist in Latin cultures as well, but other factors may also enter into problem denial for the Latino youth. These Spanish speaking young men, primarily from Mexico and Central America, may fear deportation if they admit to having problems and seek help. The lack of bilingual service providers may also reinforce problem denial. Why would youth identify problems when they know that no services are available?

In summary, in this evaluation males and females differ in the way they communicate the existence of problems. Females tend to exaggerate and males tend to deny problems. Ethnic differences also emerged in the way respondents from the African American, Asian, Latino and Caucasian backgrounds relate their need for help. It was found overall, that respondents from ethnic minority backgrounds were less likely to admit to problems. Among the ethnic minority cultures represented, the Latino youth were much more likely to deny problems than African American, Asian Pacific, Native American or mixed race youth.

## C.    RELATING TO OTHERS AND SEXUAL ABUSE

Sexually exploited youth often consider themselves incapable of affecting their environment. They cannot make things happen and they feel "stuck", unable to move. They also feel alone, without help or support from anyone. Such feelings are evidenced in the "cry for help" configuration of the validity scales. Almost half (44%) of these young people indicate that, in order to be heard and to get help, they must exaggerate or "act out" their problems. Just as they are more likely to admit they have problems, females are also more likely than males to present a "cry for help" configuration (61% versus 28%).

When their cries for help are not heard, these young people find other ways to get the attention they need. They have learned to use their bodies as currency and they relate to others by being overly seductive and sexual. This response is seen in the Scarlet O'Hara configuration. (Named after the coquettish and manipulative heroine of the film and novel "Gone with the Wind"). Among the young people in this evaluation the Scarlet O'Hara configuration suggests that early sexual abuse predisposes 68% of them to behaving in sexually provocative ways. It has been reported by some of these respondents, as well as by other youth who are involved in survival sex, that when they are "working" they assume another name or a different identity. Given that they are involved in ego dystonic behavior this practice may serve to protect the self. At times "being wasted" (being high on drugs) also helps youth to dissociate survival sex behavior from their core identity, a coping strategy that often leads to further victimization. Involvement in survival sex also puts these youth at high risk for contracting HIV and other sexually transmitted diseases as well as for spreading them among both exploiting adults and peers. This risk is further elevated by the drug use that often accompanies involvement in survival sex and prostitution.

Additionally, many young men (57%) present MMPI profiles which indicate they were concerned about their sexual identities. Such males tend to be passive and esthetically inclined, preferring artistic and creative occupations. Other males with similar MMPI profiles to these youth have often reported that they have been sexually abused by males. Initially, many sexually abused young men deny such abuse for several reasons because: (1) they believe "men don't get raped," (2) same sex abuse can raise sexual identity issues, and (3) many youth, especially males have difficulty identifying incidents of sexual abuse, particularly those perpetrated by females.

13

These MMPI profiles and the high incidence of sexual abuse reported by youth in the Los Angeles sample are not surprising in light of knowledge from the field about high rates of sexual abuse among youth involved in survival sex. These findings bring to the forefront the challenge of developing trusting counseling relationships with these youth in which they can begin to confront issues of victimization and explore alternative coping and survival techniques. Only when rapport has been firmly established can issues related to sensitive topics such as sexual abuse and exploitation begin to be addressed in counseling. Until then, patterns of coping that perpetuate victimization are likely to be repeated. A stabilized living situation and support network are also essential ingredients to recovery for youth with long histories of repeated abuse.

## D. MENTAL HEALTH PROBLEMS

Compared with other young people, the general mental health of these sexually exploited youth is quite poor. Peck, a leading authority on adolescent suicide, suggests that up to 10% of the youngsters in any public school may be considered at some risk for suicide (Peck, 1980, p.3). Eighty three percent of the young people in this evaluation suffer from a moderate to severe affective disorder. Almost half of the entire group (47%) indicated they are depressed, 36% are at high risk of suicide and 58% should be referred to a psychiatrist to assess their need for medication.

Of those youth at high risk for suicide, 58% were female. Unlike depression, which is spread relatively evenly among ethnic groups, different likelihoods of suicidality were found across different ethnic groups: Asian Pacific 4%, African American 17%, Caucasian 33% and Latino 46%. Overall, the Latino youth seemed more isolated and withdrawn than any other ethnic group.

As a group, these young people are extremely depressed and isolated. They have experienced multiple episodes of loss, separation and abuse from significant others. Bowlby (1973) an expert clinical researcher in the area of child attachment and separation, has written at length about the consequences of experiences of chronic neglect, separation and abandonment for infants and children. Some of these children exhibit excessive clinging and dependence, high need for attention and fears of separation from caregivers, while others evidence aloof, detached, and self-centered behavior. Children expressing fears of separation

and high need for attention usually also present more indications of depression over losses. Detached and self-centered children, on the other hand, seem to have given up hope of rescue and lose the ability to connect with caretaking adults. The youth in this study fall into both groups, depressed and apathetic. Depressed youth, however, are often better candidates for therapeutic intervention than their detached, aloof counterparts.

Stefanidis, et al., (1992) have shown that depression is an appropriate response to the toxic and abusive backgrounds from which these young people come. Depression can be a motivator for change, if appropriate help and resources are available. Henderson (1974) and Bowlby (1978) suggest that suicide attempts, vague complaints of physical illness, eating disorders and substance abuse and addiction are the result of strong unconscious yearnings for love and support on the part of youth. Where resources are not available, these young people may enroll themselves in a self medication program, using illicit drugs and alcohol to deaden their emotional pain and loss. These MMPI profiles indicate that over half (52%) of these sexually exploited youth, particularly the males, are at very high risk of abusing drugs and/or alcohol. Only 8% of the youth are at very low risk or no risk of substance abuse. In addition, 20 out of the 23 youth interviewed in Los Angeles (87%) indicated that substance abuse was a serious problem for themselves or their families. Thirteen of these youth (56%) reported this substance abuse was considered extensive and included many members of the family. In several cases parental substance abuse led to the youth's removal from the custody of parent/guardian at a very young age, usually before they were three years old. (Similar information was not available for the youth interviewed in the San Francisco area.)

Research literature also addresses the connection between abandonment and loss and the onset of substance abuse and other addictive behaviors. Hansburg (1980) suggests that one of the most common defenses against feeling unwanted and unloved is "an addiction of some sort, such as alcoholism, overeating, drug abuse and related addictions" (p. 54). Van Houten and Golembiewski (1978), Mirken, et al., (1984), and Carman (1974) strongly suggest that young runaways and throwaways use substances to "gain acceptance" from their cohort, to relieve stress and to escape from the unacceptable complications that substance use invites.

Animal research also suggests poignant connections between substance use and the management of feelings of depression, agitation and despair. McKinney's (1972) animal research suggests that, at low doses, alcohol alleviates the despair response in much the same way as antidepressant medication (cited in Reite & Field, 1985). His research finds a similar response for humans to low doses of alcohol and the antidepressant Imipramine.

15

Morphine is also seen to alleviate separation anxiety and agitated behavior in animals (Beatty & Costello, 1982; Newby & Norton, 1981). Snyder (1977) cites drug use by narcotics addicts for the purpose of counteracting "profound emotional distress." It is not surprising, therefore to find many of these young people using drugs and alcohol to self medicate their emotional distress.

## E.    READINESS FOR COUNSELING

As the amount of time between their "cry for help" and the availability of services increases, so do the defenses and detachment of these youth. They become resentful, angry, hostile and distrustful. They are then less likely to initiate or agree to therapy. The MMPI profiles indicate that 23% of these young people are not good candidates for traditional psychotherapeutic interventions. This means that it is unlikely that they will follow a regimen of regular appointments in a counselor's office, which focus on understanding the connection of past events to current behaviors and feelings. More Latino youth (47%) are averse to formal therapeutic interventions than either African American (27%) or Caucasian (27%) youth. While ethnic differences in readiness for intervention were present, gender differences were not. Eighteen percent of the males and 15% of the females are not ready for traditional psychotherapeutic interventions. Most of these youth show the "Conversion V" in their MMPI profile. This suggests that they tend to somatize their feelings, expressing them in headaches, stomach aches, lower back pain and other physical complaints.

On the other hand, the MMPI profiles indicated that one third (33%) of these young people are ready for the traditional psychotherapeutic interventions discussed above. On a continuum of readiness from not-at-all ready to completely ready, ethnic differences were found. Latino youth were found to occupy both extremes on this continuum. This suggests they tend either to deny their problems or to admit them and require immediate intervention for optimum effectiveness. Counseling services must be made as readily available to these homeless sexually exploited youths as are the variety of more destructive coping strategies-- alcohol, drugs, and sex. These young people need services available "on demand." While the availability of immediate service is an aid in working with homeless and runaway youth in general, it seems especially crucial to success in engaging ethnic minority youth, and Latino youth in particular.

The remaining 44% of the youth are considered to be potentially accessible to counseling. This accessibility depends on the effectiveness of counselor's approach. The best results are produced when the counselor is well trained and aware of his/her limitations and needs. To ensure this, counselors must have constant access to support, training, and supervision. Having undergone successful personal therapy can also be very beneficial.

An additional concern in counseling homeless sexually exploited youth is the potential danger of challenging long established coping defenses that are vital to street survival before a youth has established a stabilized living situation and a support system. Such premature interventions leave youth less able to protect themselves from the hazards of street life and more vulnerable to the use of street solutions to coping with emotional pain and solving problems--substance abuse, sexual exploitation and abusive relationships. The careful timing of therapeutic interventions with homeless sexually exploited youth is, therefore, a crucial ingredient in effective counseling.

# CHAPTER III.  YOUTHS' EXPERIENCE AND PERCEPTIONS OF MENTAL HEALTH SERVICES

*People who really care could help our spirit to keep us going....It is really hard to trust--especially people in offices and especially authority people. I lost faith and trust in them. It is also hard to trust people in the street. You have to trust yourself--a lot of times it's only yourself.*
**(16 year old male of mixed racial background--on his own for three years)**

*A friend [14 or 15 year old] helped me to find the shelter. I think a counselor needs to be a friend and staff here should be more like friends. I mean really care about you and listen to your side--your story. What do we need more of? We need more shelters to help and we need LOVE--we really need friends and love.*
**(13 year old white female--on her own for 7 months)**

## A.  MENTAL HEALTH SERVICES INTERVIEW: INTRODUCTION

The chapter that follows presents the voices of 34 runaway and homeless sexually exploited youth as they speak about their experiences with and attitudes towards mental health services. In presenting the results of this evaluation project, the investigators emphasize the use of the youths' own words to add richness and clarity to the telling of their stories.

The Mental Health Services Interview sample included 19 male and 15 female adolescents age 13 to 18. Half of the youth were of Latino racial/cultural background including 17 youth, primarily males, of Mexican, Mexican American, Central American and Puerto Rican cultural groups. The balance represented European American, African American, Asian Pacific and mixed racial/ethnic group youth. As previously mentioned, the investigators intentionally over-sampled Latino youth to begin to get a better understanding of the experiences and issues facing this diverse and growing service population. The sample included naturalized, American born and undocumented Latino youth. Twenty three were interviewed in a shelter and drop-in center program in Los Angeles and 11 were interviewed in a similar program in the San Francisco area. The San Francisco group included 9 monolingual Spanish-speaking youth.

The responses of these youth to face-to-face, semi-structured interviews are presented in Chapter III and Chapter IV. A sample of the interview instrument is presented in Appendix C. In these two chapters the words of the youth are intermingled with discussion about the implications of the information gathered. Chapter III considers the impact of personal, family and friends' counseling experience on the attitudes of the youth towards counseling as well as youths' views of the meaning of counseling. Chapter IV discusses youths' views of effective counseling strategies and behaviors and youths perspectives on their access to counseling services as well as their suggestions for improving services to runaway and homeless youth.

While these youth chronicle a litany of encounters that reinforce their distrust of adults, many still seemed to savor the opportunity the interviews provided to talk privately with someone interested in their opinions and their life experience. Many of the youth thanked the interviewers for the chance to talk and some had a difficult time bringing the interview to a close. Some appreciated the personal attention and interest of the interviewers, others liked the break from the shelter or drop-in center routine, and still others participated primarily to get the fast food coupons with which the interviewers thanked them for their time. Several young people stated that they hoped the interviewers would come back to talk with them again. In the words of one youth:

> *Thank you for letting me talk and listening to me--it helps to talk about it. It's good to talk about my life without having to cry about it.*
> **(15 year old Asian Pacific female)**

A second youth also emphasized his appreciation for the opportunity to talk without being pushed to go say more than he wanted to:

> *I'm glad we talked. I like to think about problems myself before talking to people. That is hard here because people are always in your face and loud. I act like I'm asleep at the shelter a lot to get away from it--to try to think or relax. Talking is better when there is no preaching or prying too much--like when they keep asking me about my brother's death. They need to respect your space and feelings. It's okay if I want to avoid feeling sad and going through changes--no one should make me.*
> **(17 year old African American male whose older brother was killed by girlfriend. He was abandoned by mother at age 15 and has been on his own for 2 years)**

## B. YOUTH'S EXPERIENCE OF PERSONAL, FAMILY AND FRIENDS COUNSELING

*This counseling [at the shelter] is helping me to deal with a lot of things. My relationships and daily stress and problems I have getting along with people. It was my own decision to go. I was in counseling before, I think it was in fourth grade because I was having trouble in school with work and gangs and maybe drinking -- I didn't like school -- it was hard and boring and I would drink or do drugs and sleep. I had a bad temper and would fight with anybody. The counseling [at school] wasn't helpful at all. I had to go for a year because the school made my parents send me.*
**(17 year old Latino male on his own for 12 months)**

*One of the counselors [psychology interns at the agency] talked to me a few times when I was about to get into a fight...about how to work it out and how to work on my feelings without fighting. Other staff just say don't fight or you'll get kicked out. The Intern knew I didn't care about that. The Interns seem different than the other staff. They take time to listen to you instead of just telling you the rules.*
**(17 year of African American male—on his own for 2 years)**

Part One and Two of the following section present examples and discussion of the characteristic counseling experiences of female and male youth respectively. Part Three covers the impact of family beliefs and attitudes about counseling on the youth. Part Four discusses the engagement of youth in counseling despite negative family beliefs and Part Five addresses the implication of the findings for current and future engagement of youth in counseling services.

### 1. Characteristic Counseling Experiences of Female Youth

*When I was 12 they said I was manic depressive and hyper and rebellious besides and I also ODed [overdosed on drugs] at my boyfriend's home and he socked out the windows he was so mad and upset. I also had AA [Alcoholics Anonymous] counseling and got 90 days clear [alcohol free]--I might go back. Some of it was helpful--AA but not the counseling at the group homes. I would run away or get kicked out to avoid that...All together it was two years [of counseling]--maybe more. But I'm not going to counseling here--at the shelter. I'm just waiting to go stay with my mother in Texas since no one can handle me here.*
**(14 year old white female who had been in 6 placements and has been on her own for the past year. She is now pregnant)**

Over half of the adolescent women interviewed had long term experience (over a year or two) with counseling during their childhood, garnered in both outpatient and residential

settings. Many were also aware of other family members' counseling experience. This was especially true for the girls from white racial background and true for half of the mixed racial group as well. The quotations presented are typical of the experiences of this subset of girls.

> *I've been in counseling sort of--at the 11 placements [she pulls out a letter and shows me social worker's report documenting these 11 placements]. I had too many problems and can't control my temper. Some of it [the counseling] was helpful. The thing that made the difference was where I was at...if I wanted to talk.*
> **(17 year old mixed racial background female who is now pregnant and was awaiting placement at home for pregnant teens)**

Of the 15 girls who were interviewed, only three had no previous personal counseling experience. All three of the girls without counseling experience were from 'minority' racial backgrounds (African American and Asian Pacific) and two were from families that did not see counseling as a viable means of solving problems, an issue discussed more fully in a later part of this section. Two of these girls had become involved in counseling since coming to the shelter/drop-in services. One as a result of self mutilation behavior that concerned staff enough for them to mandate counseling as a condition of staying in the program and the other at her own request.

Overall, girls appeared to have more personal counseling experience than boys and more awareness of the counseling experiences of other family members. It is unclear from such a small sample whether girls' families actually had more counseling experience or whether the girls were just more aware of such counseling than boys and more willing to talk about it.

## 2. Characteristic Counseling Experiences of Male Youth

> *I went to counseling with my parents because they were treating me wrong and I was always in trouble. The school counselor sent us. I was drinking and in a gang and my mother didn't like my gang dress or my friends. I was also doing bad in school. My mother used to beat me. We only went a few times--three or four times. My mother stopped going. It helped some...I drank less for a while.*
> **(17 year old Mexican born male--on his own for 4 months)**

In contrast to the long term counseling experience of many of the girls, the previous counseling experience of those boys who became involved in mental health services was more likely to be short term, often limited to several sessions. A number of the boys in the evaluation group had no previous counseling involvement and some also stated that they knew no family members who had been involved in counseling. The number of girls involved in counseling was greater than the number of boys, and more girls reported family and friends involvement in counseling as well. There were also a number of boys who were experiencing counseling for the first time in the context of the agencies and shelters where the interviewing was conducted. The introductory and following comments by boys are typical of their counseling experience:

*I talk to T or D [psychology interns at agency] when I am low or depressed. It is better for me to let things out than to hurt someone or the wall. I also talked to a pastor before and to a counselor in a Christian program before I got kicked out of there--too many rules and fighting. I still talk to the pastor or the counselor now and then when I am around home. They helped me because they had some experience like mine with drugs and also being the middle child and left out--left alone.*
**(17 year old Latino male referred to counseling at a shelter program after cutting his arm when depressed--on his own off and on for 12 months)**

There were several young men who had longer term counseling experience averaging about one year in duration. One had begun his counseling experience in the year since he left home, largely through agencies serving homeless youth:

*Well, I'm gay, so I've dealt with sexuality issues. Then there's the verbal and physical abuse stuff and problems with my family, so that led to depression and school problems and drug use. Although I don't have a drug problem, it's kind of all tied together. Once I ran away, then there's the survival, day to day stuff to deal with....[In the past month I am dealing with] problems with my parents, how to 'come out' to them; about my homosexuality and other stuff...I would never 'come out' to anyone until I came to San Francisco. The counseling has been good for all that.*
**(16 year old Latino male on his own for 1 year and now involved in counseling with agencies serving homeless youth)**

Another of the few boys with a longer term history of previous involvement in counseling became involved at his own request after the death of his mother and a resulting hospitalization for depression:

*I had some counseling when my mother died. I was 11 or 12 when I asked for it. My mother's side of the family--they understand counseling...I saw a psychiatrist once a week for about a year. It helped--now I can celebrate holidays again and it doesn't hurt as much. It was very helpful.*
**(16 year old gay Latino male--on his own for 18 months)**

The finding of a difference in amount and duration of counseling experience between female and male youth is probably influenced by the different racial/ethnic compositions of the female and male groups and by their differing socioeconomic statuses as well. The female group included more white youth; the male group was predominantly Latino. Class factors may also be operating here although our data collection instruments did not allow for the examination of socio-economic factors.

3. **The Impact of Family Beliefs and Attitudes about Counseling**

*Getting counseling wasn't what I do--I just work it out myself--it isn't what my family does either. You talk to family or you work it out yourself.*
**(17 year old African American male--on own 1 year)**

*My uncle wouldn't participate in counseling. He says he isn't telling anyone the family's business.*
**(15 year old Asian Pacific female--on own 1 year)**

Youth from families where needing or using counseling is seen as a sign of weakness, of being crazy, of being unable to handle your own affairs, or of telling family secrets--often expressed more resistance to the idea of seeking counseling help. Such youth, especially young men, were less likely to request counseling on their own initiative and were more reluctant to accept it when offered:

*My father would say "he [the minor] will do what I say--he doesn't need any outside help. I'll take care of it--he's mine."*
**(16 year old male of mixed ethnic background --on his own for 3 years)**

*My family doesn't really believe in counseling. Counseling was for crazy people or people who can't deal with problems their own self.*
**(17 year old male of African American ethnic background--on own 2 years)**

*Yeah, I guess you have to be crazy [to get counseling]--or maybe not crazy but really
needing help--not like me--I've never been like that.*
**(16 year old Latino male-on his own for 3 months)**


## 4.    Engagement in Counseling Despite Negative Family Beliefs

Many youth from families expressing negative beliefs about counseling were still able
to be engaged in the counseling process. Several youth tried counseling when it was suggested
by staff as a way to solve a particular problem. Other youth started counseling in the face of a
crisis such as severe depression, self-mutilation and suicide attempts, dealing with issues of
sexual identity and orientation. A few youth began counseling simply because it was mandated
by staff as a part of the program or a condition for continuing to receive services:


> *I'm going to counseling so that I can get into the residential program at the agency--
> It's a requirement. If it weren't, I wouldn't talk with the counselor... The counselor
> I'm talking to now is the only one [who made it easy for me to talk]. I like him more or
> less and we get along pretty well.*
> **(17 year old Latino male on his own for 7 months)**


> *Counseling doesn't scare me anymore. It's for when something is wrong or crazy or
> you're in trouble. That's one reason why you are here. They try to help you and it's
> confidential--that's important.*
> **(17 year old African American male)**

The last quotation is taken from the interview of a youth who came to the shelter thinking
counseling was only for crazy people and who now reports that he seeks out a psychology
intern for informal problem solving sessions or when something is bothering him, "to get
things off my mind."


## 5.    Discussion: Family Beliefs and Previous Counseling Experience

Overall, a family's beliefs about the use of counseling as a means of dealing with
family problems, as well as their concerns about seeking help outside of the family, appear to
be related to both youth involvement in counseling and youth attitudes towards counseling as
an acceptable problem-solving option. This finding may also be related to the fact that most
youth in our project sample, the males in particular, are from Latino and African American
cultural groups. These groups are often more traditional than mainstream white families and

less likely to trust majority cultural institutions and concepts due to experiences with racism as well as more limited familiarity. This can be especially true for members of lower socioeconomic groups (whites and people of color), as well as immigrant and less acculturated families. (Boyd-Franklin, 1989; Gibbs, 1985; Gibbs, et al, 1989).

As a result, some families from both Latino and African American cultural groups may not see counseling as a useful approach to handling family problems. They may also be reluctant to trust service providers from outside the community. In addition, many of these Latino males are natives of Mexico and Central America where service systems are different. These youth and their families may also be concerned about using services in the U.S. due to their refugee or undocumented status. Finally, counseling services are often in short supply in minority communities, and services for monolingual families with often limited financial resources can be very hard to find--finding services for undocumented youth and families is even more difficult.

The youth we interviewed presented a wide range of previous counseling experiences, both personal and family. Some denied any knowledge of past family counseling experience and stated that counseling was not one of the ways their family solved problems or handled crises. Many other participants and their families had experienced counseling briefly but dropped out after several sessions. Still other youth had participated in counseling, whether individually or with other family members, for a period of one to several years or more. The opinions regarding whether or not the counseling was helpful were also very mixed across the various counseling experiences.

