Published in final edited form as:

Psychiatr Rehabil J. 2012 September ; 35(5): 360–368. doi:10.1037/h0094494.

Engaging Youths with Serious Mental Illnesses in Treatment: STARS Study Consumer Recommendations

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Abstract

BACKGROUND—individuals experiencing their first psychiatric symptoms can be difficult to engage in treatment, for reasons including developmental stage and social environment. Early and consistent treatment, thus engagement in treatment, is critical to improved long-term outcomes.

OBJECTIVE—to identify better methods of engaging youths in mental health services by asking experienced mental health consumers for suggestions for clinicians.

METHODS—177 members of an integrated health plan, ranging in age from 16–84 years and diagnosed with schizophrenia, schizoaffective disorder, bipolar disorder or affective psychosis, completed four in-depth semi-structured interviews over 24 months as part of a study of recovery from serious mental illness. We transcribed and coded interviews, extracted a set of common themes addressing consumer recommendations to clinicians, and compared these themes across age groups.

RESULTS—five primary themes emerged in participants' recommendations: (1) use an age-appropriate approach that reflects youth culture and lifestyles; (2) foster development of autonomy; (3) take a personal, rather than diagnostic, approach; (4) be empathetic and authentic; and (5) create a safe and supportive environment. Consumers age 30 and older described three additional areas in which clinicians could contribute to youths' well being: (1) help find the right diagnosis and the right medication, (2) counsel youths to avoid using alcohol and drugs, and (3) take steps to help prevent social isolation.

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE—findings suggest that many strategies recommended for working with adults may benefit young people, but that developmentally-appropriate modifications to these approaches are needed to foster treatment engagement among youths.

Keywords

Adolescents; Treatment Engagement; Consumers; Qualitative Research; Schizophrenia; Bipolar Disorder

INTRODUCTION

The majority of individuals who develop serious mental illnesses experience their first symptoms relatively early in their lives (1–3)—most during the critical periods of adolescence and what Arnett has called emerging adulthood (4). These consecutive periods are characterized by profound change, during which young people complete their educations, test new roles, explore identity and employment choices, try out romantic partnerships, and become self-sufficient (both financially and in terms of decision making) (4). When self-sufficiency has been achieved, most people begin to think of themselves as having reached adulthood (4). Serious mental illnesses often intervene during these periods, disrupting the critical work taking place (5) and potentially undermining the ability to attain self-sufficiency. Complicating matters further, the onset of psychiatric symptoms during this time of profound change may be difficult for young people to understand, with some viewing their symptoms as “normal,” and just part of who one is (6). Others, however, may see those symptoms as a threat to being “normal” when they are desperately trying to “fit in” with peers (7).

Given the timing of onset of these disorders, it is not surprising that accepting the idea of having a mental illness is often problematic for young people, which can lead to unwillingness to seek or continue in treatment. Nevertheless, most attention in recent years has been focused on the dearth and fragmentation of mental health services available to young people in need (8–11), or the components of the services that are, or should be, available to young people (9,12,13). The lack of available age-appropriate services is a significant problem. Engagement in available services is equally important, however, if we are to limit developmental disruption, particularly given the improved long-term outcomes associated with early and sustained psychiatric and psychosocial treatment (14–16). Yet, we know little about how to improve the ways that care is delivered, or how to improve early treatment experiences (17,18), even though we know that young people are reluctant to seek mental health care (19).

Adolescent mental health care is often focused on behavior that is disturbing to others, rather than on behavior that is inherently disturbed (20). This approach can lead to unwillingness to attend treatment sessions and reduce treatment readiness and willingness to follow treatment recommendations. For example, youths may reject treatment if they are brought to treatment by parents when they feel they do not have a problem (21). For these reasons, clinicians are generally cautioned to avoid being seen as parental agents (21). However, they are also encouraged to work with parents to increase engagement and treatment adherence (22). Suggestions for negotiating this delicate balance and creating a positive and effective clinical relationship include explaining the benefits and risks of recommended treatments to young people, addressing them directly (rather than talking only to parents), answering their questions, obtaining assent to treatment (in addition to parental consent) (21), and avoiding “by the book” and “by the clock” approaches (5).

In addition, treatment recommendations suggest that clinical relationships may be strengthened if clinicians adopt an empathic, direct, non-judgmental approach in which information is shared freely (22). Some research supports the latter assertions, suggesting that more collaborative relationships (23) are associated with reduced symptoms among youths (21). On the whole, however, few studies have assessed these approaches, and research is particularly limited when it comes to understanding consumers’ perspectives about best clinical approaches for young people with serious mental health problems. The Federation of Families for Children’s Mental Health’s 2001 report is the exception (11). This report made some recommendations for clinical approaches for young people following interviews with youths and their families, suggesting careful listening and involving youths

in treatment planning, but focusing more on limitations in services, coordination of care, and family involvement than on treatment engagement.