Overall, findings in this section suggest that the majority of youth in the sample can be engaged in counseling if a flexible, short term, crisis-oriented model is employed, at least initially. Some may graduate into longer-term counseling modalities and others will continue to find counseling of limited interest or value. It appears, at least initially, from both the interviews and the MMPI results, that girls may be more willing to engage in the traditional counseling arrangements requiring set appointments and a contract over time. Many males and some of the females who have been more prone to expressing emotional pain in acting out behaviors, may do better with short-term, focused, problem-solving modalities and crisis intervention. This seems appropriate at least initially until more trusting relationships are built and stable living situations are more firmly established. Resistance was also lowered by counseling approaches designed to empower the client in the decision-making process and to

limit the emphasis on treatment or therapy in favor of dealing with "problems in living" faced by many of the youth.


## C. YOUTH'S VIEWS OF THE MEANING OF COUNSELING

*Counseling is to help you solve problems so you aren't such an idiot--deal with things and realize when you are wrong and realize you are not always the one to be at fault. Parents always blame you anyway.*
**(14 year old white female)**


*It means when two people or a group of people are having trouble then somebody with no personal stuff in it tries to help--to give advice and prevent problems from coming back.*
**(17 year old Latino male)**


*Counseling is to help you with your problems--brain picking--making you get rid of a lot of pain and stuff if you have any.*
**(15 year old female of mixed racial background)**


For most of the 34 youth interviewed, counseling was seen as a positive process of problem-solving and getting help which is built on the foundation of a relationship characterized by trust, understanding and confidentiality. Of the thirty one youth who responded to the question about the meaning of counseling, over two thirds (22) saw counseling in a positive light. The remaining nine youth expressed negative or ambivalent views. Their definitions are presented in the next three sections: 1) Characteristics of Positive Definitions of Counseling, 2) Characteristics of Negative and Ambivalent Definitions of Counseling and 3) The Implications of Youth's Counseling Definitions for Engagement in Counseling.


### 1. Characteristics of Positive Definitions of Counseling

*Counseling means giving someone hope--a way out. Sticking with you--being there.*
**(16 year old male of mixed racial background whose family opposes counseling)**

Positive definitions of counseling generally focused on it as a process of talking with a knowledgeable and trusted person who is "there for you", who listens and suggests options. Youth made it clear, however, that it was their perogative to decide on action. Confidentiality

was also emphasized as was the need for counselors who really understand the lives and experiences of homeless sexually exploited youth. Positive responses included the following:

> *Counseling means a lot of help. It means people who are willing to listen to your problems, someone who's there for you, who you can trust; they help you solve your problems.*
> **(16 year old Latino male)**

> *A counselor explains the different options a person has. They help people to choose the reasonable option.*
> **(16 year old Latino male)**

> *Counseling means understanding--listening and trying to help out. Not being an enemy--being a friend.*
> **(13 year old white female)**

> *Counseling means trying to help you out with your problems. Trying to do anything they can to get you where you want to be.*
> **(15 year old Asian Pacific female)**

## 2.    Characteristics of Negative/Ambivalent Definitions of Counseling

> *If I have bad ideas about things they [counselors] help me to get good ideas. But it doesn't work because I don't want it to.*
> **(17 year old Latino male)**

Many of the youth with negative definitions felt misunderstood or controlled by counselors:

> *Well, they talk to you and they slap you in the head. You're going to write that? I was just kidding--I mean they try to get you to do right the way they see it.*
> **(16 year old Latino male)**

> *Counseling is just repeats of questions and nodding heads. Talking about problems to hopefully get it out. Bringing up the past and asking the same thing a lot.*
> **(16 year old female of mixed racial background)**

Some youth believed you had to be crazy to need counseling and went to great lengths to avoid it:

*Like you might be sick in the head--counseling doesn't bother me.*
**(14 year old Latin female)**


*I don't know anything about counseling. That's one reason why I left placements--because I don't like to talk in counseling.*
**(16 year old female of mixed racial background with long counseling and placement history)**


Several youth also felt that counselors could not be trusted to be there for them or to keep their "business private":


*Counseling is just talking--like a private diary--well not private--shared with a bunch of others--on file--nothing sacred. I had more than five counselors in less than a year.*
**(13 year old White female)**


While positive responses emphasized the process of talking problems out with an understanding listener who helps you see all the options and helps empower you to take action, negative and ambivalent responses often saw counselors as labeling and judging youth, taking away control, trying to make you do things their way and being unable to help.


*Counseling to me is...being down on me a lot...saying "Oh, he's bad", but don't look inside to see who I am--Just seeing the gang dress and not trying to understand.*
**(17 year old Latino male)**


**3.      Implications of Youth Definitions for Engagement in Counseling**

In general, positive perspectives of counselors and the counseling process seemed to emphasize five themes.   The first is empowerment of youth in the decision-making process with the youth in control of setting the agenda and determining its pace.   The second theme involves control and the potential abuses of power when counselors seek to make youth follow their goals rather than those of the youth or try to "rescue" the youth. A third theme involves the importance of trust and reliability on the part of the counselor.   A fourth and related theme emphasizes the need for confidentiality in the counseling relationship.   In the words of one youth:

*You need to pick and choose counselors. You need to avoid the emotionally weak counselor playing off the emotionally drained [youth]...Empower the youth, find a balance, be real, be clear, be understanding, but not too compassionate, grieving...be their [the youth's] friend.*
**(17 year old white male)**

It seems that this population is particularly vulnerable to counselors who may be unconsciously focused on meeting their own needs and not those of the youth they are there to help. Counselors need a continuing awareness of the issues raised for them in working with abused, multiproblem youth, as well as a clear sense of their own personal and professional boundaries. The description of a counseling relationship provided by the following youth is an example:

*My counselor bought me presents and she still calls me. She never said "We have to end now", she'd say "I need to go back to work now but who cares!" She took me to a jewelry store and had me pick out what I wanted and then bought it saying it was for her. Then she'd ask me if I was angry. She'd say she knew I was angry and I couldn't fool her about it. Then later she would give me the necklace or the ring. She took me to eat or go to the park and took a real interest in me--but I took advantage and just got what I wanted--I wasn't ready to change. She trusted me though.*
**(14 year old Latin female)**

Several of the service providers we interviewed also mentioned issues of counter- transference and over-identification with the client as problems needing intensive supervision, especially for less experienced staff.

A fifth and final theme involves the need for counselors to be non-judgmental and to work hard to understand the complexity of the lives of street youth and their survival strategies. Youth discussed feelings of judgment and stigma they had experienced with counselors in relationship to issues like gang participation, gay and bisexual identification, undocumented status and race or ethnicity. These issues are discussed in more detail in the following section and in Chapter IV.

4.      Discussion: Youth's Experience and Perceptions of Mental Health Services and

        Views of the Meaning of Counseling

As evidenced in section one and two, both family beliefs about the viability and meaning of seeking counseling help and the youth's previous experiences in the counseling

process can complicate the process of engagement in future counseling. Youth with past negative counseling experience and those whose families do not endorse counseling are often harder to engage, less likely to seek counseling of their own volition, and more prone to use counseling that is presented as short-term problem-solving or crisis intervention.

A 17 year old Latino male and a 16 year old pregnant female client were both willing to engage in counseling because it was mandatory in order to receive other agency services they desired. Both of these youth had had previous negative counseling experiences, one in long term counseling at a placement and the other in facing racism at a previous agency. While they were not initially willing to make long term commitments to counseling, they were able to make use of it in their current programs. Several previously reluctant youth also became involved in counseling around crisis issues related to suicidal ideation and depression, problems of adjustment to gay or bisexual sexual identity and coming out, and on-going struggles with alcohol and drugs. Thus the impact of previous experience and negative youth and family view of counseling can often be overcome by a counselor who can connect with youth, especially in times of crisis and through the use of a range of counseling strategies, including mandatory counseling experiences.

Chapter IV will explore the youth's ideas about effective counseling strategies as well as their access to services and their suggestions for service improvement.

# CHAPTER IV.   YOUTHS' IDEAS ABOUT EFFECTIVE COUNSELING STRATEGIES AND SERVICE IMPROVEMENT

## A.   YOUTHS' IDEAS OF EFFECTIVE COUNSELING STRATEGIES AND SUGGESTIONS FOR SERVICE IMPROVEMENT

*A good counselor is like a friend who listens and understands and will be there for you.  We [runaway and homeless youth] need friends.  Counselors need to be real open and help you out.  If I were a counselor I would talk and listen and make them understand and work out problems.  It has to be confidential so you can trust.*
(17 year old Latino male-on own for 12 months)

*Counselors need to be concerned, genuine and able to adapt to young people.  They need a lot of patience...my counselor is very helpful.  He is like a big brother and takes time to listen and sit and talk.  He is open and you can ask him anything.*
(17 year old African American male on own for over one year)

*I felt very comfortable with my counselor at the Agency.  I liked him because he knew about drugs and he helped me to quit.  I stayed there 26 days during April. Now I'm doing better.*
(18 year old Latino male on his own for more than three years)

The counseling strategies and behaviors seen as effective by homeless sexually exploited youth fall into 4 major areas.  Overall, youth preferred counselors with the following characteristics:

1) An understanding of homeless youth: similar life experience;
2) A counseling philosophy that emphasized issues of:
    a) empowerment,
    b) nonjudgmental respect, trust and acceptance,
    c) confidentiality,
    d) a sense of humor, and
    e) the patience and endurance to stick with the youth through the difficult process of establishing a trusting working relationship; and
3) A broad range of tools and techniques for engaging and working with multiproblem youth.

Such counselors generally also had access to :

4) Extended training or experience and/or the ongoing supervision of more experienced counseling staff.

## 1. Understanding Homeless Youth: Similar Life Experience

*It's good if counselors have some experience like us and know our life. Also don't think we are bad guys [because of gangs and drugs, etc.] Ask a lot of questions...alot of them [counselors] don't seem like they care about us. They need to have more life—energy.*
(17 year old Latino male)

*They need to try to understand you—try hard to understand. It might help if they had my experience or work hard to understand it.*
(13 year old white female—on her own for 7 months)

The feeling that counselors needed similar life experience to clients in order to understand their lives and problems was the most common theme in the youths' discussion of counseling concerns. Counselors who have been abused, run away, grown up in a different culture, had an alcoholic parent or in other ways endured some of the issues confronting these youth were seen as more likely to understand and empathize with them. A counselor who has been trained to understand these youth without overidentifying or judging them is also highly evaluated. While some of the youth conceded that a 'sensitive and open' counselor or one with extensive experience with homeless youth could make up for not having experienced (and surmounted) the troubles facing these youth. The overwhelming majority felt that having overcome similar life trials and traumas would help counselors to understand and empathize with youth as well as help them find solutions.

*People who have been through what we have been through are the best to understand but someone who really cares can understand us.*
(16 year old Mexican-American male— on own for 3 years)

Still, for some youth the issue of similar experience does not matter as much as the feeling of being understood and getting help:

*She [my counselor] is the kind of person you can confide in. She's very intelligent. She's very understanding of others and communicates very well. It doesn't matter to me if a counselor is male or female or whether they are a native Spanish speaker or not as much as if they understand.*
(16 year old female Latina)

The issue of similar experience or familiarity with the life issues of these youth can be especially poignant for youth who struggle with the added issues of gay sexual identity, gang

involvement, immigrant/refugee or minority cultural status, substance abuse or some combination of these concerns--in addition to the many problems and stresses of homelessness.

> *And the Latino staff member at the shelter, I talk to him a lot. It is bad when I try to sleep. That is when I get missing home and sad and scared. He helps me a lot. He understands me and tells me about when he was growing up back home in Central America--he knows how it is for me growing up.*
> **(16 year old Central American youth--on his own 9 month here in the U.S)**

> *It helped that the person was also gay and could relate to me. A good counselor would never tell someone there was something wrong with their sexuality. There are no rights or wrongs with sexuality.*
> **(16 year old gay Latino male)**

> *I never had a counselor but, I think a good counselor would be someone who can talk and listen and even better if they have similar experience to me--then maybe they understand me better...they help me talking about problems but not telling your business to anyone or lecturing you.*
> **(16 year old Mexican American male with no previous counseling experience)**

> *Counselors need to recognize that we are street kids and really get to know us--you can't solve our problems easily. Tell them [counselors] don't assume they know me or tell me they know or understand me. Don't say you know what I'm going through--you don't.*
> **(17 year old African American male on his own for 2 years)**

## 2. Counseling Philosophy:

### a. Empowerment and Issues of Control:

> *A good counselor is someone who listens but who can tell you the consequences of your decisions. They should never try to make someone change, they should just be there for them.*
> **(16 year old Latino male)**

Issues of control and empowerment were also mentioned frequently among the concerns of youth about counseling. These issues included the feeling of many youth that counseling should be voluntary and not forced, that they should control the topics and pace of discussions and that they should be in charge of any actions taken. Some saw counseling as a process of shared control where the counselor helped you see options and consequences but youth made the final choices and lived with the results. Counselors could help youth to see and use their own power, strength and resources better in the process of solving problems.

*She [the counselor] was at my level, I felt comfortable with her. We were more like friends. We're still friends and I can still talk to her....Counselors should listen, don't put word in our mouths. Give advice, don't dictate what they should do. Don't pressure them--there's enough pressure as it is. Don't tell them what's best for them.*
**(16 year old Latino male talking about his case manager in contrast to his previous counselors)**

Listening to the words of many of the youth, you can clearly hear the underlying request--don't treat me like my parents did--really listen and be a friend or the kind of parent I wish I'd had. In fact, many of the youth used family terms to talk about their best counselors, stating that these counselors were like a father or brother, sister, or special friend--the kind of family they wish they had.

*I had a psychologist. I got to know him really well and he was like a dad--I could tell him anything. [I would tell counselors] that there needs to be a choice about counseling. Get to know us and understand us. Don't pressure us or tell us how to feel. Don't pressure us into saying what we don't want to say...Don't put things in their heads and don't try to make decisions for them.*
**(15 year old female of mixed racial background on her own for 3 years off and on)**

*Don't sound like a parent to a kid if they can't talk to their parent. Don't use "why" talk--it makes you feel bad inside--like they can't see it from your point of view.*
**(15 year old white female)**

*My counselor was a social worker and my best friend. He don't push me to talk or try to push me into anything. He would give advice but don't push and I could trust him.*
**(16 year old female of mixed racial background--on her own for more than a year and waiting for placement in home for pregnant teens)**

*A good counselor goes with what the person wants and not telling the person what to do. They should be easy to talk to and what can I say--my counselor goes with it--she understands me.*
**(15 year old Asian Pacific female)**

While control was a major issue for many youth, other youth believed that agency staff must use their authority to help youth move toward change and break the cycle of negative behaviors. For those youth mandatory counseling also played an important role in the process of change:

*I've been in counseling for one thing or another since I was 5. This last time it was because my Dad made us go to counseling after we got picked up by the police....It was helpful in the hospital [drug treatment program]...I got a lot of stuff out of me in one month that I didn't get out for years. Feelings and dark secrets and it helped my sister*

*too. I told about sexual abuse--all my life by my mom's friend and a guy I used to know and my foster family.*
(15 year old mixed racial background female--on her own off and on for the past 3 years)

## b. Nonjudgmental Respect, Trust and Acceptance:

*Counselors need to know that people who dress like a gang member--not to think they are bad. You have to do it to have friends--especially for people--if you don't have a family--no one to take care of themselves. Homeboys are like a family. Counselors, they shouldn't put you down and say you have to do this. Give more experience about life--what it is all about. That is what we need. No put downs--more ideas and more help.*
(17 year old Latino male on his own for 4 months)

*What do kids need? More fairness and more justice. Counselors should be educated not to treat you differently--if you are a slow learner or not educated. Bring more positive attitudes.*
(16 year old male of mixed racial background--on his own for 3 years)

Another area of almost universal concern on the part of these youth in relationship to counseling experience are the related issues of respect, trust and nonjudgmental acceptance. The youth quoted above is a young man who just started counseling with a psychology intern based at one of the shelter agencies. He is struggling with issues of substance abuse, significant depression and suicidal thoughts as well as his involvement in gang activity and his current homeless status. Although he had previously been involved in counseling through his school, he described his current counseling experience as the first time someone had listened and not judged him because of his gang affiliation and dress. He felt this counselor might be someone he could trust.

For youth whose growing up experiences have been characterized by a lack of respect by others and an absence of adults in whom they could trust--respect, trust and acceptance become crucial issues if they are to begin to break the cycle of repeated victimization and negative, self destructive patterns of coping. The statements that follow are typical of the youth's concerns in this area:

*If I were a counselor I would try to gain a person's confidence so that they would speak with me. I would involve/commit myself totally so that they would see that I want to help. I would involve myself in every way.*
(16 year old female Latina)

*Yes. I have a good person to talk to, my caseworker. I feel I can trust her and she talks to me. After I was raped--she asked me what was wrong and she started talking with me. (But I'm not going to talk about that now--so don't ask). It was my decision to start counseling but my counselor--she noticed I was acting different--like something was bothering me. Trust is important. I would not be a staff. I don't care about most of them.*
*(17 year old African American female--on her own for 8 years)*

Four behaviors that compromised trust for homeless youth are breeches of confidentiality, broken promises or commitments, the feeling that counselors were siding with others against the youth (parents, other youth or staff) and simply feeling that they were not cared about or understood. In the words of the youth:

*I never had a counselor I could really trust or talk to--someone who understood me. I would just ignore them or run away or get in fights or break the rules and get thrown out.*
**(14 year old white female with a long history of residential placement--on her own for a year)**

*The counselor was putting words in my mouth and made the whole thing look like it was worse than it was; he sided with my parents.*
**(17 year old white female--on her own for 2 years)**

Several other youth also commented about issues of respect and caring among both staff and agency supporters and volunteers:

*This place is a madhouse. Some of the staff are incompetent and they are full of themselves. Rude, disrespectful, looking down on you, bad attitude.*
**(15 year old Latino male on his own for 18 months)**

*The staff are rude to us. They don't understand and they say, "If you guys are here or not we still get paid." [The shelter staff person] says that all the time. I can talk to the case workers though...but they want to send me to a group home and I want to go to Texas and live with my friend [17 year old male she met at the agency].*
**(14 year old white female-on her own 4 months)**

Several youth also commented that to some counselors and staff caring for them seemed to be " just a job." Others stated they felt that some counselors, case managers and other staff were there to meet their own needs and not those of the kids. Several youth felt that way about a celebrity fund raiser that brought the participation of stars from television, film and sports to raise money for the agency. While their feelings may sometimes be a carry-

over from the hurts and rejections of the past or evidence of how hard it is for some of the youth to believe they are cared about, several youth reacted negatively to some of the celebrities:

> *Find stars who really care--and baseball players. Not like a lot of the people who came out [for the fund raiser]--they just came out for themselves to say they did something. Do they really care? Stars who really care could help our spirit to keep us going.*
> **(16 year old male of mixed racial background--on his own for 3 years)**

### c. Confidentiality:

> *If I were a counselor I would talk and listen and make them [youth] understand and work out problems. It has to be confidential so that you can have trust. I had a bad experience about my case file. They should have told me that they write everything down that you say and other people [counselors, staff] read it. [Name of case manager] wrote some stuff I said--it was about sex, and other staff teased me about it. I talked to her that I didn't like it--but I don't trust her. It makes it hard to trust any of them.*
> **(17 year old Latino male--on own 12 months)**

Confidentiality was another area of frequent concern and most of youth mentioned it as very important to a trusting counseling relationship. Most confidentiality violations related to private information being shown, read or told to other staff, parents, youth or on occasion to other service agencies or child protective services. Concern in this area was especially high for youth who had already had negative experiences in counseling, with the child welfare system and in placements or sometimes in connection with school.

> *I also went to counseling at school last year. I went most of the year about 3 times a week to see my counselor. Everyone had to go a few times but you could go more if you wanted. It helped some. It was because I didn't get along with my family--the counselor knew my brother too--so she knew my parents were off. She understood me but she would call and tell my parents everything I said and my sister too.*
> **(14 year old white female on her own for 4 months)**

> *I watch what I say because they can put it in the file or tell some one or report you about child abuse. They tried to do it to my mother.*
> **(17 year old Latino youth)**

Other youth felt that agency breeches of confidentiality replicated their previous experience of having parents share information about their lives in disrespectful and hurtful ways. Anything that serves to damage the ability to build trusting relationships for these youth

37

can become a major roadblock to providing the services they need. The youth whose quotation opens this section had often been teased by his mother about sexual matters. He was particularly vulnerable in this area. The unprofessional handling of his case file information made it less likely that he would use counseling services, impeded the development of positive relationships with staff and might have generated much greater problems had he not been able to discuss his concerns with staff and gain some support. Issues related to sex and sexuality are especially sensitive ones for sexually exploited, abused youth.

Another youth expressed her concern about confidentiality this way:

*Where would I send a friend for help? Not here to this agency--they talk about your business here--it's hard to trust--not confidential.*
**(14 year old white female--on her own for four months)**

#### d. Counselors Need a Sense of Humor:

*Don't be too serious. Have a sense of humor. Listen and help them [youth] let off stress.*
**(16 year old female of mixed racial background)**

*I had a good counselor...She was funny and made jokes to cheer me up when I was depressed with stuff.*
**(13 year old white female)**

Many youth were convinced that a sense of humor was a very valuable asset for any counselor working with homeless and exploited youth. Laughter is viewed as a tension reliever, helping youth to feel at ease with counselors and lifting dampened spirits. Humor also helps to prevent burnout in very draining and difficult jobs--several of the youth stated they would never be counselors because it was too hard to be patient and listen to everyone's problems.

*If you are a counselor you have to put up with your patients. I wouldn't be a counselor--not even for a million dollars. It's a very difficult job.*
**(Latino male age 17--on his own for 2 years)**

However, the humor and laughter must not be at the youth's expense. Despite the adoption of 'street personas' and hardened exteriors, these are vulnerable youth who are extremely sensitive to disrespectful comments, misdirected humor and sarcasm.

### e. Patience and Endurance: "Don't give up on me!"

*Good counselors understand and don't put you down and they try to encourage you—*
*They never gave up on me—not from 1990 to now. [She says this with amazement and*
*a sense of pride]. Counselors shouldn't preach or tell you about 'when I was little'*
*but should say how do you think you should handle this and respect people's*
*opinions. [After two years] I just started counseling for the first time. It was my*
*decision because of stress and hatred of men—stuff builds up and one day I explode*
*and hit someone or something. Sometimes it's too nosey—sometimes they persist too*
*much, but I'm trying.*
**(17 year old female of mixed racial background with a long history of physical and**
**sexual abuse, running away and shelter use—on her own for the past 2 years)**

Many counselors and caseworkers and some of the youth who have been involved in
counseling for longer periods of time, speak about the need for counselors to realize that
change for these youth is often a slow and erratic process. They give up and then return to
street life, trying other lifestyles in between. Each of these different lifestyles has its own
problems and challenges. Counselors must be able to stand by youth even though one step
forward can be followed by two or three steps backward.

Counselors and staff need to understand the periods of testing that are part and parcel
of the development of trust for distrustful youth. Often the feeling of being cared about and
accepted back for another chance—even when you broke the rules and had to leave the program
for a while—is a new one for many of these abused and abandoned youth. Sometimes youth
feel the need to reject the helpers in anticipation of being rejected by them. Other youth are
reliving and reacting to rejections of the past. Such feelings can make it difficult to use the
help that is available:

*I didn't really go along with the counseling at my school. I was not ready, too into*
*drugs and gang stuff. I didn't think my parents would change. I felt they gave up on*
*me.*
**(17 year old Latino youth—on his own for 4 months)**

This 17 year old youth did become involved in a counseling relationship with a psychology
intern and began to explore his current concerns and some of his past hurts and frustrations.
This involvement began after staff noticed his increasing depression and insisted he talk with
counseling staff.

### 3. Tools and Techniques

*Young people don't want to go to the services because there is nothing to do. There should be places to go with pool tables and weights, some sort of recreation center.*
**(17 year old Latino male— on his own for 7 months)**

The inclusion of activities in counseling with youth and children is a time honored way of reducing anxiety, breaking the ice, taking some of the intense focus off the here and now, creating an additional medium for communication and expression of feelings and just having some fun. A number of youth mentioned how helpful and enjoyable their experience had been in counseling modalities and related activities with a 'therapeutic' or healing goal or focus.

*Counselors should use more art in treatment and have better food and activities and recreation. It is too boring and I like to paint and draw.*
**(17 year old female of mixed racial background)**

*Tell counselors they should bring food and we should draw pictures of how we are feeling--it's easier--better to express yourself.*
**(16 year old female of mixed racial background--on her own for just over 12 months)**

*The kind of counseling doesn't really matter--it depends on the people around you. I like the Improv group. It helps get things out and is fun also. There should be more of that.*
**(13 year old white female--on her own for 7 months)**

Several youth in the Southern interview group mentioned an improvisation group and art activities as important times for expressing feelings and working issues out. Other youth suggested that the gym and more physical activities were important to them in learning to manage feelings in more productive ways. One youth, with an unsuccessfully hidden kitten peeking from her shirt, made a strong case for the benefits of pets to homeless youth who were "away from their family and nobody much to care about them". She stated, "I think it can be a better way to learn to take care of someone than having a baby. But at most shelters they would throw you out." She was accompanied by a recently homeless adolescent with a young infant.

Another youth found help and support in a group focused on gaining the skills needed for independent living:

> *The independent living group has been very helpful to me in staying focused and realistic about what I need to do. I am working and saving for an apartment. It is very hard but [the counselor] is so proud of you when someone does well. It helps you keep going.*
> (17 year old African American male)

Still, youth knew the difference between activities related to counseling and just "goofing off". In the words of one young woman:

> *I had one counselor who only wanted to play pool and not work on anything!"*
> (16 year old white female—on her own for 2 months)

4.    Training, Experience and Supervision

> *Yes. I could really talk to the counselor [psychiatrist] that I went to when my mother died. It was mostly talking and physical [activity] therapy—no medication. My counselor was a woman. I could trust her and she was easy to talk to. I asked for the counseling...and it helped me a lot. Some of the staff here [drop in center] is incompetent. Why? It's a lot of things—mainly their attitudes. Like [name of case manager], he is always making you wait for him. "Wait until I finish the newspaper". Like we have nothing to do and he does. They need to have professional counselors like the one I had before. [Some]one who is sensitive and professional, competent—who knows what they are doing and what they are there for.*
> (16 year old gay Latino male - on his own for 18 months)

Although it is not always expressed by youth in terms of the need for "more professional" counseling, many youth recognize that their problems are serious and not easy to address without well trained, experienced, sensitive and caring staff. In addition, many of the areas already discussed (and some of those that follow) point to the need for both initial and ongoing training for both professionally credentialed counselors and other counseling and case management staff working with homeless, sexually exploited and multiproblem youth.

> *Tell counselors don't stare—ask questions and just talk—don't wait for the [youth] to talk. My counselor just sits and stares at me and doesn't talk or ask questions much. I hope this counseling will get better...Put them [youth] at ease. Ask questions and help*

*them talk. Maybe play a game or cards—not just talking. It's easier to talk in a group sometimes—it's not just me.*
(15 year old African American female)

Issues around the process of engagement in counseling also underline the importance of counselor experience, training and supervision in working with this population. One young African American woman was referred for counseling because of self inflicted cuts up and down her arms. She was uncomfortable talking to a counselor because she said that he stared at her, waiting for her to initiate the conversation. She felt she really needed gentle questioning, support and perhaps an art project or other activity to make the focus on the counseling process less intense and direct. In many cases these troubled and challenged youth are receiving services provided by counselors and staff with little formal training or experience and few opportunities for inservice and continuing education. At the very least these staff need the support of experienced and consistently available supervision.

## B. YOUTH'S ACCESS TO COUNSELING AND SUGGESTIONS FOR SERVICE IMPROVEMENT

*Have there been times when you felt you could use some counseling but didn't know where to turn or who could help?*

*Yes. I traveled for a long time. During the trip, for months and years, I felt angry, like I wanted to destroy the world. I went around with the eyes of a "lechuza". It's an animal in the forest with the devil's eyes. When it calls, if you don't respond, it kills you. It's better to have someone to speak with. If I need to talk with someone. I really need to, and I'm not satisfied until I do....The counselor is very helpful. But it's that I don't really participate. I'm not interested, and I'm going to stop going.*
(17 Year old Latino male—on his own for two years)

The final domain in this chapter on homeless and runaway youth's experience of mental health services covers their impressions of the accessibility of counseling services and their recommendations for general service improvement. We asked if they had ever needed counseling but didn't know where to go for it or would not or could not use it. We also asked if they would consider use of counseling in the future and whether they would suggest counseling to a friend who needed help. Responses were diverse, but their comments are important to understanding and overcoming the problems and challenges inherent in providing effective mental health services to homeless, sexually exploited youth.

The findings in this final section are presented in four parts. The first two present information about access to use of mental health services, first youth focused issues (1) and then agency focused issues (2)). The third part covers youth's willingness to obtain counseling in the future and their recommendations to friends who need counseling. The fourth and final part presents youth's suggestions for general service improvement.

## 1. Access to Services: Youth Focused Issues

Our participants discussed a variety of reasons why youth may or may not use services. Analysis suggests this information can be collapsed into five distinct themes:    a) Readiness and desire for counseling, b) Alternative coping patterns and beliefs about being helped, c) Material resources, d) Family/friends beliefs and previous experience seeking help, e) Knowledge about where to get help. Each theme is discussed in turn.

### a. Readiness and Desire for Counseling

*I went to counseling for my drinking problem. Well, really for all the things that are problems for me. But I don't participate in the counseling. I talk, but I'm really not interested....The counselor is very helpful. But it's that I don't participate.*
(17 year old Latino male on his own for 2 years)

*I always knew where to go for counseling. I thought about it and decided to cope by myself. But I was wrong. I couldn't do it. There are some things you just can't handle by yourself.*
(16 year old gay Latino youth)

*Back in junior high back East. The counselor I was working with at school suggested further counseling. I told him no, I didn't wish for it. I felt I didn't need it.*
(17 year old white male on his own for 4 months)

One of the most frequently mentioned barriers to the use of counseling services was the youth's own feelings of "not being ready" to talk about problems or not wanting or needing to accept counseling help. Typical statements include:

*People have suggested counseling, mainly teachers, but I said no. I let some stuff out then I would try to hide it--to try to protect myself and not be hurt again.*
(17 year old Latino male on his own for 12 months)

43

*I didn't stay at the hospital when my parent's took me there after I tried to kill myself. I told them I wasn't going to stay and I left with them. If I needed help again I might talk to a counselor, maybe, or talk to a friend.*
**(16 year old female of mixed racial background)**

*I didn't need counseling. Everyone watches out for me and I can always talk to friends.*
**(13 year old white female—on her own for 7 months)**

*I didn't follow through with counseling cause I did not feel like talking at that moment. I knew where I could get help—mostly I didn't need it and I didn't have money anyway.*
**(17 year old African American female-on her own for 8 years)**

The last quotation mentions the youth's lack of material resources as an obstacle to securing services. In discussing barriers and access issues, it is difficult to separate the responses into discrete categories. Rarely, it seems, is lack of access related to one single factor--especially for these multiproblem youth. However, "not feeling like talking seemed to be the over-riding theme.

### b.      Alternative Coping Patterns and Beliefs

*I didn't follow through with counseling when they sent me at school—I was not ready, too into drugs and gang stuff.*
**(17 year old Latino male—on his own 4 months)**

Youth tended to rely on other means of coping with problems. Some of these other means were, themselves, incompatible with constructive use of counseling help.

*I would drink or get drunk three times a week or more to get away from problems with my Dad or family. My Dad would beat me and put me down. I got in trouble for not going to school but I didn't go anyway because kids put me down and I got hurt easy. There was no help for me.*
**(16 year old male of mixed ethnic background--on his own for 3 years)**

*Yes. There have been times when maybe I needed help but I would talk to friends or sit it out till it got better or off my mind.*
**(16 year old Latino male--on his own for 4 months)**

The belief that they will not be understood and cannot be helped by counseling was mentioned by many youth. The fear of being beyond help or not worthy of it is a strong force in the lives of these often multiply exploited youth. The words of the youth in the following quotations illustrate the depth of this fear.

*Yes. I needed help but I kept it to my self--I thought nothing would help but getting off this earth. Mostly I kept it to myself but I also didn't know where to go. Now I know about getting help here at the agency.*
**(16 year old female of mixed ethnic background)**

*When the counselor suggested I get help I just didn't pay any attention to him. I thought that the counselors wouldn't understand me and wouldn't be able to help me.*
**(16 year old gay Latino youth--on his own for 2 weeks)**

*I felt really desperate and I didn't know who could help me. Later I told my story to my social worker and she helped me. Still I was doubtful that she could help me.*
**(16 year old female Latina dealing with issues of sexual identity, family rejection and suicidal ideation)**

*I thought that the counselors wouldn't understand me and wouldn't be able to help.*
**(16 year old Latino gay male)**

c.      **Lack of Material Resources**

*Lots of times I needed help. I didn't know where to go or had no money or no ride-- sometimes I was scared to go. I would just stay with friends. It was scary.*
**(15 year old female of mixed racial background--on her own for 3 years off and on)**

Many youth could not get counseling because they or their families lacked the money or insurance to pay for services or the transportation to get there.

*Yes. I had to quit counseling--because of transportation and also because of money--no insurance or cash. When I was living at home my parents couldn't afford it anymore. Now I can't get back to the old place I got help because of no money or it's too far or I got kicked out before.*
**(16 year old white female on her own for 2 months)**

### d. Family/Friend's Beliefs and Previous Experience

*I thought about getting counseling help a lot growing up but my mother said no and told me not to bring it up again. I wanted counseling because I was depressed a lot and no one listened--no one understood me. My mother said no and I didn't know where to go but I could have found something if my mother didn't say no. No one agreed when I brought it up.*
(15 year old African American female starting counseling for the first time at the agency--on her own for 1 year)

Family beliefs about and attitudes toward counseling act to socialize youth about whether or not to consider it an option. Negative attitudes can hinder engagement in counseling:

*After my mother moved away without me and took my little brother--I just talked to a friend. I cried a lot. I worried about my brother--I was the one who took care of him really and missed him. I would have tried to live on my own but a friend of my mother's took me in for a while. I wouldn't have gone to counseling. It wasn't what we do. Besides, the teachers at my school were crazy. I wouldn't go to them for help. I thought counseling was for crazy people.*
(17 year old African American male on his own for 2 years)

*Yes. There were some times I needed help. I worked it out myself. Sometimes I talked to my sister--when I had family problems. Counseling wasn't what I do or what my family does [with problems]. I guess I also didn't know where to go. It's funny. My mom had an alcohol problem too--mainly on the weekends. She worked as a drug rehabilitation nurse and they both [mother and father] had alcohol problems and none of us got any help.*
(17 year old African American male on his own for more that a year)

Positive attitudes on the part of the family can make it easier for youth to consider counseling as a viable choice:

*My mother had counseling after she killed someone in self defense. It was bothering her and the counseling helped. My mother's understands counseling. She would have been glad I went.*
(15 year old Latino youth who sought counseling to help him cope with his mother's death)

The attitudes and experiences of peers can also influence a youth's willingness to participate in counseling:

46

*My friends thought counseling was a bad idea. They wanted me to keep taking drugs.
They pressured me a lot. But now all of them are in the slammer [jail]. I felt good for
not getting involved in drugs again. But it also made me think about getting high when
friends pressured me. Now that they are all in the slammer I feel alright.*
**(17 year old Latino male on his own for 7 months)**

Youth's previous experience in seeking help both from agencies and other sources has a
distinct impact on their willingness to access services. When they have been abused,
threatened or humiliated by service providers, they are harder to engage in future services.

*One day when I was in L.A. a counselor told me he didn't want to help me because I
am Mexican. It was a youth service agency in L.A. So I left.*
**(Same youth as above)**

*I don't know. There is racism against Latinos. The Americans want everything for
themselves. They try to help, but they are racist. Not here at the agency, but in the
streets and in Los Angeles.... When I was in the street they told me they were going to
help me but they made me sell drugs. I couldn't speak about that to anyone.*
**(17 year old Latino male on his own for 6 months)**

Both agency and street contacts made in the course of their struggle to survive can be
problematic for homeless youth trying to get help. Attempts to find help bring youth face-to-
face with exclusive agency regulations, insensitive staff, and insufficient services. Seeking
help through street contacts can lead to victimization at the hands of both adults and peers. All
of these experiences make trust just that much harder to come by.

**e.     Knowledge About Where to Find Help**

Many youth lack knowledge about the availability of services and where to find help--
particularly services for "special populations" like minority youth, bilingual and monolingual
youth, undocumented youth, gay, lesbian and bisexual youth, youth who are gang involved
and youth struggling with issues of substance abuse. Youth are particularly sensitive to the
appropriateness of services:

*Yes. There were times when I didn't know where to turn for counseling help. It's very
difficult for me to confide in someone. It would help if it were someone who knew what
it means to be gay. I think that is the most important problem with counseling services.*
**(16 year old gay Latino male)**

47

*There should be more counselors available and more Latinos. There are Americans who speak Spanish, but they are racist in various small ways.*
(17 year old Latino male)


*Out here I don't know the places to get help--there is no place to go here. I don't have money either and don't know where to go when I think about help. They haven't asked me about counseling here at the agency. I don't know--maybe I would go. I don't know other people getting help here.*
(14 year old white female on her own for 4 months)



2.    Access to Services:  Agency Focused Issues


Agency centered barriers to access to counseling services for youth fall into four major areas: a) Lack of services and service gaps, b) Lack of publicity and information about services, c) Problems with the nature of the services and d) Need for additional specialized services and training. Each issue is discussed in turn.


    a.    Lack of Counseling Services and Service Gaps


    *It takes a long time to get help from counselors and services. You have to wait a number of days. When kids are involved in drugs and street life, they get bored in places like the agency.*
    (17 year old Latino male on his own for 6 months)


Many of the youth interviewed feel that there is a lack of adequate counseling services and many gaps in the general services provided to homeless youth. Four frequently mentioned concerns are presented below:


    1. Youth see counselors both as information resources and as role models for dealing with difficult issues and life circumstances. They emphasized the need for more counseling staff, especially bilingual/bicultural counselors, gay staff or staff knowledgeable about gay issues and lifestyles, staff of color, staff knowledgeable about gang issues and life styles, staff knowledgeable about substance abuse, and staff familiar with job placement and training, transitional and long term housing and education. Inadequate resources make this modeling even more difficult.


    2. They also discussed the need for more resources and services in the areas of housing, independent and transitional living programs and services, education, job training and placement services and substance abuse treatment.


48

3. In addition to more appropriate staff, youth also felt all staff needed more training. General staff training in areas of working with gay youth, anti-bias training: racism, sexism and homophobia, information about substance abuse, transitional and independent living services, cross cultural counseling and helping youth from different cultural groups to learn to work and live together.

4. Many youth also noted the need for longer shelter stays, extending beyond the frequency encountered two week limit to allow more time for stabilization work.

5. Finally, youth feel penalized by the fact that at 18 they must move into the adult world for which they feel unprepared. They want services to be extended to youth in the 18 to 21 (or even 24) year old group. At 18 or 19 youth are often finally stabilized enough to make effective use of services first offered to them with more limited success when they were under 18. In other cases, these 18 to 21 year olds are still in need of extensive help with issues of independent living and with transitional services designed to augment deficits born of years of street life with very limited and unstable support from caring adults. They often enter young adulthood still more connected to the world of homeless exploited youth than to the world of homeless and unemployed adults.

### b.     Lack of Publicity and Information about Services

*A guy sent me to the Agency when I was selling drugs in the Park—he said I was young and should get out. I hope I do.*
(16 year old Latino youth here 6 months from Central America)

*I need material and physical things, but not emotional help. But there are a lot of guys in the street who need emotional support. They don't know that these services exist.*
(17 year old Latino male on his own for one and a half years)

As part of an assessment of youth's access to counseling services, we asked them whether there had ever been a time when they felt they needed counseling help but did not know where to get help. Eighteen of the thirty-two youth who answered this question stated that they knew where to find help (56%). This group included youth who had successfully sought counseling help, those who felt they never needed it and those who knew where to find it but declined to use the services. Fourteen youth (43%) stated that they had not known where to get help.

Many youth said that they knew about available services through friends, street information networks, various hotlines and other service agencies, but that many of their friends did not. Other youth said that, at first, they had a hard time locating help.

Youth of color, monolingual and undocumented youth and gay youth often had an especially difficult time finding help. Their access to information about services in general, and to services sensitive to their cultural needs in particular was limited both by agencies' lack of knowledge about how to reach them and insufficient staff with appropriate experience in working with these client populations. For undocumented youth, services are also limited by statutory and contractual agreements that preclude services to youth without legal resident status. This is not a concept easily understood by homeless and exploited undocumented youth:

> *There are centers where young people come and don't get help. I don't know if they don't get help because they are illegal. There are a lot of kids in the streets who don't know that services exist. There is a lot of publicity in the American community. They discriminate at a lot of services...they discriminated against us because we are Latinos and we are gay. It makes me feel useless, like I'm not worth anything.*
> **(16 year old female Latina on her own for 6 months--quoted previously)**

Overall, while over half of our youth stated they knew about services when they needed them, there is still a considerable need for both publicity and extended services. This is especially true when it is considered that all the youth interviewed were already involved with service agencies. Many researchers suggest that far more youth need services than receive them. In fact, in a 1983 report, the U.S. Department of Health and Human Services suggests that only one in every twelve homeless youth are served by federally funded emergency shelters (U.S. Department of Health and Human Services, October 1983)

c.     Need for Additional Specialized Training and Resources

> *I had/have a lot of different problems. The biggest thing is that I tried to commit suicide. The counselor gives you certain points of view that make you think that suicide is not the solution. The counselor gave me therapy and it helped me a lot...I still see the counselor. She gives me a lot of suggestions and options. When I think about killing myself, I think about what my therapist said.*
> **(16 year old Latina female on her own for 7 months)**

Augmenting the general counseling skills needed for effective work with any youth -- counselors working with runaway and homeless youth need additional training. This training must help counselors to effectively interact with youth impacted by issues of recurrent family separations, unresolved grief and suicidal depression, child abuse and family violence, substance abuse, sexual identity concerns, issues of immigrant, refugee and undocumented

status, cultural issues and the impact of racism as well as the sexual exploitation and other damage inherent in life on the streets. They also need to know how to network with other agencies and how to work effectively with child protective services, the juvenile justice system and other related youth service systems. Many of the youth clearly feel this need for additional training and services in specialized areas.

Several youth expressed concerns about the difficulty of finding counselors who could understand and help them with issues related to coming out and the establishment of a positive gay or bisexual identity. This is definitely an area where more training is needed by many agency staff both professional and paraprofessional. In the words of a young Latino gay male:

> *It's very difficult for me to confide in someone. It would help if there were someone who knew what it means to be gay. I think that this is the most important problem with counseling services....I thought that the counselors wouldn't understand me and wouldn't be able to help me.*
> **(17 year old Latino male)**

Racism presents another powerful issue for many youth. For some of the Latino youth these issues are complicated and multiplied by their undocumented legal status.

> *At the agency they spoke only English. There is some racism there and here also. At first I thought there weren't enough Spanish-speaking counselors. Now I think there are enough but at first they are hard to find. Also the American clients here are racist.*
> **(17 year old undocumented Latino male)**

> *They don't enforce the rules the same for everyone here at the agency. The counselor treats the girls different and some things seem racial to me--some of the way they treat me is racial.*
> **(17 year old Latino male on his own for 12 months)**

One Latina bisexual female, age 16, felt multiply victimized as a bisexual, undocumented young woman of color:

> *They should pay more attention to young people. There are centers where young people come and they don't get help. I don't know if they don't get help because they are illegal. There are a lot of kids in the streets who don't know that services exist. [In the American community] they discriminate at a lot of services.*

Confronting racism (among both staff and clients), increasing multi-cultural awareness and the exploration of staff biases such as homophobia that may affect the provision of services are difficult but crucial areas for on going training and awareness. An additional and often more effective strategy in creating a welcoming environment for youth from varied ethnic and racial background is the hiring of staff representative of the populations served. In the word of one African American youth:

> *We need to have counselors who have similar experience to ours....These counselors don't know how I feel...how kids feel.*
> **(17 year old African American male youth recently in California from a Southern state)**

## 3.    Willingness to Participate in Future Counseling

Investigators also asked youth about four additional issues related to counseling access and utilization: a) Had they ever had a counselor whom they felt that they could really trust?; b) Would they try counseling in the future?; c) Had they ever suggested counseling to a friend or family member?; and d) What would they recommend to a friend who needed counseling. These four access related issues are discussed in order.

### a.    Have you ever had a counselor that you could really trust?

Of the 33 youth who answered this question based on their current or past counseling experience, 21 (64%) answered "Yes", 8 (24%) answered "No" and 4 (12%) answered "Maybe or Sort of". The qualifications mentioned by those who answered "maybe" related to problems in the counseling experience. Thus, almost two thirds of the youth interviewed had had at least one counseling person they could really trust and talk to; while the remaining third had either negative or ambivalent experiences.