Most of the other relevant literature assessing consumers' perspectives focuses on explorations of adult viewpoints (24–26), on mental health problems (27,28), or seeking health care (29,30) more generally. Much can be learned from these studies, however. For example, among adolescents seeking medical care, primary concerns included confidentiality, shame, and embarrassment about discussing sensitive health topics and emotional problems (29,30). In addition, young people receiving care for depression in primary care settings were more likely to be satisfied when clinicians nurtured a sense of connection, normality, and autonomy (31), while the characteristics youths identified as most desirable in mental health clinicians included a friendly disposition, the ability to empathize, and a non-judgmental approach (32). One study of recovery and resilience among youths in the mental health system found that adolescents and their families suggested an approach that focused on hope, optimism, and planning for the future (33). Findings that there are important discrepancies between the viewpoints of clinicians and their young patients regarding working alliances, however, suggest the value of more carefully exploring what young people need and want from their mental health clinicians (34).

Experienced consumers of mental health services offer unique perspectives about mental health treatment that clinicians and others may not have. In particular, they offer insight into the effectiveness of various approaches to providing care for young people based on their personal experiences of receiving care, most as emerging adults. In this paper, we present the results of an exploratory analysis of experienced consumers' recommendations to clinicians about best strategies for approaching youths with mental health problems. We also examine the extent to which this advice differs by age, because our sample spanned a full age range. Our goal was to explore, identify and understand possible approaches and techniques for interacting with youths that could be used to inform clinicians and researchers, with the hope of fostering new approaches that improve treatment engagement and enhance clinical outcomes.

METHODS

Setting

The "Study of Transitions and Recoveries" (STARS) is a longitudinal, mixed-methods exploratory study of recovery from serious mental illness, conducted within Kaiser Permanente Northwest (KPNW). KPNW is a not-for-profit prepaid integrated health plan in the Pacific Northwest that provides inpatient and outpatient medical, mental health, and addiction treatment services to about 500,000 members.

Inclusion and Exclusion Criteria

Participants had been KPNW members for at least 12 months prior to enrolling in the study, were a minimum of 16 years old, planned to live in the area for at least one year, and had been diagnosed with schizophrenia, schizoaffective disorder, affective psychosis or bipolar disorder, for at least 12 months. Exclusion criteria included diagnoses of dementia, mental retardation, or organic brain syndrome, as well as people whose mental health clinicians felt they were unable to participate at the time we attempted to recruit them for the study.

Recruitment

Beginning in November 2003, letters were sent in small batches to 418 of 1,827 potential participants identified through health plan records (recruitment was stopped when the goal

of 175 participants was reached). Only one person per family was approached if more than one family member had an inclusion disorder. The goal of recruitment was to obtain a representative sample of the health plan population of eligible individuals. The study's principal investigator and the member's mental health care clinician (or primary care provider if the participant did not visit the mental health department) signed recruitment letters. We stratified recruitment letters according to gender and diagnostic group (mood vs. schizophrenia spectrum) to balance the sample. Clinicians screened out 15.8% of potential participants—those who they deemed unable to participate in the study at the time of the request. Telephone calls were made to potential participants who did not respond to letters. Of 418 letters sent, we contacted 350 individuals, received 127 refusals, and found 22 individuals ineligible for the study. Overall, we enrolled 184 of the 418 persons we attempted to recruit, 46% of those who were eligible. Of these, three were excluded because they did not complete both baseline interviews and four were excluded because study staff determined that psychiatric diagnoses in the medical record were in error.

At enrollment and prior to participation, participants received a complete description of the study and provided written informed consent. The KPNW Institutional Review Board and Research Subjects Protection Office approved and monitored the study. Participants were provided \$50 gift cards to a local one-stop shopping center chain as compensation for completing the baseline interview, \$60 gift cards for completing each of the following interviews, and a \$75 gift card at the end of the study if all interviews were completed.

Participants

We enrolled 177 individuals, 92 women (52%) and 85 men (48%) ranging in age from 16 to 84 years at baseline ($m = 48.8$, $SD = 14.8$). The enrolled sample distributions for age and sex, within diagnosis, were representative of the study-eligible population of health plan members and did not differ statistically from that population. Consistent with KPNW's service area, 94.4% ($n = 167$) of participants reported being White, 5.6% ($n = 10$) Black or African American, 2.8% ($n = 5$) American Indian/Alaska Native and 1.7% ($n = 3$) Asian/Pacific Islander (note that participants were allowed to select multiple racial categories so categories sum more than 100%). Overall, 4.5% ($n = 8$) reported being of mixed race and 0.6% ($n = 1$) reported Hispanic origin.