### b.    Would you seek counseling services in the future?

Over 87% of these youth stated they might consider counseling in the future if they thought it would be helpful. This number includes 24 youth (75%) who said yes they would try it and 4 youth (12.5%) who said they might try it depending on the counselor or problem. Only three youth said no and all were youth with previous negative counseling experiences. The number of affirmative answers to this question was even larger than the number of who defined counseling in a positive way. These points suggest that most youth can be engaged in counseling when the timing and sensitivity of the provider are aligned with their needs.

c.      **Have you ever suggested counseling to a friend or family member?**

Twelve (39%) of the thirty one youth who answered this question had suggested counseling to peers, other friends or family members. In the Northern sample which included a large number of monolingual Latino youth only 2 of 10 youth who answered had suggested counseling to a friend. Overall 19 (61%) of the youth said they had never suggested counseling to friends or family.

Of the youth who did suggest counseling, most suggested it to a friend. Several however, spoke about suggesting counseling to a parent or step parent, mostly because of drug or alcohol use. None of these suggestions to parents were acted upon.

d.      **What would you recommend to a friend needing counseling?**

Almost two thirds (62.5%) of the youth answering this question stated they would refer a friend to one of the agencies or counselors that they knew or to previous counselors that they had worked with. One fifth (22%) said that they would counsel these friends themselves (even if they were suicidal) or refer them to a peer or adult (non-counselor) who "gives good advice" or who "has less problems than the kid does." Three youth said that they didn't know what they would do, two youth said that they wouldn't interfere even if asked because "it is up to the person what they want to do--it's not my business or concern."

4.      **Suggestions for Service Improvement**

*We need more groups and counselors like mine. He runs the independent living group. He talks to people straight and makes you look at the real issues--it's time to grow up. I get strength from talking to him and he is really proud of the ones who make it. He needs more help though. People need counseling, too, about verbal abuse and neglect. That is what they had growing up. A lot of these kids have no home training. They are cursing and staff don't have time to counsel them. We need more counselors to tell them they are better than all that cursing and cursing don't make them big. They spread that disease from the streets in here to the shelter. It's not bad people. They are just caught up in a trend. Have a heart--they just don't know. Help them to get on the right track.*
(17 year old African American male--on his own for more than a year)

*We need more free clinics and more open shelters and more placements, long term shelters--as long as you need it so you can really get help. Open shelters with no limits--all ages.*
(15 year old female of mixed ethnic background on her own for 3 years)

*What about peer counseling. You know, people my age --people with similar problems and people in some similar things who have worked their stuff out. And if*

*I was a counselor it would always be pay what you can and everybody can get help.*
(16 year old white female who ended previous counseling due to parental
unemployment that led to loss of insurance coverage)

The youth we interviewed were vocal about their views of service needs. Their
perspectives are presented in six theme areas that cover the following issues: a) Shelter and
drop-in services, b) Housing and transitional living services, jobs, education, and independent
living skills, c) Health care, d) Publicity about available services and e) More voice in service
planning and decision making. These areas are discussed in turn in the concluding section of
this chapter.

### a. Shelter and Drop-In Services

*I don't know what else we need. They help me at the drop-in center--they give me
what I need. If a friend needed help I would tell them to go here.*
(17 year old Latino male on his own for 7 months)

*We need some more staff. It's too much for them to handle all the kids--everyone
can't get the help they need and you have to wait a lot.*
(17 year old Latino male on his own for 12 months)

Many youth mentioned current agency drop-in and shelter services as significant
sources of help for them and a service they would like to see extended to more youth in need.
They also had ideas for the improvement of agency services including: a) additional treatment
modalities (group, sports and recreation, art therapy, drama and improvisation groups), b)
staff training, c) additional staff, d) choice of male/female counselors and e) more staff of
color and gay staff, f) longer shelter stays. The following are some of their suggestions:

*Don't dictate, but look at problems in a holistic way (food, shelter, anger, school,
gender, etc.), deal with the details. Also, better communication between services so
that the youth don't get caught up in the process; the battles between agencies can hurt
the kids.*

*More groups. Group is easier than individual because you have the support of friends
and people with the same problems.*
(15 year old African American female)

*Counselors should use more art in treatment and have better food and more activities
and recreation. It is too boring and I like it when I can paint or draw.*

**(17 year old female of mixed-ethnic background on her own for more than two years)**

*For me--women for women and men for men--they understand better--I have hate for men--maybe not for R--he's different--he says all men are not the same.*
**(Same 17 year old female as above)**

*They need more counselors who can talk to you in Spanish and know about your life.*
**(16 year old Central American youth)**

**b. Housing and Transitional Living Services, Jobs, Education, and Independent Living Skills**

*We need services that give housing and food. At least shelters and group homes.*
**(16 year old Latina on her own for 6 months)**

There is also a concern among youth about their ability to "graduate" from street life to stable housing situations without the independent living skills and resources available to many youth living at home. Independent living and transitional housing programs are beginning to be available to youth emancipating from foster care and group homes funded by child welfare services. There is a great need for these services among homeless youth as well. A recent proposal for transitional housing for foster youth age 17 to 19, prepared by the Housing Committee of the State Department of Social Services, included the following quotation as part of the background rationale for the Independent Living Skills Program Housing Proposal:

"Nationwide, more than one-third of all homeless youth had been in foster care the year before they took to the streets, and California statistics are even higher, with 45% saying they had been in foster care in the last 12 months (Los Angeles Times, 1 January 1992, p.A5). Studies from New York have shown the percentage of former foster youth in the nation's homeless population to be as high as 39%. For instance, 1,000 youth emancipate from foster care annually in Los Angeles County alone. At least 400 of these youth are in need of immediate housing. These youth are not a priority for low income housing programs and many end up in homeless shelters. These are people who spent their formative years trying to cope with extraordinary life challenges. The focus of their life was to survive in a family that was not their own at the same time they were trying to make sense of a series of events that would change their life forever. Compounding this is the reality that the protection of the foster care system in California only lasts until a minor reaches the majority age of eighteen. Consequently, at eighteen years of age foster youth find themselves without a place to live, many times without adequate educational background, and having not developed the knowledge and skills necessary to function as a productive member of society" (Housing Committee Staff, 1992, p.1).

Many of the youth we spoke with related both unsuccessful group home foster care experience and serious concerns about their lack of readiness and resources for employment and independent living. They have often spent several years on the streets and in shelters without even the stability and guidance foster or group home care optimally provides. Funding is greatly needed to help extend independent living skills programs and resources to the homeless youth population 16-24 as well as to youth emancipating from foster care. Both independent living skills and transitional assistance are especially urgent in light of the large number of homeless youth who are "drop-outs" of the foster care system or casualties of the lack of needed aftercare services and planning. There are currently programs at the state level through the Department of Social Service seeking to fund housing assistance for emancipating foster youth. These resources are desperately needed by homeless youth as well (Housing Committee Staff, 1992).

*We need help with housing and jobs and staying off the street.*
**(17 year old African American male)**

*We need services that give jobs and job training. There is discrimination in getting jobs also.*
**(16 year old Latina female)**

Jobs, job training, educational opportunities and independent living skills were also on the list of services to be expanded to serve the needs of street youth struggling to transition to independent living. There are large gaps in the school attendance histories of many of these homeless youth due both to time "on the run" and changes in family living situations. In addition, twenty-five percent of the youth in the evaluation were former participants in special education programs.

*There needs to be more schools, places to get job training so that young people will have a profession.*
**(17 year old Latino male on his own for 7 months)**

## c. Health Care

*In the General Hospital they didn't want to help me because I am Latina and I didn't have papers or immigration documents. I had a dislocated bone. In a lot places...they discriminate against us because we are Latinos and we are gay. It makes me feel useless, like I'm not worth anything.*

**(16 year old female Latina youth)**


*We need shelter and housing. We also need oral hygiene and VD treatment.*
**(17 year old white female)**


Some of the youth were also concerned with the issue of access to health care services. The youth quoted above found access to health care difficult because of her undocumented status. Many other female youth were pregnant and found it difficult to find both health care and shelter situations that accommodated homeless pregnant teens. Others were concerned about dental problems and sexually transmitted diseases. All of these youth, as sexually active adolescents, participants in survival sex and prostitution and frequent drug users and their partners are at high risk for contracting HIV, especially those involved in IV drug use. All of these youth need regular access to risk reduction services and treatment when needed. Many also suffered with colds, allergies, head and stomach aches and problems with parasites (e.g. lice). Keeping up with medication regimens as well as with medication themselves was difficult for these mobile youth.


*I have a vaginal discharge and I'm also pregnant so I can't take some medicines. I just keep itching. I need to see a doctor before we finish this interview.*
**(15 year old white female)**


*I had an AIDS test at the Free Clinic. They said I was a: risk for it from drugs and sex.*
**(17 year old Latino male on his own for four months)**


**d. Publicity About Available Services**

*There are a lot of kids who in the streets who don't know that services exist.*
**(16 year old Latina female)**


Lack of knowledge of available resources among youth on the street is another area where additional resources are needed to "get the word out" about where to get help. Here too youth have many ideas.


*There are a lot of guys out there in the streets that don't know that there are services. The agencies should publicize themselves--with a radio station, with posters, in the schools.*
**(16 year old gay Latino youth)**

*We need more information—hotlines and signs in the street and in the phone books, phone booths—more clear information. My sister don't know where to get help. All ages need more information about services.*
**(15 year old female of mixed ethnic background)**


### e. More Voice in Service Planning Decisions Making

*There should be more choices. More structure for some youth and less for others. Involve the kids in making decisions and being responsible. Give us more experience with independent living.*
**(15 year old of mixed ethnic background on her own for 3 years)**

A final and perhaps most important theme among the many suggestions for service improvement from these youth is the request for more of a voice in the planning and decision making about services to homeless, sexually exploited youth. This chapter of the evaluation study is an example of the energy and clarity that youth can bring to the discussion of issues that draw on thei life experience and impact on their future.


Chapter V will present the results of the survey of youth- serving agencies and discuss the findings.

# CHAPTER V: YOUTH-SERVING AGENCY SURVEY

## A.    INTRODUCTION

In the chapter that follows, we present the results of the Youth-Serving Agency Survey. In order to gain a perspective on the mental health services available to runaway and homeless youth in California, a mail survey of existing service providers was conducted. In total, 201 youth-serving agencies were sent a questionnaire and a cover letter. The letter explained the purpose of the study and elicited agency personnel's cooperation in the study.

The agencies were located in four metropolitan areas in California: San Francisco, Santa Clara, Los Angeles and San Diego. Table 1 illustrates the number of responses to the agency mail survey.

### TABLE 1
### Survey Response Rate by Study Area

| Study Area | Number of Responses |
|---|---|
| San Francisco | 7 |
| San Jose | 6 |
| Subtotal Northern California: | 13 |
| Los Angeles | 26 |
| San Diego | 19 |
| Subtotal Southern California: | 45 |
| Total: | 58 |

A total of 30 agencies were contacted in Northern California (San Francisco and Santa Clara Counties), with 13 (43%) of these agencies responding to the survey. Of the 171 surveys sent to agencies in Southern California, including Los Angeles and San Diego, 45 agencies (26%) responded. The overall response rate for this agency survey was 29%. While this overall return rate is low, these data, combined with information gathered in five in-depth interviews with experts in the field of mental health and homeless youth, provide insight into some broad issues and trends in the homeless and runaway youth service system.

## B.    AGENCY CHARACTERISTICS

An analysis of the characteristics of those agencies who responded to the mail survey reveals the following:

- Respondents to the mail survey included representatives from homeless youth shelters, youth residential programs, outreach programs, family counseling agencies, legal services agencies, detention facilities, county mental health agencies and primary health care facilities.
- Overall, the number of staff positions at participating agencies ranged from two to 150 full-time equivalents (FTEs) with a median staff size of 14. The responding Northern California agencies had a higher median staff size (17) than the Southern California agencies who had a median staff size of 13.
- Just over 12% of the responding agencies had the capacity to serve English-speaking clients only. Approximately 82% of the responding agencies reported being able to accommodate Spanish-speaking clients, while an additional 6% of the responding agencies reported the ability to provide services in basic Spanish. Many agencies also reported having staff fluent in several other languages including Japanese, Cantonese and Mandarin Chinese, Vietnamese, Korean, Tagalog, Cambodian, French, German, and American Sign Language.

The mail survey asked respondents to report on their staffing patterns. Respondents were asked whether they had licensed professionals, unlicensed professionals, para-professionals and/or volunteers on staff at their agencies. Table 2 provides the total number of agencies who described themselves as having at least one staff member in those categories.

### TABLE 2
### Staffing Patterns Within Responding Agencies

| Agencies Having at Least One of the Following Types of Providers | Total Agencies (n=58) |
|---|---|
| Licensed Professionals (PhD, MD, MFCC, LCSW, etc.) | 48 |
| Unlicensed Professionals (MSW, MA, BA, etc.) | 54 |
| Para-professionals | 36 |
| Volunteers | 32 |

The data in Table 2 indicate that most of the agencies who responded to this survey had at least one unlicensed professional on staff (n=54). Overall, agencies stated that reliance on paraprofessionals and volunteers was limited.

- The interviewees indicated that the benefits of having licensed professionals on staff include: 1) the theoretical and practical training and experience they bring to the agency; 2) their ability to provide supervision and in-service trainings to other staff members; 3) their ability to supervise clinical hours for the unlicensed staff who may be working towards a license; and, 4) the private insurance requirement that in order for the agencies to be reimbursed, licensed professionals provide the care.
- The follow-up interviews also indicated that while volunteers allow the agencies to broaden the scope of the services they offer, they require close supervision and coordination. The interviewees indicated that while volunteers sometimes provide services that are therapeutic, few agencies use volunteers in the provision of mental health services such as counseling or more formal therapy.

The survey questionnaire asked respondents to define the geographical areas their agencies served. Table 3, below, shows the areas served by the responding agencies.

## TABLE 3
### Areas Served by Responding Agencies

| Geographic Area Served | Number of Agencies (n=58) |
|---|---|
| City of San Francisco | 4 |
| Bay Area | 1 |
| City of San Jose | 2 |
| Santa Clara County | 4 |
| City of Los Angeles | 2 |
| Los Angeles Area | 23 |
| City of San Diego | 7 |
| San Diego Area | 11 |
| Southern California | 2 |
| National/International | 2 |

As shown in Table 3, agencies serving clients in the Los Angeles area were the most common respondents to this survey. The second most common area served was the San Diego area. Slightly over a quarter of the responding agencies said they served youth in the cities of San Francisco, San Jose, Los Angeles or San Diego. Interviewees pointed out that while this data gives the impression of a service system that is open to youth in need, the geographical areas of service depicted above can sometimes act as barriers to youth seeking services. The informants were particularly concerned about the many runaway or homeless out-of-state or out-of-county youth who may not be eligible for services because they do not meet the service area or residential requirements of the agencies.

## C.  CLIENT CHARACTERISTICS

The selection criterion for inclusion in the mail survey was the provision of services to youth between the ages of 12 and 17. All of the 58 agencies responding provided services to youth, but youth accounted for different percentages of their client load. These percentages ranged from 4% to 100%, with a mean of 62% and a median of 56%. Thirty-seven of the responding agencies (64%) reported that half or more of their overall clients were between the ages of 12 and 17. Overall, most agencies (69%) reported serving homeless youth and more than 70 % reported serving undocumented youth (79%), HIV infected youth(76%), and youth with dual diagnosis (74%) of mental health problems and substance abuse. Table 4, below, shows the youth populations served by the 58 responding agencies.

### TABLE 4
### Youth Populations Served at Responding Agencies

| Population: | Total (n =58) |
|---|---|
| Homeless Youth | 40 |
| Undocumented Youth | 46 |
| HIV-Infected Youth | 44 |
| Youth With Dual Diagnoses | 43 |

The following concerns were raised by survey data and/or the testimony of interviewees in relationship to agency services:

- Table 4 shows that some of the youth-serving agencies who participated in the survey do not currently serve some of the most vulnerable youth populations: homeless youth, undocumented youth, HIV-infected youth or youth with dual diagnoses.

- Interviewees pointed out that in order to protect the majority of the youth receiving services, agencies sometimes find it necessary to exclude youth from services who may be dangerous to others or to themselves. Licensing requirements may also dictate who can be served by the agencies. Appropriate referrals for these youth are often hard to find.

- In the composite, the responding agencies reported some of the following restrictions to service access: youth who are wards of the court, those who have run away from detention facilities; those who are undocumented; those who actively use drugs; those who are suicidal; those who are actively psychotic; those who have a history of arson, sex offenses, theft, or violence.

- Interviewees identified additional constraints to receiving services: an inability to pay for services, the lack of insurance coverage, or an unwillingness on the part of youth to have parents or guardians be contacted for consent.

- Interviewees astutely pointed out that given these barriers to services, all youth, but especially youth with special needs, such as homeless, undocumented, HIV-infected or youth with dual diagnoses, may need assistance negotiating their way through the maze of agencies into the appropriate services.

- While 40 of the agencies reported having served homeless youth, only 38 did so in the past year. Of those, ten agencies served 25 homeless youth or fewer in the past year. Of the 38 agencies serving homeless youth in the past year, 15 had budgets 50% or more dedicated to serving runaway and homeless youth. Of these fifteen, six had budgets 100% dedicated to serving homeless and runaway youth.

■ A total of 27,866 homeless youth were reported served in the past year by those 38 agencies. The total number of clients served ranged between 3 and 10,880 clients, the mean number of youth served was 733, and the median was 154. When the agency that reported serving 10,880 youth is removed, the mean becomes 459 youth and the median 147 youth served. These figures do not represent unduplicated numbers of clients. These data also illustrate the dissimilarity of the agencies in terms of both size and the numbers of youth they are able to accommodate.

Respondents to the survey were asked to further describe the homeless youth their agency had served in the past year. They were asked to provide a percentage of those youth by gender and ethnicity. Overall, the 38 agencies reported serving a percentage of males that ranged from 25% to 100%, with a mean and median of 60%. Female clients ranged from 5% to 75%, with a mean of 39%. The remaining 1% were transgender clients, with 3 agencies reporting serving one transgender client each.

Table 5, below, shows the ethnicity of youth served in 1990-91 in mean percentages.

TABLE 5

Ethnicity of Youth Served in 1990-91 in Mean Percentages

| Ethnicity of Clients | Total Percentages (n=38) |
|---|---|
| Caucasian | 49% |
| African-American | 20% |
| Hispanic/Latino | 24% |
| Asian/Pacific Islander | 4% |
| Native American | 1% |
| Other | 2% |
| Totals: | 100% |

The data in Table 5 indicate that overall, slightly less than half of all of the homeless youth served in 1990-91 by the responding agencies were Caucasian while slightly less than a

quarter of the youth served were Hispanic/Latino, and a fifth were African-American. The remaining were Asian/Pacific Islander, Native American and youth of mixed ethnicity. Interviewees agreed that many of the youth-serving agencies in California are making a concerted effort to reach youth of color. The interviewees described a trend in which agency personnel are being recruited to more closely match the ethnic composition of their communities. The expectation is that in the future, more youth of color will be represented in the agency statistics.

## D.  SERVICES OFFERED

Respondents were asked what types of services their agencies provided to homeless and runaway youth last year. Table 6, next page, shows the results of that query.

### TABLE 6

#### Services Offered to Homeless and
#### Runaway Youth by Responding Agencies

| Service | Total (n=38) |
|---|---|
| Counseling Services | 35 |
| Crisis Intervention | 35 |
| Substance Abuse Services | 23 |
| Outreach Services | 22 |
| Other | 20 |
| Hotline Services | 20 |
| Educational Services | 16 |
| Employment Services | 12 |
| Shelter | 12 |
| HIV Testing Services | 11 |
| Drop-In Services | 10 |
| Residential Treatment | 4 |
| Day Treatment Services | 3 |

As indicated in Table 6, crisis intervention and counseling services were the most common services offered by the 38 responding agencies who served runaway and homeless youth last year. The data does not describe the provider of the service.

- When interviewees were queried about the prominence of crisis intervention and counseling services among responding agencies, they pointed out that crisis intervention is often the first step in working in a therapeutic capacity with homeless and runaway youth. Interviewees unanimously agreed that the majority of runaway and homeless youth who are being served by these agencies have multiple needs, not the least of which is the need to sort through their many issues. Once youth are stabilized out of the crisis mode, they can then begin to address their longer-term needs through additional counseling.

- Given the high proportion of runaway and homeless youth who use drugs, it is not surprising that many agencies who cater to their needs provide drug treatment as part of their overall services. Interviewees mentioned the benefit of providing basic drug education and intervention services to the youth within the agency versus sending the youth out of the agency for treatment.

- A total of 22 responding agencies provided outreach services and 20 agencies provided hotline services. Interviewees pointed out that outreach is often an effective way to bring into services youth who may not otherwise know about the services or who may not initially choose to go into services. Hotlines often respond to youth who may be seeking services but may not know where to go. Interviewees were clear that a selected number of agencies can provide outreach and hotline services, acting as referral sources for other agencies who offer education and employment services, shelter and drop-in facilities, HIV-testing, day or residential treatment.

Respondents were asked what types of counseling services their agency offered runaway and homeless youth. Table 7 shows the findings from that query.

## TABLE 7

## Types of Counseling Offered by Responding Agencies

| Type of Counseling | Total Number of Agencies (n=35) |
|---|---|
| Individual Counseling | 35 |
| Family Counseling | 28 |
| Group Counseling | 25 |
| Peer Counseling | 15 |

The data in Table 7 show that the most common type of counseling offered to runaway and homeless youth by the responding agencies was individual counseling. The second most common type of counseling was family counseling, followed by group counseling. Interviewees felt that given the trust issues faced by the homeless youth population in general, a strong program would provide a youth a number of different types of counseling options. Hopefully, they said, the youth would engage in more than one type.

## E.    ACCESS AND PAYMENT

The survey asked respondents to describe their application procedure. Table 8 presents the findings from that question.

## TABLE 8

## Service Access Procedures of Responding Agencies

| Access Procedure | Total Number (n=38) |
|---|---|
| Referrals Accepted | 31 |
| Call for Appointment | 29 |
| Call for Information | 27 |
| Walk-In | 25 |
| Referrals Required | 2 |
| Other | 5 |

As indicated in Table 8, the majority of agencies who responded to this survey and who serve homeless youth have multiple access procedures for their clients. Most of the agencies accept referrals, calls for appointment, calls for information, and walk-ins. Only two agencies required referrals for their clients. Interviewees indicated that given the nature of the population, the immediacy of their needs, and their reluctance to trust adults, the more streamlined the application procedure, the more likely youth would enter services. As such, the interviewees felt it was good news that only two of the agencies that served youth last year required referrals into their agency.

Respondents were asked to describe their agency's funding sources. Table 9, below, provides that information.

### TABLE 9
### Sources of Funding by Site

| Source of Funding | Total Agencies (n=38) |
|---|---|
| County Government | 29 |
| State Government | 28 |
| Foundations | 28 |
| Federal Government | 24 |
| United Way | 23 |
| Client Fees | 21 |
| City Government | 21 |
| Corporations | 18 |
| Third Party Reimbursement (including MediCal) | 16 |

As indicated in Table 9, most of the responding agencies who served homeless youth last year relied on a combination of public and private funds. Conversely, third party reimbursement accounted for the least common source of funding among the responding agencies.

■ Interviewees suggested that the low level of reliance on third party reimbursement may be an indicator that many of the homeless youth who enter the service system have no private health insurance. Additionally, many of the

homeless youth do not qualify for MediCal or most other forms of public support because it is difficult for them to obtain the necessary documentation.

- Interviewees also pointed out that client fees may act as a barrier to youth who may not have the funds to pay for the services they receive.

## F. CONCLUSIONS

The mail survey of youth-serving agencies in Northern and Southern California, focusing on San Francisco, San Jose, Los Angeles and San Diego, has provided some insight into broad issues in the homeless and runaway youth service system in California. These themes are as follows:

- Many of the youth-serving agencies are making a concerted effort at reaching youth of color. Interviewees described a trend in which agency personnel are recruited to more closely match the ethnic composition of their communities. The expectation is that in the future, more youth of color will be represented in the agency statistics.

- In seeking services, many homeless and runaway youth may be frustrated by the eligibility requirements which may include residency, mental health criteria, documented legal status, sobriety, income, insurance, or parental consent. Given these diverse eligibility requirements, youth may need assistance negotiating their way through the maze of agencies into the appropriate services. At a systemic level, this points to the pressing need for greater service coordination and integration.

Given the nature of the population, the immediacy of their needs, and their reluctance to trust adults, the more streamlined the application procedure, the more likely youth will enter services.

In regard to funding, most of the responding agencies who served homeless and runaway youth last year relied on a mix of public and private funds. Third party reimbursement was the least common source of funding among those agencies responding to the survey.

In the final chapter, we present the key findings of the evaluation and recommendations for change in the areas of training, service needs and gaps and state policy in regard to the mental health need of homeless, sexually exploited youth.

# CHAPTER VI.    KEY FINDINGS AND RECOMMENDATIONS

## A.    INTRODUCTION AND KEY FINDINGS

To this point, this evaluation has brought together three distinct types of information. First, psychometric data (MMPI) about the mental health diagnoses of homeless, sexually exploited youth was considered.  Second, data was presented from youth interviews regarding their experiences and perceptions of counseling.  Finally, survey data was collected from agencies which serve these youth.  Each data source has provided a different perspective on both the need for mental health cou  eling and the most effective ways to provide it.

In the final chapter, these data are interwoven and used to form the basis for the recommendations of this evaluation.  First, we will summarize the primary findings from each of the three initial data sources.  Then we will introduce a fourth and final data source, experts in the fields of service provision and policy analysis.  These experts provided a broad range of suggestions regarding the mental health services needed by homeless, sexually exploited youth.  Their suggestions were used to support and refine the recommendations presented here.

### Key Findings: The MMPI

The MMPI data document the high prevalence of mental health problems among homeless, sexually exploited youth and show that the prevalence of affective disorders and suicidality are particularly high.  As a group, these youth are extremely depressed and isolated.  Many tend to somatize their depression, feeling completely alone with no one to listen to or care for them.  They spend much of their time in rumination over what they could have done differently to hold on to lost parental figures who betrayed them.  Many of the youth feel the only way they can "connect" with others and get what they need is through engaging them sexually.

Based on their MMPI profiles, over half of these youth should be referred to a psychiatrist to assess their need for psychotropic medication.  Most of the youth, particularly the males, are at high risk for abusing alcohol and other drugs.  Overall, these data suggest that effective counselors should be well trained in the following areas: the identification and

treatment of substance abuse, depression, grief and the mourning process, suicidality, sexual exploitation and child abuse, and issues of sexual identity; as well as crisis intervention and a wide range of carefully selected treatment modalities.

### Key Findings: Youth Interviews

These homeless, sexually exploited youth eloquently argue the need for both additional services and sensitive and well-trained counselors. Such counselors understand their particular life experiences and concerns and adopt counseling philosophies which emphasize youth empowerment. These philosophies include non-judgmental acceptance of the youth, patience, and respect for confidentiality. Despite the challenging and often anti-authoritarian attitudes of many youth, counselors must maintain respect for both the youth and the coping strategies they employ to survive on the streets. This climate of respect is essential as counselors work with youth to add new coping and survival skills to their repertoire.

Clearly effective counselors need many tools and techniques and considerable training to meet the varied needs of this population. In addition to counselor training, youth suggest that, in general, there are still insufficient services and insufficient staff to meet their demands for help. This includes a need for increased shelter, drop-in and related services as well as programs to strengthen education, build independent living skills, and provide youth with transitional living support, job training, and placement opportunities. Many youth identified a need for the availability of longer shelter stays for those who need them and more services to youth who have reached 18 to 24. Youth also feel strongly that their voice should be included in the planning and implementation of any additional services that are developed to meet their needs.

### Key Findings: Youth-Serving Agency Survey

While the agency-survey data suggests that agencies are attempting to be more sensitive to youth's needs, many services and programs still remain inaccessible, unaffordable and frustrating for youth. Increasingly, agencies are attempting to recruit staff who more closely reflect the heterogeneous nature of the homeless youth population. Even when they hire more culturally diverse staff, agencies may still have eligibility requirements which can exclude many youth. Even when youth are eligible for services, agency intake procedures can be time

consuming and difficult to understand. Homeless, sexually exploited youth have little patience for such systems. Clearly such service entry requirements must be streamlined to be more easily understood and accessible to youth.

This survey data also suggests that some youth-serving agencies do not serve the most vulnerable youth populations including homeless youth, undocumented and refugee youth, HIV infected youth and/or youth with dual diagnoses. In addition, restrictions to service access were also reported by some agencies in regard to youth who are actively using drugs, are suicidal, or are acutely psychotic. Often these agencies find it difficult to locate appropriate referrals for these troubled homeless youth.

### Key Findings: Expert Provider and Policy Interviews

To augment the three primary sources of data for this evaluation, (the MMPI, Youth Interviews, and the Agency Survey), interviews were conducted with experts from the fields of mental health service provision and policy development in relationship to homeless, sexually exploited youth. Additional information about issues related to the mental health needs of immigrant and refugee youth was garnered from presentations by an additional expert who has worked extensively with those populations. These experts are profiled in Appendix A of this report.

The input of these experts contributed greatly to the depth and clarity of the final recommendations of this evaluation. The frequent duplication of suggested recommendations both between these experts and the investigators and among the experts themselves on a variety of issues added to the strength of the evaluation findings and the resulting final document. Among the most strongly held expert opinions and concerns were the following considerations about statewide policy, training service providers, and service needs and gaps.

### Experts' Views: Statewide Policy

In the area of statewide policy, the experts emphasized the need to educate service and intervention systems personnel, particularly law enforcement, to see sexually exploited homeless youth as victims rather than criminals, especially in relationship to their involvement in survival sex and related activities. This implies a change in policy, making arrests of

juveniles for prostitution and related activity (currently a 602 penal code offense for most youth) lead to court proceedings under the Welfare and Institutions Codes relating to child abuse (WIC 300) rather than to juvenile or adult criminal courts. The focus of the intervention process with these sexually exploited youth would then be on treatment and services, as logical alternatives to detention.

Experts would also like to see statewide problem-solving efforts in regard to increasing the number of affordable mental health and substance abuse treatment services available to homeless youth, especially those in need of residential programs. In addition, they would like to see an increase in options for funding mental health treatment for homeless youth including the following: extended and improved access to Medi-Cal, Supplemental Security Income (SSI), and other service application processes that often function as service barriers to homeless youth. Providers stated that gaining access to Medi-Cal funding is often difficult even in cases where youth are eligible such as in the case of pregnant homeless youth. In addition, providers felt that Medi-Cal funding for mental health and health services should be extended to cover services to homeless youth in shelter situations and transtional living programs. Furthermore, several providers expressed an interest in the possibility of accessing parents' private insurance coverage to pay for counseling and health services to homeless youth--especially in cases of child abuse. Concern was also expressed about the lack of housing and related financial help and the need for job training and placement assistance and easier access to work permits for homeless youth attempting to transition to independent living.

A special area of concern for all experts was the lack of services available to help undocumented and refugee youth, a growing population on the streets. These youth often manifest unique mental health needs and concerns related to both traumatic experience with war and/or poverty in their country of origin and with abuse and deprivation during their passage to the United States. As a result many suffer from depression and suicidality, anxiety disorders and post traumatic stress disorders as well as grief reactions in the face of separation, loss and continued isolation from traditional sources of support.

A final and over-riding area of concern was the need for the development of a comprehensive statewide policy approach to the problems of homeless youth, especially the many who become prey to ongoing sexual exploitation through involvement in survival sex and prostitution. This evaluation, as well as research by others in the field, suggests that many of these youth are "programmed" for involvement in survival sex by previous experiences of

sexual and physical abuse, often at the hands of family members. They then are locked in by the requirements of survival on the street as well as by the substance abuse with which many of them attempt to "medicate" their emotional pain. The complex needs of these youth require a comprehensive and coordination policy addressing issues of shelter, case management and crisis services, the need for assistance with the transition to independent living for those youth up to the age of 24 who will not or cannot return home. Outreach services (hotline, outreach workers, etc.) are also required to reach those youth most in need. All of these services should be provided in coordination with the mental health services documented in this evaluation. Such a policy must also address service providers needs for ongoing training and technical assistance as well as research into more effective avenues of programming and practice to meet the growing need of homeless youth.

### Expert's Views: Training and Research Needs

In regard to training there are a wide array of need areas recognized by the experts. The most often requested training areas for counselors, casemanagers and other youth workers included the following eight training and research issues:

1. Issues of child development and the life experience of homeless sexually exploited youth;

2. Issues of effective counseling with homeless youth including realistic expectations, recognition of signs of progress, healthy boundaries, countertransference issues, avoiding burnout and a broad range of counseling tools and techniques;

3. Issues related to substance abuse identification and treatment;

4. Issues related to child abuse and family violence, rape, sexual exploitation, survival sex, prostitution and pornography;

5. Issues related to counseling work with special populations and concerns such as gay youth, undocumented and refugee youth, youth of color, pregnant youth, gang involved youth, et cetera;

6. Issues related to training about advocacy for homeless youth in relationship to eligibility/application for Medi-Cal, SSI, Victim Witness Assistance funds and related benefits as well as further information about the legal rights of minors;

7. Issues related to HIV/AIDS prevention education and risk reduction, mental health issues of HIV infected youth, and assertiveness training for youth around issues of both STD prevention and birth control; as well as

8. Research and demonstration projects geared to the development of more effective programs and practice techniques with this difficult to reach population as well as increased opportunities for exchange of information among service providers and between providers and state/local agencies.

OCJP funded Project PACE (People Against Child Exploitation) training programs in the Los Angeles area have tackled many of these issues in the past four years of training designed for agency staff working with sexually exploited youth. Although these training programs have consistently been rated as very valuable to agency staff, they usually reach only a few staff members per agency each year. This is due to both limited training funds and agency concerns about staff coverage, especially at smaller agencies. High staff turnover at many of the agencies, largely due to the frequently low salary scale and limited funding, leaves a continual need for training of new staff and staff unable to attend due to coverage concerns.

### Experts' Views: Service Needs and Gaps in Services

In regard to expert providers suggestions on service needs and gaps, there are six primary areas of concern. The first is the need for service providers and programs to really understand the needs and realities of homeless, sexually exploited youth and to design their services accordingly. This would include providing services at shelter sites, and providing access to a wide range of treatment modalities ranging from crisis intervention and short-term problem-focused counseling to art, drama, and activity-based therapies designed to reach these youth. It would also include maintaining a flexible, holistic and comprehensive approach to working with the multiple problems that homeless, sexually exploited youth bring with them to counseling, and emphasizing coordination with other community service providers and well-trained, sensitive staff.

A second issue is the need for the development of more responsive and comprehensive treatment resources for both acute mental health emergencies such as suicidality and psychosis among homeless youth and for youth in need of long term psychiatric follow-up and/or psychotropic medication. A third issue mentioned almost universally by the expert providers

is the need for additional treatment resources for substance abusing youth, especially detoxification and residential services. Fourth, concern was expressed about the lack of services available to those homeless youth who are often at highest risk and have special service needs such as gay youth, youth of color (especially monolingual and limited English speakers), undocumented and refugee youth, HIV infected youth, gang-involved youth and pregnant and parenting youth. Each of these groups represents an increasing population of youth on the streets. One shelter estimated that over 60% of the female youth they are seeing are pregnant.

A fifth issue of concern to experts was the need for additional services of all kinds to meet the needs of HIV infected homeless youth, a group expected to increase dramatically if effective prevention and education services are not made a priority. Finally, concern was expressed about the need for increased outreach designed to identify and assist those long-term, often severely troubled street youth seldom reached through current, limited outreach efforts. In a 1980 research study, Miller found that only one out of five runaway youth are aware of the availability of shelters and other agencies designed to help them.

The final recommendations drawn from the four data sources of this evaluation are presented below. Recommendations regarding several important areas of state-wide policy are presented first, followed by service recommendations, and ending with consideration of recommendations for additional training for counselors and youth workers.

## B. FINAL RECOMMENDATIONS: STATEWIDE POLICY

In the course of this study, several opportunities to improve the well-being of homeless, sexually exploited youth have emerged. The first three recommendations address the problem of financing mental health services for runaway and homeless youth. Additional recommendations cover issues of consent to treatment, access to educational services, the need for transitional and independent living programs, and the treatment of youth arrested for prostitution and solicitation.

1. **OCJP shoul[l] work with the State Board of Control to improve the access of homeless sexually exploited youth to the Victim Witness Assistance Fund.**

The statewide Victim Witness Assistance Program was created to provide reimbursement for medical, psychological and psychiatric expenses, and crime-related income loss incurred by victims as a direct result of crime. Reimbursement for the cost of mental health treatment for physically and sexually abused adolescents is a legitimate basis for claims to the State Board of Control Victims of Crime Program (VOC), which oversees the Victim Witness Fund. It has been difficult for homeless sexually abused youth to take advantage of the services available through the Victim Witness Program Fund due to several factors in the way it is implemented. First, until recently, filing a police report was necessary to establish that victimization occurred and the signature of a financially responsible adult (usually a parent or legal guardian) was required on application forms. Many homeless youth have not reported their abuse or have run away from placement settings and are reluctant to use services that require parental notification or participation, especially if they have been abused by family members.

Secondly, homeless youth often need considerable assistance in filing claims, obtaining required documentation of services and attending necessary hearings as part of the application process. Many youth have learning disabilities or large gaps in school attendance and participation that make assistance with forms and documentation especially important. Such assistance would usually be provided by parents if a youth were at home. A third, and final issue is the difficulty some of the agencies most appropriate to provide counseling and other services to these youth have in accessing reimbursement funding from Victim Witness resources.

Recent changes in regulations permit a report filed with county Child Protective Services to carry the same weight as a police report in establishing victimization. This change should facilitate the processing of claims for mental health services. Exploration is needed into additional changes that may be needed to address remaining barriers to use of Victim Witness services by homeless victims of sexual and physical abuse.

OCJP should work with the State Board of Control Victims of Crime Program to clarify the eligibility of homeless sexual abuse victims to the resources of the Victim Witness Program Fund. In addition, OCJP and the State Board of Control should work

to establish and/or clarify procedures for using Victim Witness funds to reimburse those agencies providing mental health services to homeless sexual abuse victims and to maximize the ability of eligible homeless youth to make use of the VOC program. OCJP should also facilitate the provision of training to OCJP-funded programs so that they are familiar with the Victim Witness program and its recent revisions and requirements.

2.      **OCJP should work with the State Department of Social Services to get local welfare agencies to designate a Youth Expert or Deputy in local areas to be available to address questions of Medi-Cal eligibility of homeless youth and to improve their access to Medi-Cal funding for mental health, health and related services as well as to extend Medi-Cal benefits to homeless youth involved in shelter and transitional living programs. Similar arrangements should be made with the Social Security Administration in regard to Supplemental Security Income (SSI).**

The State's system of providing medical and mental health care to low-income people has not been easily accessible to many sexually exploited youth needing mental health and/or medical services. Youth-serving agencies are often not familiar with Medi-Cal eligibility criteria and homeless youth are easily frustrated by long waits and seemingly complex application processes. Consequently, many youth in shelters or transitional living programs are unsuccessful in gaining access to Medi-Cal to pay for mental health services or any other medical care.

Program statutes should be changes to extend Medi-Cal access to homeless youth involved in shelters or transitional living programs to ease their access to mental health and medical treatment and medication beyond the limited situations under which youth are covered currently.

OCJP should work with the State Department of Social Services to establish a homeless youth expert or ombudsperson in each local welfare agency to be available to address issues of youth eligibility and documentation for services when questions arise. In addition, training should be made available to assist shelter and drop-in center staff in advocacy for youth seeking Medi-Cal funding for mental health and related services. These mechanisms would allow youth to more easily obtain the benefits to which they are entitled and would enable service agencies to more effectively advocate for and

provide accurate information to youth in need. Similar work is needed around access to Supplemental Security Income for those homeless youth who would meet eligibility criteria if they were adults with similar mental health and/or medical status.

3.  OCJP should work with the Department of Insurance to maximize access of homeless youth to use of their families' private insurance coverage to pay the cost of mental health services including residential and outpatient treatment and medication, especially for homeless youth who are victims of Sexual and Physical Abuse.

Even when youth are able to obtain mental health services, there are severe limits on the amount of help available due both to a lack of needed services and to lack of financial resources on the part of homeless youth. Service providers state that youth in need of long-term residential treatment are often released from emergency psychiatric facilities within a few hours of their admission. If they return to the streets or to a shelter, they can pose a danger to both themselves and other youth. Costly psychiatric medications are sometimes prescribed for youth in emergency rooms with little or no provision for follow-up or monitoring by physicians. Many mental health treatment facilities are unavailable to these youth due to lack of funds and insurance, especially private facilities. Every effort must be made to secure funding for essential mental health services for severely disturbed youth.

OCJP should work with the State Department of Insurance to explore avenues for accessing the private health insurance of parents of homeless youth with serious mental health problems in order to pay for their treatment. This access is especially needed for those youth with a history of familial abuse. OCJP should also work with the State Departments of Mental Health, Social Services, and other appropriate agencies to extend access to mental health services for severely disturbed youth without insurance coverage.

4.  OCJP should work with relevant state agencies to maximize the ability of Homeless youth to provide Consent to Mental Health treatment and General Medical Care including Physical Examination and routine Non-invasive/non-surgical medical treatment. In addition, OCJP should work

80

with relevant state agencies to clarify confusion about consent issues and other legal issues relating to minors by sponsoring the development and publication of a manual on issues relating to youth law for counselors and youth workers and by providing training to youth workers in the area of youth law, especially as it relates to issues of consent for minors.

One of the barriers to obtaining needed mental health and non-invasive general medical care for homeless, unaccompanied youth is confusion about the requirement for parental consent in the provision of services to youth and the ability of mature minors (12 and over) to provide consent for their own treatment. In some circumstances, youth are refused medical or mental health treatment because they are without the consent of their parent or guardian. This is often due to confusion on the part of service providers about the situations in which youth can provide their own consent to services. Recent legislation, A.B. 3353 (Gotch), sponsored by Assemblymen Mike Gotch and John Vasconcellos and State Senator Presley will make it possible after January 1st, 1993 for minors, age 12 and over, to utilize shelter and counseling services on an extended basis without the consent of their parent or guardian. Homeless minors also need the ability to consent to general medical care including physical exams and treatment for stomach aches, colds, backaches and other frequent medical concerns.

OCJP should work with the State Departments of Mental Health, Health and other appropriate agencies to clarify regulations regarding the ability of youth to consent to mental health treatment and to general, non-invasive medical care. In addition, OCJP should facilitate the development of a manual outlining legal issues relating to youth and the training of agency staff in the area of the rights of and limitations to minor's powers of consent.


5.    OCJP should work with the State Department of Education and other relevant agencies to Improve the Access of Homeless Youth to Educational Services Meeting their specialized educational needs, thus increasing their chances for success in the transition to independent living.

Local school districts have the legal responsibility to provide educational opportunities and programs to meet the needs of all youth including both homeless and emotionally

disturbed youth in their jurisdictions. Accessing these educational and related services for homeless youth, especially those with mental health problems has often been difficult due to the complexity of administrative regulations (such as those surrounding the development of an Individualized Educational Plan--IEP), procedures, and increasing budget constraints in most districts. The Stewart McKinney Act has assisted the State Department of Education and local school districts in beginning to develop plans to address the problems of homeless youth seeking to reconnect with the education system. A recent initiative supported by Governor Wilson, the Healthy Start Program, could also be serve to increase the access of homeless youth to needed education by providing additional access to mental health and health services at both school and community sites providing educational services to homeless youth.

OCJP should work with shelter agencies, the State Department of Education, the Healthy Start Program and community agencies to maximize the access of homeless, sexually exploited youth to educational programs and related services (including counseling and psychological assessment) that will support their ability to participate in educational programs and develop needed independent living skills. In addition, staff in shelters, drop-in programs and other youth-serving agencies should be trained in issues related to advocacy for homeless youth in regard to educational services in California.

6.      OCJP should work with relevant departments and agencies to amend the penal code in regard to systems response to youth arrested for prostitution and solicitation, changing the focus of intervention from an emphasis on hearing such cases in Juvenile Court as Penal Code 602's (delinquent minors) or in Adult Criminal Proceeding to handling them in Dependency Court proceedings under the Child Abuse Code (Welfare and Institutions Code 300) or through Non-Judicial Interventions and diversion.

Sexually exploited youth involved in survival sex and prostitution must be seen as victims of continued sexual exploitation rather than criminals. Many of these youth were also victims of sexual abuse and/or physical abuse at home. Intervention with these youth should focus on the provision of treatment and related services as a logical alternative to detention. Treatment services offer these youth a chance to break the cycle of repeated victimization and sexual exploitation. Many of these youth are

already drop-outs or 'failures' of traditional group homes, foster homes and treatment facilities and will require the intervention of agencies and programs experienced in working with sexually exploited, homeless youth as well as the development of additional treatment approaches.

OCJP should work with agencies currently providing treatment services to these youth as well as juvenile diversion programs and related services to develop additional alternatives to incarceration for sexually exploited youth involved in survival sex, solicitation and prostitution.

7. **OCJP should work with the State Department of Education, other relevant State agencies, Youth-serving Agencies, and Business and Community Organizations to increase the availability of programs assisting Homeless, Sexually Exploited Youth with the acquisition of Independent Living skills, job training and placement, and the transition to independent housing arrangements as well as access to work permits to further enable these multiply challenged youth to acquire the tools necessary to transition to self-sufficient living in the community.**

While all youth face challenges in the tasks of emancipation in today's economy, homeless, sexually exploited youth face multiple challenges with few sources of information and financial assistance. Many are hindered in their struggle to leave the streets by gaps in educational experience, lack of independent living skills, lack of jobs skills and an inability to afford housing on the wages of jobs they are able to acquire. These problems are compounded by the difficulties homeless youth often face in accessing work permits which are usually attached to both school and parental consent, neither of which are readily available to many long-term homeless youth.

Currently some school districts, Los Angeles Unified School District for example, allow caseworkers or social workers to sign required work permit forms for homeless youth seeking summer employment. This arrangement could be extended to permit long-term homeless youth to get work permits during the school year. Easing the requirements for work permits for this special group of youth will allow them to gain needed work experience in safer, more suitable jobs than those available to youth without work permits and to better provide for their needs for food and shelter. These

youth are often unlikely to return to school and have fewer social services available to them as they approach the age of majority. Currently, even those homeless youth who do reconnect with school have difficulty obtaining work permits without parental signature. Changes in current regulations in this area would seem to support the goals of the Stewart McKinney Act to provide equal opportunity to students who have no home. The Act is meant to apply not just to the children of the homeless but to all youth who are without adequate housing and support, certainly these homeless youth are a part of that population.

OCJP should work with the State Department of Education to develop a comprehensive strategy to deal with the issuing of work permits to these long-term homeless youth. OCJP should also take the lead in working with youth-serving agencies, the Department of Education, the Department of Social Services and employers and community organizations in making independent and transitional living skills programs and related services available to assist homeless youth in the emancipation process..

## C. FINAL RECOMMENDATIONS: TRAINING AND RESEARCH

The following issues were consistently mentioned by expert providers, agency staff, and some by clients themselves as necessary elements in strengthening the training of counseling staff working with homeless, sexually exploited youth. They involve both increased understanding of the complex mental health needs and life experiences of sexually exploited youth and additional training in relationship to effective treatment techniques and modalities for counseling work with this challenging population.

**Counselors need experience working with youth, access to expert clinical supervision and continuing education, as well as additional training in the following crucial areas for effective work with homeless, sexually exploited youth:**

1. **Critical issues in child development (birth to young adulthood) as well as in issues related to the special mental health needs of sexually exploited youth.**

Counselors need to augment their basic academic training to be effective with multi-problem homeless youth, especially in regard to the following:
   a) keeping realistic expectations of the pace and content of counseling sessions;

b) tools and techniques for engaging and working with youth with long histories of abuse/neglect and premature independence;

c) recognition of signs of progress;

d) understanding transference and countertransference issues and maintaining healthy boundaries--especially for new and young staff.

e) establishing trust and empowerment techniques;

f) guiding youth through the process of mourning losses; and

g) group dynamics and family systems theory.

This training would involve helping counselors to redefine change to include the advance and then retreat, or drop out and return, pattern of many homeless youth in counseling. It requires the development of a new view of progress in the counseling process--a change from expecting emotional growth to identifying areas of strength and enhancing functioning and decision-making in daily life.

2.   The recognition and treatment of problems of substance abuse frequently found among homeless, sexually exploited youth and the mental health consequences of growing up in a substance abusing home or environment.

Substance abuse and related problems are major issues for many of the youth in regard to both themselves and their family members and peers. MMPI profiles in this report found high numbers of sexually exploited youth at risk for abusing alcohol and drugs. The abuse of substances by sexually exploited youth frequently represents an attempt to 'self medicate' in order to cope with the pain of mental health problems and traumatic life experiences. Continued abuse of alcohol or other drugs becomes an obstacle to the use of counseling services, unless those services are also designed to intervene with substance abuse and/or to coordinate with additional substance abuse intervention programs (i.e. Alateen or Alcoholics Anonymous). Counseling skills in substance abuse recognition and treatment were recognized as essential by all of the experts.

Several experts voiced concern about counselors mistaking drug-related behaviors for psychosis, hyperactivity or other disorders due to lack of experience and training in this area. Additional information about psychiatric medication, the conditions under which it is prescribed, side effects, and problems associated with stopping use abruptly were also suggested as a fruitful area for training.

3.  **Counselors must have extensive training in the area of child abuse and neglect with a special emphasis on issues of sexual abuse and exploitation and their impact on adolescent development and mental health.**

Homeless youth are a population with a high incidence of physical child abuse, neglect, and sexual abuse. (Burgess, 1984; Robertson, 1991; Rothman & David, 1985). Homeless youth who become involved in survival sex, child pornography and other experiences of sexual exploitation have an even higher incidence of sexual abuse in their background, often at the hands of family members (Burgess, 1984; James & Meyerding, 1977; Janus, 1984; Silbert & Pines, 1981, 1982). Many of these homeless youth encounter rape and other sexual abuse as an everyday fact of street life. Forty-eight percent of the youth in our Los Angeles sample had been victims of sexual abuse and 49% physical abuse, 19% were victims of both.

4.  **Counselors must have training in effective work with special populations including:**
    a) gay identified youth;
    b) youth of color;
    c) undocumented and refugee youth;
    d) gang involved youth;
    e) pregnant and parenting homeless youth; and.
    f) HIV infected youth.
All of the above are growing groups within the population of homeless youth.

Both interviews of youth and experts and recent research speak to the high incidence of depression and suicide attempts among gay adolescents seeking, like all youth, to develop a positive sense of sexual identity (Kruks, 1991; Schneider et al., 1989). Youth of color and especially monolingual and undocumented or refugee youth also face special challenge growing up in today's society (Jensen, 1991). Gang-involved youth, like several of those interviewed in Chapter III, often see gang membership as the sole avenue to a sense of belonging, family and self esteem that is crucial to mental health. Pregnant and parenting teens face yet another set of urgent problems and concerns. The issues of all of these special populations are magnified in situations of homelessness, on-going abuse, and exploitation. Counselors need considerable training to become optimally effective with these youth and to avoid becoming overwhelmed.

5.    **Counselors must have training about family violence and its impact and mental health consequences for youth who are often caught "in the crossfire."**

The high incidence of family violence discussed by these youth in talking about their family life represents an increasing area of concern for counseling work and was mentioned by several of the experts. Family violence, in addition to being tied to family issues of substance abuse, has been found to have many negative consequences for youth who witness it, especially repeatedly (Roy, 1988).

6.    **Counselors must have additional training in effective advocacy for homeless, sexually exploited youth as they interface with service systems such as the public schools, the Department of Social Services, Victim Witness Assistance programs and other programs or services for which these youth may be eligible as well as training regarding the legal rights of minors.**

Homeless, sexually exploited youth greatly need the help and advocacy of counselors and youth service workers in accessing the services and other resources they are entitled to from school systems, Medi-Cal, SSI, Victim Witness Assistance programs and other sources. Many counselors and youth workers in youth serving agencies are not well prepared to advocate for the needs and rights of youth interacting with these often complex and confusing systems and may be unaware of programs and other resources for which homeless youth may be eligible. Other staff are unaware of minor's rights in regard to the ability to consent to treatment or services. The need for and content of this training are more fully documented in recommendations One, Two, Four, and Five of the State-wide Policy recommendations, Section B of this Chapter.

7.    **In addition to the training needs mentioned above, OCJP and other relevant agencies should provide funding for clinical research into the development of more effective clinical practice and programs for the**

mental health treatment of homeless, sexually exploited youth and increase opportunities for the sharing of knowledge among mental health service providers working with these youth and between service providers and relevant state agencies.

The section that follows will present the final recommendations in the area of service needs and gaps in services.

## D.    FINAL RECOMMENDATIONS: SERVICE NEEDS AND GAPS

The following recommendations address the needs and gaps in current mental health and related services for homeless, sexually exploited youth as seen by the investigators drawing on the data of this evaluation.

1.    Homeless, sexually exploited youth need access to mental health treatment services in the community that understand their needs and problems as well as the realities of providing effective services to this population.  This includes the following:

a. Providing mental health services appropriate to this population.

This includes the provision of crisis intervention and short-term, problem-focused counseling as an entree to mental health service use and longer-term treatment modalities.

b. Providing mental health and other services in a flexible and comprehensive way that recognizes the multiple and often interlocking problems confronting these youth.

This means having a full range of mental health and related services available to a homeless youth.  For example, it would include services for a pregnant 15 year old white female involved in survival sex, and who is using drugs as a

means to cope with her current problems and her past history of incest at the hands of her step father. It would also mean providing appropriate mental health and related services to a 17 year old gang- involved, homeless Latino youth whose depression and suicidality are masked by heavy drug and alcohol use. In addition, it would mean meeting the treatment and service needs of a homeless 17 year old African American youth struggling with issues of sexual identity while engaged in frequent sexual activity on the streets for money for food, clothing, drugs and simple human contact to combat loneliness.

These youth require mental health services that are multifaceted, well coordinated with other needed services, and flexible enough to allow the engagement of youth not used to scheduled appointments and without the patience to deal with long waits and complex intake procedures and application forms.

**c. Increasing coordination of services to limit duplication and client manipulation of service providers, while providing necessary protections of confidentiality; and**

**d. Increasing outreach and publicity about services to reach unserved and under-served homeless youth populations.**

2.      **Homeless, sexually exploited youth need well-trained counselors, clinical supervisors and psychological and/or psychiatric consultants available at shelters, drop-in centers and other agencies providing mental health services to this complex, multi-problem population.**

Masters level counselors experienced in work with this population are needed to provide supervision to more prevalent bachelor's level counseling staff in order to assess and treat the mental health problems of sexually exploited clients. Counselors need training in the use of crisis intervention and short-term, problem-focused treatment modalities as well as skills in the identification and treatment of youth exhibiting post traumatic stress disorders (PTSD), depression and suicidality. Training is needed in the use of a broad range of treatment tools, techniques and modalities designed to engage and treat these youth (e.g. art and drama therapies, recreation/activity therapy, process groups, etc.).

Finally, consultation should be available from psychologists and psychiatrists to assist counselors in working with and finding additional services for youth in need of residential treatment and medication. These needs are especially acute in light of resent research suggesting that homeless youth as a group are becoming increasingly younger, more diverse and more troubled and abused (Robertson, 1991).

3.   **Homeless sexually exploited youth need access to appropriate treatment resources when they are acutely psychotic or suicidal or suffering from chronic mental health problems, especially those youth requiring long-term medication and aftercare.**

4.   **Homeless sexually exploited youth need access to affordable substance abuse treatment services including detoxification, out-patient and residential treatment programs, and aftercare.**

5.   **Homeless sexually exploited youth need continued access to mental health, transitional and independent living and shelter services when they reach 18 and beyond. Sexually exploited youth in particular have long term problems that require long term service involvement for lasting solutions. Services should be extended to youth age 18 to 24 and this age group recognized as an extension of the youth service population with special needs that often go unmet in adult focused systems of care.**

Despite their bravado, these older sexually exploited youth retain much of the vulnerability of youth under 18 and lack the maturity, education and life experience of adults. They are often a poor fit in service programs designed for homeless adults. Providing these youth with additional mental health and and transitional living services as well as independent living skills training in adolescence and young adulthood will aid them in avoiding later welfare dependency, more chronic and long term mental health problems and incarceration for street crimes--all of which are far more costly to the State and the public in the long run.

6.  Homeless sexually exploited youth need mental health services addressing their doubly jeopardized status as gay youth, pregnant and parenting youth, youth of color, undocumented and refugee youth and gang-involved youth.

## F.  CONCLUSION

The funding provided by the Child Sexual Exploitation Intervention project (CSEIP), as well as additional funding provided to youth-serving agencies by OCJP to augment services to sexually exploited homeless youth, have contributed greatly to the strengthening of mental health, case management and related services available to these troubled, multi-problem youth. In addition, these funds have facilitated extended staff training for OCJP funded agencies. In the current climate of decreased mental health and related resources CSEIP funding has been particularly valuable and timely.

The results of this research project suggest that unserved and underserved youth remain on the steets and that the mental health needs of sexually exploited youth are more diverse, severe and urgent than previously recognized. Although CSEIP funding has helped youth-serving agencies to begin to meet the mental health needs of many youth since it's implementation, suicidal youth, psychotic and chronically mentally ill youth and youth in need of psychotropic medication often remain beyond the ability of drop-in and shelter facilities to adequately service alone--especially while maintaining the safety and meeting the needs of less severely troubled youth. Few referral or funding resources exist for these youth and more are desperately needed. In addition, existing case management, counseling and other youth service staff need increased training and supervision to consistently and effectively meet the multiple mental health needs of homeless sexually exploited youth.

The mental health problems of homeless sexually exploited youth, as they emerge from the analysis of the four data sources used in this evaluation, are both complex and compelling. Even experts working with homeless youth were surprised at the prevalence and severity of the mental health concerns evidenced by the MMPI profiles of the homeless youth studied. The high incidence of depression and other affective disorders, suicidality, substance abuse risk and

possible need for psychiatric medication suggests a population with increasingly critical needs in a climate of constricting financial resources.

Action taken now to increase specialized assitance to homeless sexually exploited youth can help to break the cycle of abuse and exploitation. By providing increased access to comprehensive and flexible mental health and related services and tailoring them to the needs of sexually exploited youth, we can help these youth gradually develop the skills and build the emotional foundation necessary to establish stable and self supporting lives. Early attention to the mental health and related needs of these youth will improve their chances of avoiding more serious psychiatric problems, long term unemployment and financial dependence, and incarceration for street crime-- representing a considerable savings to the public and the State. In addition, youth interviewed in this evaluation document the prevalence of family violence, child abuse, substance abuse, depression and suicidality in their lives. Interviewed youth have also spoken eloquently about their needs for both additional shelter, drop-in and transitional living services services and sensitive, well trained, counselors and youth workers coming from the many cultural and ethnic backgrounds increasingly represented by California's homeless youth. Along with the provision of greatly needed transitional and independent living services, addressing the issues raised by youth and experts in this evaluation will move forward the process of developing a comprehensive state policy to respond to the dire needs of California's homeless youth. Let us answer their "cry for help."

# REFERENCES

Adams, G.R. & Murno, G. (1979). Portrait of the North American runaway: A critical review. Journal of Youth and Adolescence, 8, 359-373.

Archer, P.R. (1987). Using the MMPI with adolescents. Hillsdale, N.J.: Lawrence Erlbaum Associates.

Beatty, W.W. & Costello, K.B. (1982) Naloxone and play fighting in juvenile rats. Pharmacology, Biochemistry and Behavior, 17, 905-908.

Bowlby, J. (1973). Attachment and loss: Volume 2: Separation--Anxiety and anger. New York: Basic Books.

Bowlby, J. (1977). The making and breaking of affectional bonds. British Journal of Psychiatry, 130, 201-210..

Bowlby, J. (1978). Attachment theory and its therapeutic implications. Adolescent Psychology, 6, 5-33.

Boyd-Franklin, N. (1989). Black families in therapy: A multisystems approach. New York: The Guilford Press.

Burgess, A. (Ed.). (1984). Child pornography and sex rings. Lexington, MA: Lexington Books.

Capwell, D.F. (1945). Personality patterns of adolescent girls: Delinquents and nondelinquents. Journal of Applied Psychology, 29, 284-297.

Carman, R. (1974). Internal-external locus of control: Alcohol use and adjustment among high school students in rural communities. Journal of Community Psychology, 2, 129-133.

Cuellar, I. Harris, L.C., & Jasso, R. (1980). An acculturation scale for Mexican-American normal and clinical populations. Hispanic Journal of Behavioral Science, 2, 192-217.

Dahlstrom, W.G., Lachar, D. & Dahlstrom, L.E. (1986). MMPI patterns of American minorities. Minneapolis: University of Minnesota Press.

Dahlstrom, W.G., Welsh, G.S., & Dahlstrom, L.E. (1982) An MMPI handbook: Volume I: Clinical interpretation. A revised edition. Minneapolis: University of Minneapolis Press.

Digre, P. (1991, February 2). Independent living programs: Federal action agenda. Memorandum: Los Angeles County Department of Children's Services.

Gibbs, J. T., Huang, L.N. & Associates. (Eds). (1989) Children of color: Psychological interventions with minority youth. San Francisco: Jossey-Bass Publishers.

Gibbs, J.T. (1985). Treatment relationship with Black clients: Interpersonal versus instrumental strategies. In C. Germain (ed.), Advances in clinical social work practice. Silver Springs, MD: National Association of Social Workers Publications.

Green, R.L. (1987). Ethnicity and MMPI performance: A review. Journal of Consulting and Clinical Psychology, 53, (4), 497-512.

Hansburg, H.G. (1980). Adolescent separation anxiety. Springfield: Charles C. Thomas.

Harder + Kibbe Research. (1991). Growing up too fast: An ethnography of sexually exploited youth in San Francisco. San Francisco: Harder + Kibbe.

Henderson, A.S. (1974). Care-eliciting behaviour in man. Journal of Nervous and Mental Disorders, 159, 172-181.

Housing Committee Staff (1992). Proposal for transitional housing for foster care youth 17-19. Housing Committee: State Department of Social Services

James, J. & Meyerding, J. (1977). Early sexual experience and prostitution. American Journal of Psychiatry, 134, 1381-5.

Janus, M., Scanlon, B & Price, V. (1984). In A. Burgess, (Ed.). Child Pornography and Sex Rings. Lexington, MA: Lexington Books.

Kruks. G. (1991) Gay and lesbian homeless/street youth: Special issues and concerns. Journal of Adolescent Health, 12, 515-518.

Lefokowitz, B. (1987). Tough change: Growing up on your own in America. New York: Free Press.

Marks, P.A., Seeman, W., & Haller, D. (1974). The actuarial use of the MMPI with adolescents and adults. Baltimore, M.D.: William and Wilkins.

McGill, J.C. (1980). MMPI score differences among Anglo, Black and Mexican-American welfare recipients. Journal of Clinical Psychology, 36, 147-150.

Miller, J. (1980). Runaways: Illegal aliens in thier own land. New York: J.F. Bergin Publishers.

Mirken,M., Raskin, P.A., & Antognini, F.C. (1984). Parenting , protecting, preserving: Mission of the adolescent female runaway. Family Press, 23, 63-74.

Montgomery, G.T. and Orozco, S. (1987). Mexican Americans' performance on the MMPI as a function of level of acculturation. Journal of Clinical Psychology, 41, (2), 203-212.

Mundy, P., Robertson, M., Robertson, J. & Greenblatt, M. (1990). The prevalence of psychotic symptoms in homeless adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 29, (5), 724-731

Newby-Schmidt, M.B., & Norton, S. (1981). Development of opiate tolerance in the chick embryo. Pharmacology, Biochemistry and Behavior, 15, 773-778.

Padilla, E.R., Olmedo, E.L., & Loya, F. (1982). Acculturation and the MMPI performance of Chicano and Anglo college students. Hispanic Journal of Behavioral Sciences, 4, 451-466.

Peck, M.L. (1980). Categories of adolescent suicide differentiated. Roche report: Frontiers of psychiatry. World Wide Medical Press.

Pennbridge, J.N., Yates, G.L., David, T.G., & Mackenzie, R.G. (1990) Runaway and homeless youth in Los Angeles County, California. Journal of Adolescent Health Care, 11, 159-165.

Porter, E. (1986). Treating the young male victim of sexual assault: Issues and intervention strategies. Syracuse, N.Y.: Safer Society Press

Reite, M., & Field, T. (Eds.), (1985). The psychobio..gy of attachment and separation. Orlando, FL: Academic Press, Inc.

Robertson, M.J. (1991). Homeless youth: An overview of recent literature. (pp. 33-68). In Kryder-Coe, J.H., Salaman, L.M., and Molnar, J.M. (Eds.) Homeless children and youth. New Brunswick, N.J.: Transactional Press.

Roy, M. (988). Children in the crossfire: Violence in the home--How does it affect our children? Deerfield Beach, FL: Health Communications, Inc.

Schneider, S.G., Farberow, N.L. & Kruks, G. (1989). Suicidal behavior in adolescent and young adult gay men. Suicide and life-treatening behavior, 19, (4), 381-394.

Senate Hearing (1988, December 1). United States Senate Committee on the Judiciary. The problems of homeless youth. Washington, D.C.: U.S. Government Printing Office: Serial No. J-100-89.

Silbert, M.H., & Pines, A.M. (1981). Sexual child abuse as an antecedent to prostitution. Child Abuse and Neglect, 5, 407-411.

Silbert, M.H. & Pines, A.M. (1982). Entrance into prostitution. Youth and Society, 13, 471-500.

Snyder, S.H. (1977, March). Opiate receptors and internal opiates. Scientific American, 44, 56.

Stefanidis, N., Pennbridge, J., Mackenzie, R.G., & Pottharst, K. (1992). Runaway and homeless youth: The effects of attachment history on stabilization. American Journal of Orthopsychiatry, 62, (3), 442-446.

Van Houten, T. & Golembiewski, M.A. (1978). Adolescent life stress as a predictor of alcohol abuse and/or runaway behavior. Washington, D.C.: Youth Alternative Project, 1346 Connecticut Avenue.

Yates, G.L., Mackenzie, R.G., Pennbridge, J., & Cohen, E. (1988). A risk profile comparison of runaway and non-runaway youth. American Journal of Public Health, 78, (37), 820-821.

Yates, G.L., Mackenzie, R.G., Pennbridge, J & Swofford, A. (1991). A risk profile comparison of homeless youth involved in prostitution and homeless youth not involved. Journal of Adolescent Health, 12, 545-548.

# APPENDIX A: PROFILES OF SERVICE PROVIDER AND POLICY EXPERTS

The experts interviewed as part of this evaluation include:

**Marilyn Ericksen, M.Div.,** Executive Director of the California Child Youth and Family Coalition, a state-wide youth advocacy group, with eight years of experience with high risk adolescents and related policy issues.

**Gail Hoagland, MSW,** Program Director of the Storefront Program of San Diego Youth and Community Services, with 14 years of working with homeless and high risk adolescents.

**Diane Manning, MSW,** Clinical Coordinator at Larkin Street Youth Center, a drop-in service program for homeless youth in the San Francisco area, with 4 years of experience with homeless youth and eight years of work with high risk adolescents.

**Richard Novak, JD,** Directing Attorney of the Homeless Youth Project of Public Counsel, providing legal services to homeless and at risk youth for the past 2 years.

**John L. Peel, MA,** Associate Director of Program Services and Division Administrator for Adolescent Medicine at Childrens Hospital Los Angeles, with 14 years of experience working with adolescents in a variety of settings and capacities. Currently serving on the Board of the California Child Youth and Family Coalition and Western States Youth Services Network.

**Eugene Porter, MFCC,** Marriage, Family, Child Counselor in Private Practice in the Oakland area with over 12 years of experience in work with at risk and sexually exploited youth. Mr Porter is the author of a clinical monograph entitled "Treating the Young Male Victim of Sexual Assault: Issues and Intervention Strategies" and is a frequent consultant to high risk and homeless youth serving agencies in the Bay Area.

Nikolaos Stefanidis, PhD., Clinical Coordinator of the Los Angeles Youth Network, a shelter and drop-in program in the Hollywood area of Los Angeles with 6 year experience in work homeless and high risk youth. Dr. Stefanidis also supervised the administration of the MMPI for this evaluation and analyzed the test results.

Gary Yates, MFCC, currently Senior Program Officer at the California Wellness Foundation, past President of the California Child Youth and Family Coalition and former Associate Director of the Division of Adolescent Medicine at Childrens Hospital Los Angeles. Mr. Yates has over ten years' experience in direct clinical services, policy and program development with high risk and homeless, sexually exploited youth.

Additional expert information was obtained from several presentations and personal conversations between the investigators and Monica L. Jenson, LCSW, Clinical Director of the Immigrant Refugee Children's Project of the Center for Human Rights and Constitutional Law in Los Angeles, a multi-service agency serving the needs of homeless and unaccompanied immigrant and refugee youth--primarily from Central and South America. Ms. Jenson has been providing counseling services to homeless refugee and undocumented youth for the past several years.

Finally, further information was provided by an interview with Jolene Swain Morgan, MSW, Coordinator of the High Risk Youth Program (HRYP) at the Division of Adolescent Medicine at Childrens Hospital Los Angeles. Ms. Swain Morgan has spent the past 6 years at this program coordinating a large number of services to homeless and at risk youth and providing direct clinical services.

# APPENDIX B:     FURTHER DISCUSSION: MMPI DATA

A. Findings on Validity Scales:

     1. Similar elevations on L and K scales found in this evaluation are also reported by McGill (1980).

     2. Cuellar, Harris and Jasso (1980) also report elevations on L scale. They suggest the L scale differences are reflections of the Mexican American groups tendencies toward "conventionality" and concern for "making a good impression."

B. Findings on the Mf scale:

     1. Lower scores on the Mf scale produced by Latino subjects in our sample are also reported by Padilla, Olmedo and Loya (1982). This difference is believed to be related to acculturation level with the less acculturated males scoring lower on the Mf scale indicating traditional male roles.

C. Further elaboration of MMPI Results (66 Valid profiles):

     Breakdown of 66 profiles:

| | | |
|---|---|---|
| 1. Bipolar Disorders | 15% | 10 |
| 2. PTSD | 17% | 11 |
| 3. Dysthymia | 26% | 17 |
| 4. Conduct Disorders | 26% | 17 |
| (includes anxiety disorders, impulse control, adjustment disorders, drug use, lying, stealing, etcetera) | | |
| 5. Conversion/somatization | 17% | 11 |

Fifty eight percent of youth (numbers 1,2,and 3) need evaluation for psychotropic medication. Eighty-four percent of youth (numbers 1,2,3 and 4) suffer from moderate to severe affective disorders, most often depression expressed in extreme apathy, aimless energy, high risk behaviors, conduct disorders and suicide attempts. Eighteen youth produced invalid profiles.

# APPENDIX C:     MENTAL HEALTH INTERVIEW

Client I.D. # 20-_____     Date_____

Interviewer:_____

Age:_____     Ethnicity:_____     Time on own:_____

       We want to learn more about what life is like for young people like yourself and what problems in living and emotional problems you may face. During this interview I will be asking you about your experiences with problems in living and emotional or mental health problems facing you and your family. I am interested in any counseling help or services that you may have had to help with any of these concerns. I would also like to hear about other ways of dealing with stress and problems that have worked for you. I have read the information that you gave us in your first interview and will be going over some of it again with you now. I may repeat things because I want to do my best to understand your concerns and experiences. I hope you won't mind if I take some notes while we are talking. Also, I would like to give you these Burger Bucks as a sign of my appreciation for your taking time to talk with me.

Who lived with MOST growing up?:_____

_____

_____

Who else lived in the household? (Names/Ages):_____

_____

_____

_____

_____

Other Family members (Parent, Sibling):_____

_____

_____

_____

What would you say was the biggest problem in your family when you were growing up?

_____

_____

_____

How did this affect you?

_____

_____

_____

Client I.D. # 20-_____                    Date:_____

Interviewer:_____

## DOMAIN I: FAMILY/FRIENDS EXPERIENCE IN COUNSELING

1. As far as you know, has anyone in your family ever had any emotional or mental health
   problem (inc. nervous breakdown, suicide or attempt, substance abuse)
   
                                                  1. Yes     2. No

1a.    List persons and problems:

2. Did He/She/They ever get counseling for this problem?    1. Yes 2. No

2a. If yes, Explain:

3. Were He/She/They ever hospitalized because of an emotional problem?
   
                                                  1. Yes     2. No

3a. If yes, please explain:

4. Did they receive medication? (Prescribed by a doctor)
   
                                                1. Yes     2. No
4a. If yes, Explain:

5. What was this like for you?---what happened? (family conflict? Own problems?)

6. Do you know anyone else well--close friends or family members--who has been involved in counseling? (Includes drug/alcohol)        1. Yes        2. No

      If yes, who:_____

7. Do you know what they went to counseling for? (How long?)
          (use categories from question 11 to probe)

8. How helpful would you say this counseling was to them?

     1          2         3         4         5
not at all   somewhat helpful  neutral   mostly helpful   very helpful

8a. Please explain:

## DOMAIN II:      MEANING OF COUNSELING

9. In your own words, what does the word "Counseling" mean to you?

## DOMAIN I:      GENERAL COUNSELING EXPERIENCE

10. Have you Ever been involved in counseling or therapy?   1. Yes       2. No

**IF NO, SKIP TO QUESTION 18.**

11. What problem(s) or concern(s) did you go to counseling for?:

12. Was it your own decision to go to counseling?     1. Yes      2. No

12a. If no, who made you go? _____

13. What kind(s) of counseling have you had:
    a. Individual counseling    1. Yes    2. No
    b. Group Counseling    1. Yes    2. No
    c. Family Counseling    1. Yes    2. No
    d. Alcohol or Drug Counseling    1. Yes    2. No
    e. Self Help or 12 Step Group    1. Yes    2. No
    f. Residential Treatment
        (Non Drug)    1. Yes    2. No
    g. Residential Drug/Alcohol    1. Yes    2. No
    h. Counseling at group home
        or placement    1. Yes    2. No

14. How helpful would you say this counseling was to you?
    1        2        3        4        5
Not Helpful  Somewhat  Neutral  Helpful  Very Helpful
        Helpful

14a. Please explain your answer:

15. Who knew that you were getting counseling?
    1. Boyfriend/Girlfriend    5. Parent(s)
    2. Sister/Brother    6. Other family member
    3. Teacher/School staff    7. Friends/peers
    4. Other agency staff    8. Other adults:_____

16. How did this/these person/people feel about it?
    (Probe: supportive, skeptical, made fun of me, et cetera.):

17. How did this make you feel?:

## DOMAIN V: LIFE EVENTS/PROBLEMS OFTEN LEADING TO COUNSELING

18. I'd like to ask you about some life events or personal and family problems that sometimes lead people to get counseling help. Have any of these things been problems or concerns for you?

Personal Problems:

| | | |
|---|---|---|
| a. Alcohol or drug use | 1. Yes | 2. No |
| b. Problems at school (explain below) | 1. Yes | 2. No |
| c. Problems with the law (theft, assault) | 1. Yes | 2. No |
| d. Suicide attempts or frequent thoughts | 1. Yes | 2. No |
| e. Depression | 1. Yes | 2. No |
| f. Child abuse or sexual abuse | 1. Yes | 2. No |
| g. Rape or assualt of self/close friend | 1. Yes | 2. No |
| h. Gang involvement | 1. Yes | 2. No |
| i. Pregnancy (self or girlfriend) | 1. Yes | 2. No |
| j. Sexuality or gender concern (coming out) | 1. Yes | 2. No |
| k. Serious illness (self) | 1. Yes | 2. No |
| l. Serious illness or death of friend | 1. Yes | 2. No |

Family Problems:

| | | |
|---|---|---|
| m. Parent or sibling substance abuse | 1. Yes | 2. No |
| n. Serious illness or death of family member | 1. Yes | 2. No |
| o. Family violence (battering/abuse) | 1. Yes | 2. No |
| p. Parent/sibling problems with the law | 1. Yes | 2. No |
| q. Divorce or separation of parents/step | 1. Yes | 2. No |
| r. Gang involvement of family member | 1. Yes | 2. No |
| s. Depression of family member | 1. Yes | 2. No |
| t. Mental illness or emotional problems of family member | 1. Yes | 2. No |
| u. Suicide attempt or suicide of family member | 1. Yes | 2. No |
| v. Rape or assault of family member | 1. Yes | 2. No |
| w. Incarceration of family member | 1. Yes | 2. No |
| x. Other family problems:_____ | 1. Yes | 2. No |

19. Who or what helped you to handle or cope with these problems?

**SKIP TO QUESTION #28, WITH SETUP, FOR THOSE SUBJECTS WITH NO COUNSELING EXPERIENCE.**

**DOMAIN I: SUBJECT'S CURRENT COUNSELING EXPERIENCE**

20. Are you currently involved in counseling?   1. Yes       2. No
    (In the past month)

**If NO, skip to question #26.**

21. If yes, What for:

22. For how long?

23. How often do you go?

24. How did you get involved in counseling this time?

25. How helpful would you say this counseling has been?

      1           2           3         4         5
Don't know  Not helpful  somewhat helpful  mostly helpful  very helpful

25a. Please explain:

26. Overall, how much time would you say you have been getting some kind of counseling or therapy in your life?     (Circle one)

      1. Less than a week      4. three to six months
      2. A week to a month     5. six months to a year
      3. One month to three    6. One to two years
                7. More than two year

## DOMAIN III:     EFFECTIVE COUNSELING BEHAVIORS

27. Have you ever had a counselor that you felt you could really talk to?  That really understood you?          1. Yes    2. No

27a. Please explain:
      (What made person(s) easy or hard to talk to?)

28. If NO Counseling--Use Setup---Given that you have never been to counseling.......

    If you were a counselor, what kinds of things would you do to help or work with teenagers?  (What makes a good counselor/easy to talk to, trust etc)

29. Are there things you would not do or say when working with teens.

## DOMAIN VI:     ABILITY TO OBTAIN COUNSELING

30. Have there been times when you felt you could use some counseling help but did not
    follow through with it?                    1. Yes        2. No

30a. Tell me about this:

31. Have there been times when you felt you could use some counseling but didn't know
    where to turn or who could help you?       1. Yes        2. No

31a. Explain:

## DOMAIN IV:    ATTITUDE TOWARDS COUNSELING

32. Have there been times when someone suggested counseling but you disagreed or
    refused it?                                    1. Yes        2. No

32a. What happened?

33. Would you seek counseling services again/in the future if you felt they would be helpful
to you with a problem or concern?                          1. Yes        2. No

33a. Please say more:

34. Have you ever suggested counseling or mental health services to a friend, family
member or peer/associate?                          1. Yes        2. No

34a. Tell me about that:

35. Where would you send a friend for counseling if they asked you now?

36. Are there places (kinds of places?) that you would avoid?
Please explain:

## DOMAIN IV.    SUGGESTIONS TO IMPROVE COUNSELING FOR YOUTH

37. What suggestions do you have for making counseling services to young people better, more available or more effective/helpful?

38. Do you have suggestions for other services that teens like yourself could really use?

39. Do you have any questions before we are through?

Thank you for sharing your time and concerns with me.

(wp51\ocjpssi.06 - 2\14\92)

# APPENDIX D: DEMOGRAPHIC QUESTIONNAIRE

# PROTOCOL -- OCJP -- MENTAL HEALTH

ID # 20-_____          Date _____

1.    Are you:    (circle one)          1. Male    2. Female

2.    How old were you on your last birthday?        _____(years)

3.    Do you think of yourself as... (circle one)

       1.    African American/Black
       2.    American Indian/Native American
          Which Tribe:_____
       3.    Asian/Pacific Islander
          Nationality?:_____
       4.    Latino/Hispanic
          Nationality?:_____
       5.    Caucasian/White (Not Hispanic)
       6.    Mixed (specify):_____

       7.    Other (specify):_____

4.    Do you think of yourself as...(circle one)

       1.    Heterosexual/straight
       2.    Homosexual/gay/lesbian
       3.    Bisexual
       4.    Undecided

5.    What was the last grade in school that you completed and got credit for?

_____ (grade)

6.    When you were in school, were you ever in a special education class or program (for added help in school or learning disabilities) ? (circle yes or no)

1. Yes    2. No

7.  Please circle the adult you lived with most when you were growing up. (Circle only one answer).

1.  Both Birth Parents(Mother/Father)
2.  Mother Alone
3.  Mother & Stepfather
4.  Mother & Grandmother
5.  Mother & Grandparents
6.  Mother & Live-In Partner
7.  Mother & Other relatives
8.  Mother & Other(s) _____
9.  Father Alone
10. Father & Stepmother
11. Father & Live-In Partner
12. Father & Grandmother
13. Father & Other Relatives
14. Father & Other(s) _____
15. Father & Grandparents
16. Grandmother Alone
17. Grandparents
18. Other Relatives:_____
19. Foster Family
20. Group Home Staff/Houseparents
21. Other Institutional Staff
22. Other: _____

8.  Have you **EVER**:    (circle yes or no)

| | | |
|---|---|---|
| Lived in a group home? | 1. Yes | 2. No |
| Lived in a foster home? | 1. Yes | 2. No |
| Been Arrested? | 1. Yes | 2. No |
| Spent at least one night in juvenile hall or jail? | 1. Yes | 2. No |
| Lived in another kind of placement setting (Such as a home for pregnant teens, etc.) | 1. Yes | 2. No |

9.  Have you **EVER**:    (circle yes or no)

| | | |
|---|---|---|
| Runaway from home for at least one night? | 1. Yes | 2. No |
| Runaway from a group or foster home or other placement? | 1. Yes | 2. No |

If yes, how many times altogether?    _____ times

10. Have you **EVER**:    (circle yes or no)

| | | |
|---|---|---|
| Been thrown out of your home for at least one night? | 1. Yes | 2. No |
| Been thrown out of a group home, foster home or other placement for at least one night | 1. Yes | 2. No |

If yes, how many times altogether?    _____ times

11.  Overall, how long have you been on your own?  (circle one)

    1. Less than two months
    2. 2 to 12 months
    3. 1 to 3 years
    4. More than three years

12.  Where were you living <u>3 MONTHS AGO?</u> (circle one)

    1. Living with friends
    2. Living with parent(s)
    3. Living with other relatives (not parents)
    4. Living in a foster home or group home
    5. Living in another kind of placement (home for pregnant teens, other)
    6. Living in juvenile hall/camp
    7. Living on the streets or in a squat
    8. Living in a shelter
    9. Other _____

13.  Where are you living <u>NOW?</u>  (circle one)

    1. Living with friends
    2. Living with parent(s)
    3. Living with other relatives (not parents)
    4. Living in a foster home or group home
    5. Living in another kind of placement (home for pregnant teens, other)
    6. Living in juvenile hall/camp
    7. Living on the street or in a squat
    8. Living in a shelter
    9. Other_____

14.  How old were you the very first time you had sex?  _____( years)

15.  How old were you the first time you had to trade sex for a place to stay, for drugs for money or for other things?

    ___Under 12 years   ___15 years old
    ___12 years old     ___16 years old
    ___13 years old     ___17 years old
    ___14 years old     ___doesn't apply to me

16. Have you ever received help for a mental or emotional problem or trouble with your nerves? (Not alcohol or drug problems) Circle yes or no.

<div align="center">1. Yes     2. No</div>

IF YES:

    Where did you seek help? (Circle all answers that apply)

    1. Alcohol or Drug Treatment/Detox Center
    2. Mental Health Center or clinic
    3. Health Center or medical clinic
    4. Private medical doctor or psychiatrist
    5. County Hospital or emergency room
    6. Druggist or pharmacy
    7. Nurse
    8. Counselor/psychologist/social worker
    9. Minister/Priest/Rabbi
    10. Teacher
    11. Self-help Group (AA/NA/CA)
    12. Family
    13. Friends
    14. Free Clinic
    15. Others (describe)_____

17. Have you seen anyone for counseling during the past year?

<div align="center">1. Yes     2. No</div>

    IF NO:

What are the **main** reasons you didn't seek help during the past year?
    (Circle all reasons that apply to you)

    1. No mental health problems--didn't need help/counseling
    2. Didn't know where to go
    3. Didn't want others to find out
    4. Didn't have money
    5. Inconvenient time/place
    6. Other reason (describe)_____

18. Have you ever been admitted to a hospital for: (circle yes or no for each)

Physical health problems (illness, surgery, childbirth)     1. Yes   2. No
Drug and/or alcohol problems (overdose, detox, treatment)   1. Yes   2. No

19. Have you ever stayed OVERNIGHT at a hospital or other treatment program because of mental health or emotional problems or trouble with your nerves? (depression, suicide attempt, nervous breakdown)     1. Yes          2. No

IF YES, what was the reason?_____

How old were you when this happened the first time?  _____years

Has it happened any other times?          _____times

At·what ages?          _____ages.

20. Have you ever taken medications that were prescribed for you by a doctor for a mental health or emotional problem? (Nervousness, depression, psychiatric problems, other)

1. Yes          2. No

If Yes, what medication/drug was it? _____

Are you currently taking any medication for mental health or emotional problems? (psychiatric medication prescribed by a doctor)  Circle yes or no.

1. Yes          2. No

If Yes, which one(s) _____

21. Have you ever tried alcohol or drugs that weren't prescribed for you by a doctor?
    (circle yes or no)                                  1. Yes       2. No

    IF YES, please check all the substances you were using **3 MONTHS AGO**:

    1. Alcohol (booze)
    2. Marijuana or hashish (pot or hash)
    3. Nicotine (cigarettes, butts, chew) .
    4. Powder cocaine (coke, blow)
    5. Crack cocaine (hubbas, rocks, coke)
    6. Psychedelics (acid, mushrooms, peyote, mescaline, ecstasy, XTC)
    7. Heroin (smack, H, junk)
    8. Other narcotics (codeine, morphine, opium)
    9. PCP (elephant tranks)
    10. Amphetamines/stimulants (uppers, speed, crystal)
    11. Ice
    12. Pain killers (darvon, percodan, demerol)
    13. Barbiturates (downs, seconal, quaaludes)
    14. Tranquilizers (tranks, valium, librium)
    15. Steroids
    16. Inhalants (glue, poppers, rush, paint thinner)
    17. Other_____

22. Please check all substances that you are using **NOW**:

    1. Alcohol (booze)
    2. Marijuana or hashish (pot or hash)
    3. Nicotine (cigarettes, butts, chew)
    4. Powder cocaine (coke, blow)
    5. Crack cocaine (hubbas, rocks, coke)
    6. Psychedelics (acid, mushrooms, peyote, mescaline, ecstasy, XTC)
    7. Heroin (smack, H, junk)
    8. Other narcotics (codeine, morphine, opium)
    9. PCP (elephant tranks)
    10. Amphetamines/stimulants (uppers, speed, crystal)
    11. Ice
    12. Pain killers (darvon, percodan, demerol)
    13. Barbiturates (downs, seconal, quaaludes)
    14. Tranquilizers (tranks, valium, librium)
    15. Steroids
    16. Inhalants (glue, poppers, rush, paint thinner)
    17. Other _____

23. Do you think you have or had a problem with any of these substances?
    (Circle yes or no)

                    1. Yes        2. No

    If Yes, which one(s)?_____

24.   Has anyone ever told you that you have a problem with any of these substances?
      (Circle yes or no)

                    1. Yes        2. No

    If Yes, which one(s)?_____

    Who thought you had a problem? (parent, relative, brother/sister, friend)

    _____

# APPENDIX E:     YOUTH-SERVING AGENCY SURVEY

# SURVEY OF MENTAL HEALTH SERVICES FOR RUNAWAY AND HOMELESS YOUTH

## Conducted by Children's Hospital Los Angeles and Harder+Kibbe Research

AGENCY: _____

ADDRESS: _____

_____

TELEPHONE: _____ FAX: _____

PARENT AGENCY, IF ANY: _____

NAME/TITLE OF PERSON COMPLETING
THIS SURVEY:_____

DATE COMPLETED: _____

---

1. How many full-time equivalents (FTE) staff (or contract employees)
   are currently employed by your agency?            _____ (# FTEs)

2. How would you describe your staff make-up: (Check all that apply)

   _____ Licensed Professionals (PhD, MD, MFCC, LCSW, etc.)
   _____ Unlicensed Professionals (MSW, MA, BA, etc.)
   _____ Para-professionals
   _____ Volunteers

3. What geographical areas do you serve? _____
   _____
   _____

4. What languages is your agency able to accommodate? _____
   _____

**Note: We define "youth" as being between 12 and 17 years old**

5. Does your agency serve youth?                        Yes _____ No _____

6. What percentage of your agency's clients are youth?        _____%

7. Does your agency provide services to runaway/homeless youth?   Yes _____ No _____

8. Does your agency provide services to undocumented youth?       Yes _____ No _____

9. Does your agency provide services to HIV infected youth?       Yes _____ No _____

121

10. Does your agency provide services to youth with the
    dual diagnoses of mental illness and substance abuse?        Yes _____ No _____

11. Please indicate the number of runaway and homeless youth served by your agency
    during your most recently completed fiscal year:              _____

    Of the total number of runaway and homeless youth served, what percent were:

    _____ Caucasian                _____ Asian/Pacific Islander
    _____ African American         _____ Native American
    _____ Hispanic/Latino          _____ Other ethnicity/undetermined

    Of the total number of runaway and homeless youth served, what percent were:

    _____ Male
    _____ Female
    _____ Trans-gender
    _____ Undetermined

12. Which of the following services does your agency provide to runaway and
    homeless youth?  (Check all those that apply)

    _____ Hotline
    _____ Counseling
    _____ Crisis Intervention
    _____ Outreach
    _____ Drop-in Center
    _____ Day Treatment
    _____ Shelter services (# of beds?) _____
    _____ Residential Treatment (# of beds?) _____
    _____ Employment Services
    _____ Educational Services
    _____ Substance Abuse Services
    _____ HIV testing
    _____ Other _____

13. What types of counseling services does your agency offer to runaway and
    homeless youth? (Check all those that apply)

    _____ Individual
    _____ Group
    _____ Peer
    _____ Family
    _____ Other _____

2

14. Please describe the eligibility requirements for services for runaway and
    homeless youth. (Please continue on back of page if needed)

_____

_____

_____

15. Please describe any eligibility restrictions for services for runaway and
    homeless youth. (Please continue on back of page if needed)

_____

_____

_____

_____

16. What is your application procedure?   (Please check all those that apply).

    _____  Walk-in
    _____  Call for appointment
    _____  Call for information
    _____  Referrals accepted
    _____  Referrals required
    _____  Other _____

17. What are your agency's funding sources? (Please check all those that apply)

    _____  Client Fees
    _____  Third Party Reimbursement (including MediCal)
    _____  Corporations
    _____  Foundations
    _____  United Way
    _____  City Government
    _____  County Government
    _____  State Government
    _____  Federal Government
    _____  Other _____

18. Please indicate your agency's operating budget for the most recently
    completed fiscal year.

    Your agency's total operating budget: $ _____

    Fiscal Year: _____

19. What percentage of your agency's total operating budget is dedicated
    to runaway and homeless youth services?          _____ %
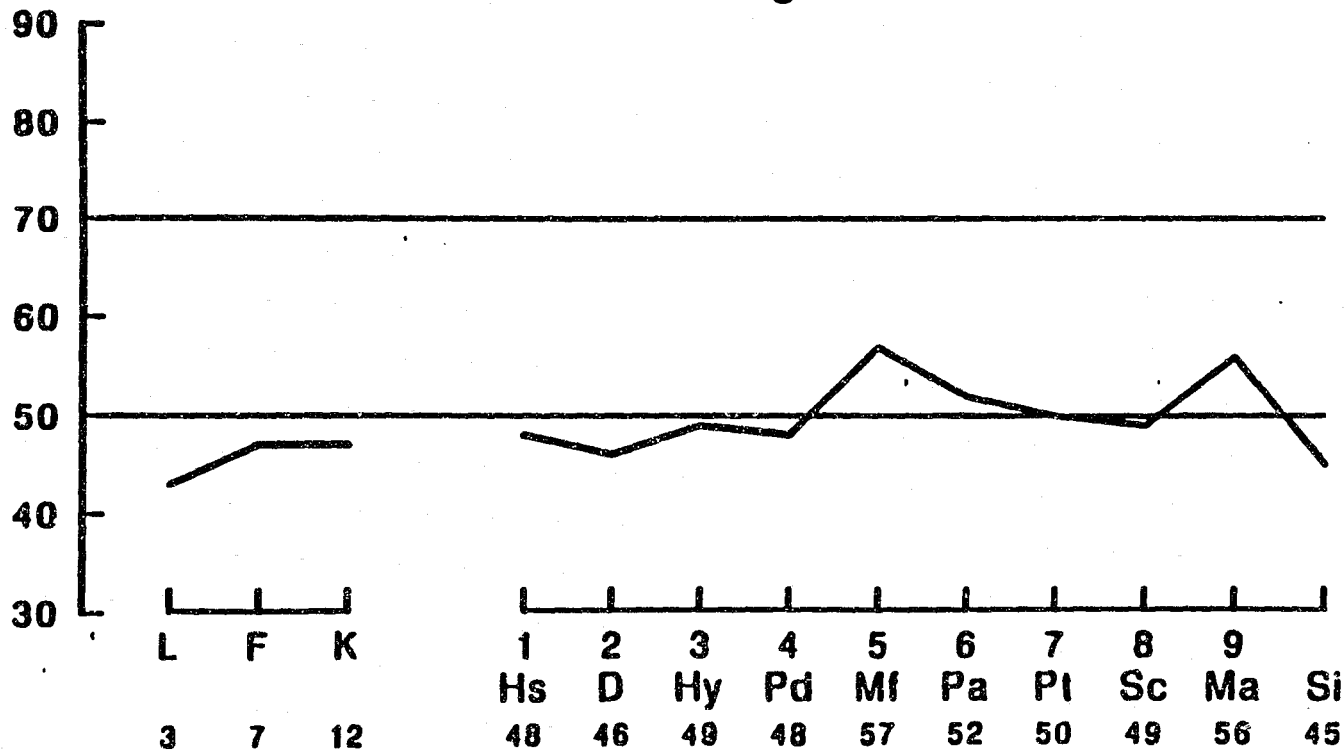
3

# APPENDIX F: SAMPLE MMPI PROFILES

THE MMPI: A CONTEMPORARY NORMATIVE STUDY OF ADOLESCENTS
MEAN MMPI PROFILE FOR CONTEMPORARY NORMAL
ADOLESCENTS USING MARKS, SEEMAN AND HALLER*
NORMS AND NON-K CORRECTED SCORES
Males:  N=113   Age=17

|  | L | F | K | | 1 Hs | 2 D | 3 Hy | 4 Pd | 5 Mf | 6 Pa | 7 Pt | 8 Sc | 9 Ma | Si |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
|  | 3 | 7 | 12 | | 48 | 46 | 49 | 48 | 57 | 52 | 50 | 49 | 56 | 45 |

948168-25 *Marks, Seaman and Haller:  The Actuarial Use of the MMPI With Adolescents and Adults: p 155-162, 1974

125

# MMPI PROFILE FORM
## ADOLESCENT NORMS: (MALE)

NAME __20·007__   AGE __17__   DATE TESTED _____

ADDITIONAL INFORMATION _____
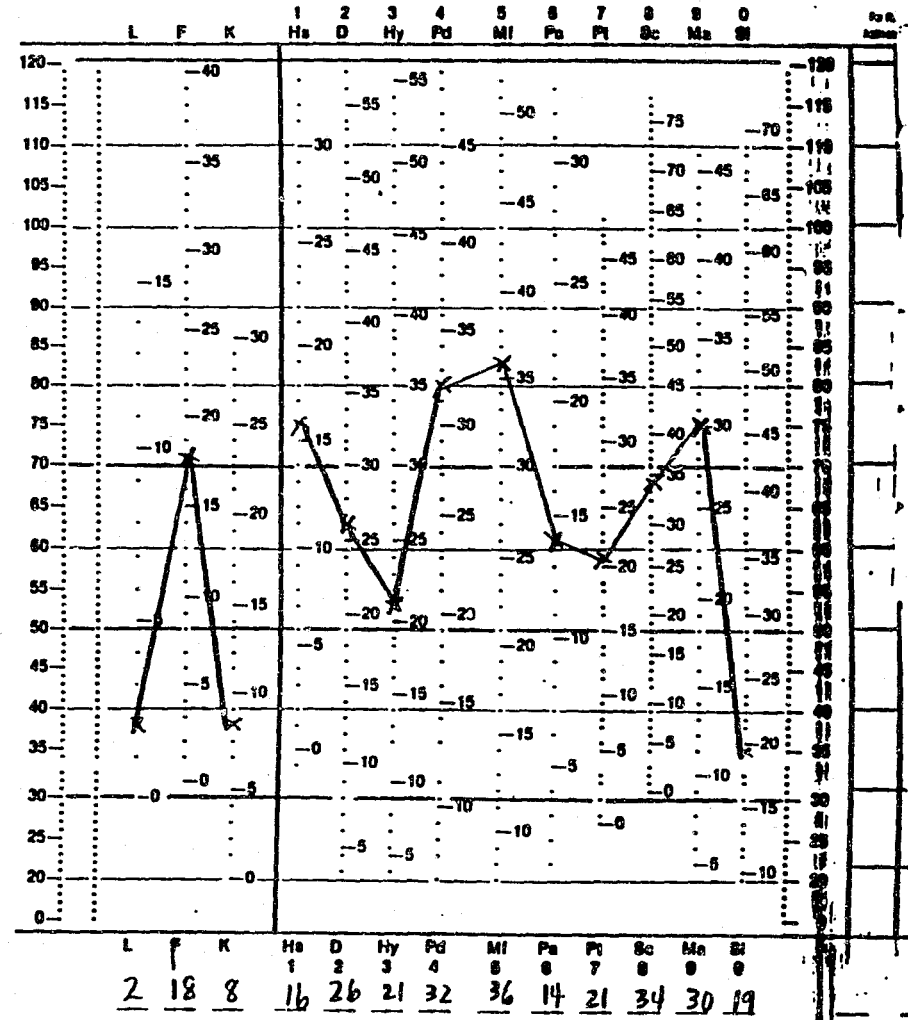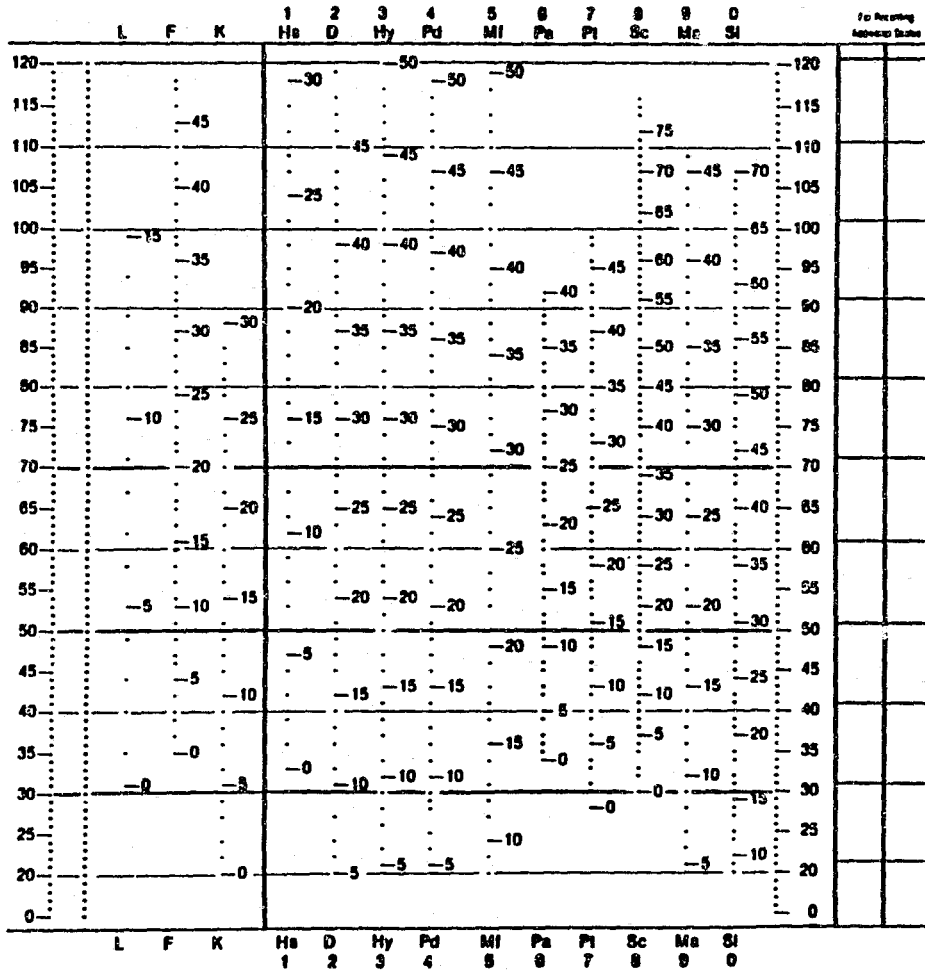
**AGE 16**

**AGE 17 & 18**



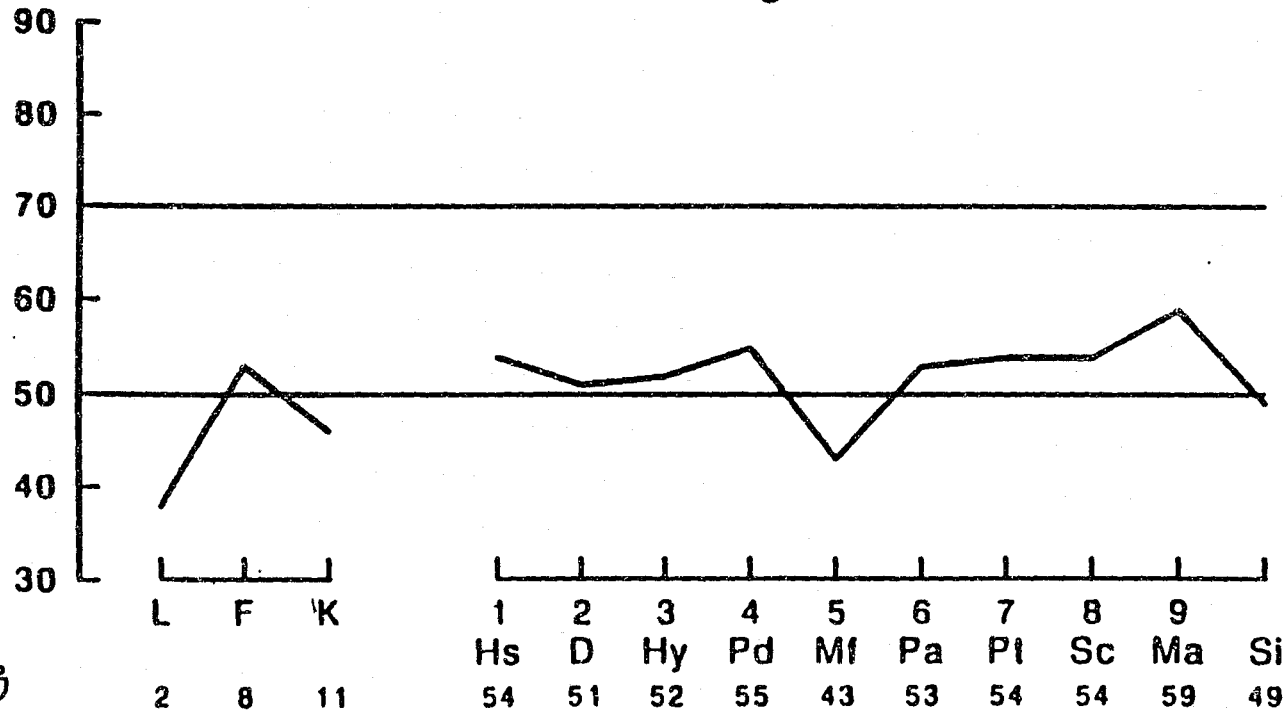| | L | F | K | Hs 1 | D 2 | Hy 3 | Pd 4 | Mf 5 | Pa 6 | Pt 7 | Sc 8 | Ma 9 | Si 0 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2 | 18 | 8 | 16 | 26 | 21 | 32 | 36 | 14 | 21 | 34 | 30 | 19 |

SCORER'S NAME _____   DATE _____

126

## THE MMPI: A CONTEMPORARY NORMATIVE STUDY OF ADOLESCENTS
### MEAN MMPI PROFILE FOR CONTEMPORARY NORMAL ADOLESCENTS USING MARKS, SEEMAN AND HALLER* NORMS AND NON-K CORRECTED SCORES
### Females: N=138  Age=16



| | L | F | K | | 1 Hs | 2 D | 3 Hy | 4 Pd | 5 Mf | 6 Pa | 7 Pt | 8 Sc | 9 Ma | Si |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2 | 8 | 11 | | 54 | 51 | 52 | 55 | 43 | 53 | 54 | 54 | 59 | 49 |

946168-29B    *Marks, Seeman and Haller: The Actuarial Use of the MMPI With Adolescents and Adults: p 155-162. 1974

# MMPI PROFILE FORM
## ADOLESCENT NORMS: FEMALE

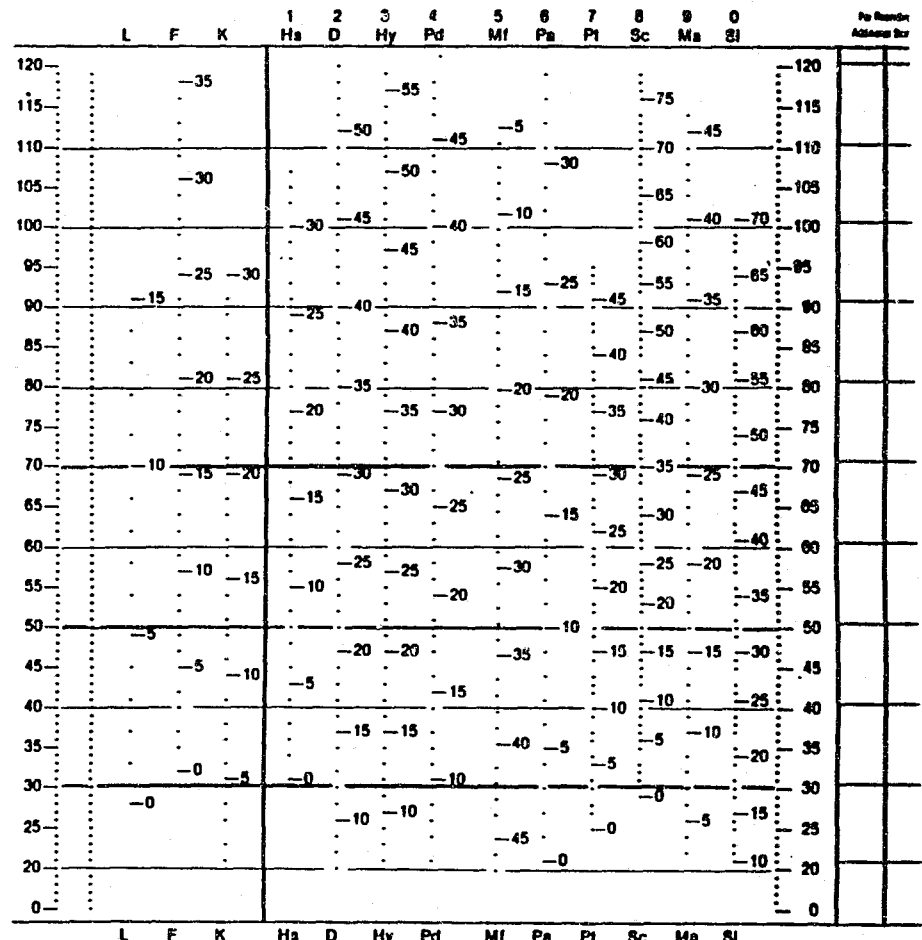NAME __20-012    92-052__     AGE _____ DATE TESTED _____

ADDITIONAL INFORMATION _____

### AGE 16

### AGE 17 & 18



L 4  F 24  K 11  Hs 17  D 23  Hy 35  Pd 35  Mf 38  Pa 19  Pt 35  Sc 43  Ma 24  Si 21

128

SCORER'S NAME _____     DATE _____

FORM #406-PF
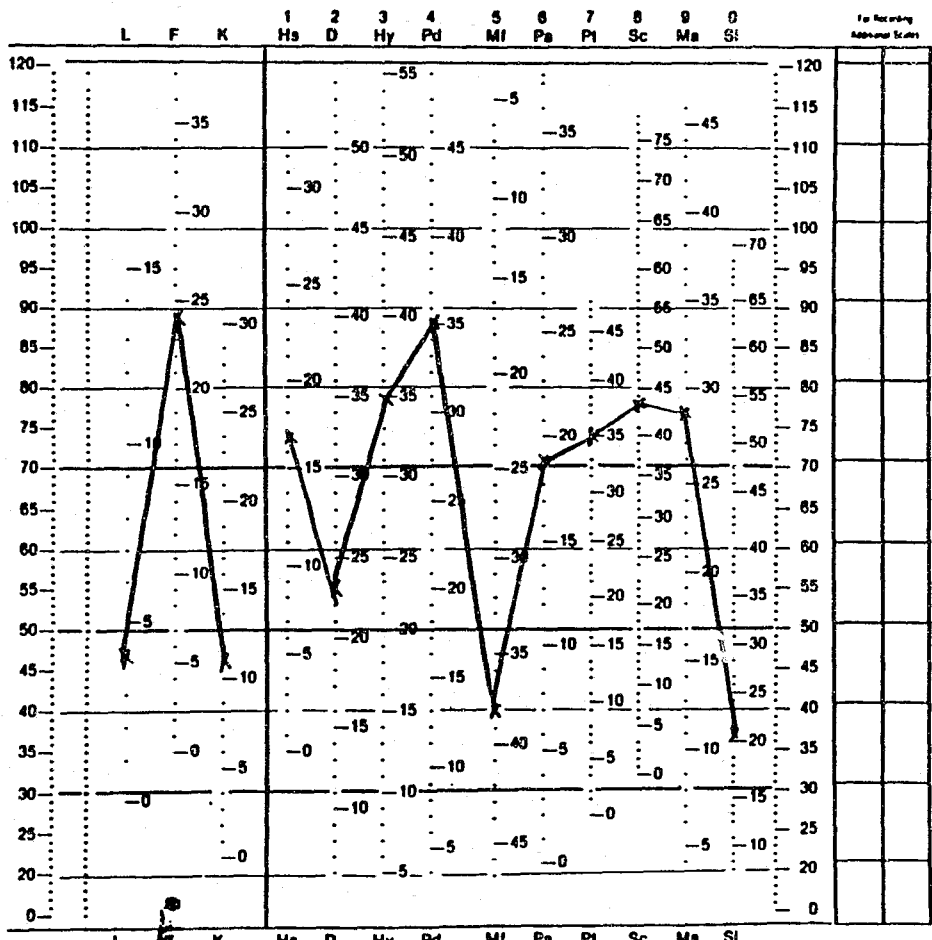
# APPENDIX G:     CONSENT FORM

## NOTICE OF PARTICIPATION IN EXTENDED SERVICES FOR EVALUATION

At the request of our funding source, we are extending our services to clients of the Los Angeles Youth Network at this time to include a questionnaire, psychological testing and, in some cases, a follow-up interview. These additional services are designed for two purposes:

1. To allow us to evaluate and improve client services in the areas of mental health and emotional problems and

2. To provide additional information to case managers in working with you as a client.

Your participation in these additional services (interview, questionnaire and psychological testing) is voluntary.

NO SERVICES WILL BE TAKEN AWAY FROM YOU IF YOU DECIDE NOT TO PARTICIPATE IN THIS PROCESS. QUESTIONNAIRE AND INTERVIEW INFORMATION IS CONFIDENTIAL AND WILL NOT BE SHARED WITH OTHER LAYN STAFF OR USED WITH YOUR NAME ATTACHED. A SUMMARY OF PSYCHOLOGICAL TEST INFORMATION WILL BE PLACED IN YOUR LAYN CASE RECORDS FOR THE USE OF CASE MANAGERS AND COUNSELORS WORKING WITH YOU AND WILL BE KEPT CONFIDENTIAL AMONG LAYN STAFF. THIS MEANS IT IS CONFIDENTIAL WITH THE FOLLOWING EXCEPTIONS:

1. There is suspected child abuse

2. There is intent to harm yourself or others

## CONSENT TO PARTICIPATION IN EXTENDED SERVICES AS DESCRIBED ABOVE

I understand that my participation in the extended services described above is entirely voluntary and no services will be removed or altered if I decide not to participate. I understand that all information gained as a result of these extended services is confidential with the exceptions mentioned in numbers 1, and 2. I also understand that I can talk with Nick Stefanidis, LAYN Staff Psychologist about any questions that I have about the testing process or test results.

_____          _____
LAYN Client Signature                                                          Date