Additional sociodemographic statistics for the sample appear in Table 1. The worst-year GAF score (35) was rated by trained study interviewers based on participants' reports of their symptoms during their worst year. We used worst-year GAF score as a proxy for severity of illness.

At the 24-month follow-up interview (from which data were derived for this paper), 167 of 177 participants completed interviews. Three participants were deceased and seven were lost to follow-up, representing a 96% follow-up rate among living participants.

Interviews and Analysis

Participants completed in-depth interviews, in English, four times over a two-year period: two at baseline, one at one year, and one at two years. Baseline interviews averaged about four hours total, two hours per interview; follow-up interviews averaged 60–90 minutes. Interviews were designed to identify factors that facilitated recovery or presented barriers to recovery. We conducted two interviews at baseline to ensure adequate time to cover mental health, recovery history, and experiences with mental health care, while keeping participant burden to a minimum. Over the course of the study, in addition to history and recovery trajectory, we covered a wide range of experiences and perspectives, in an effort to understand the recovery process. Interviews were conducted by trained masters-level mental

health interviewers, including the fourth author (AF), and by the study principal investigator (CG). Each interviewer followed the same participants for the entire study from recruitment to closeout. The study team and a consumer advisory panel identified additional topics that appeared worthy of systematic exploration in future interviews as interviews and analyses proceeded over time. The topics covered in this paper were a result of this process. We describe participants' responses to the following question: "What advice would you give to mental health clinicians about how they should approach younger people who are having difficulties with their mental health?" This question was added to the fourth (final) interview after analyses of previous interview text suggested that this topic might be important to the recovery process.

Interviews were audiotaped and transcribed, with transcripts reviewed weekly during data collection for quality control, to refine interview techniques for clarification and prompts, and to develop an initial descriptive coding scheme. We coded all transcripts with descriptive codes using Atlas.ti, a qualitative analysis software program that aids storage, organization, and retrieval of qualitative data (36). We then examined interview text for each relevant code separately by participant age groups (ages 16–29 [$n=18$], 30–44 [$n=38$], 45–59 [$n=69$], and 60+ [$n=41$]) to explore differences in themes across the life course. Throughout the interview and coding process, multiple researchers discussed and resolved discrepancies in code use and revised definitions to increase coder reliability. In addition, we check-coded transcripts from each set of interviews. We check-coded 154 passages from 16 transcripts for the 24-month follow-up interviews (from which data for the current paper were drawn). Primary coders were judged correct for 136.75 (88.8%) of these passages.

RESULTS

Participants' recommendations can be summarized as reflecting eight primary themes. Five themes were present across all age groups (Themes 1–5), while three themes (Themes 6–8) were present only among participants age 30 and older. Themes are summarized below and illustrated with quotations.

Theme 1 – Use an Age-Appropriate Approach that Reflects Youth Culture and Lifestyle

Participants noted the importance of developing an age-appropriate, culturally sensitive approach to youths with serious mental illnesses. While participants felt that youths should be treated differently than adults, their comments also reminded clinicians about the importance of showing as much respect for youths as they do for adults. Of particular significance for clinicians, participants highlighted the importance of knowing about, understanding *and* respecting youth culture and lifestyles. Participants also warned against treating adolescents as they might treat children, recognizing the transitional status of their developmental stage and adolescent sensitivity to approaches that do not reflect their increasing autonomy. For example:

...try to think on their level, not like they're lower or anything, but try to think like they think, try to learn about the stuff that they're into, the kind of experiences they have, their lifestyle, instead of going at it from an older person's perspective and being patronizing. Across participants, this theme was characterized by recognition that young people need to be approached in ways that reflect their age and personal concerns without being demeaning.

Theme 2: Foster Development of Autonomy

Theme 2 addresses the transitional nature of adolescence and the need for youths to develop a sense of independence. Participants noted that for many young people, the transition from childhood to adulthood is awkward and confusing, and can be made much more difficult by

having mental health problems. Moreover, participants recognized that adolescents are faced with a dilemma because they need to develop a sense of autonomy, yet have mental illnesses that may force them to rely on their parents more than they would like. Thus, participants made the point that clinicians need to avoid the appearance of taking on an authoritarian role. For example, one young participant exhorted:

Don't be a parent because we already have parents!

Many participants suggested that clinicians could support newly developing autonomy by using an approach that encourages young people to make their own treatment decisions. For example:

...I think the clinician might make sure the young person has some say in what's going to happen to them, like, "Do you want to try a new medicine right now?" or, "Would you rather just stay where we're at right now?"... I think clinicians a lot of times may say, "Let's talk to your parents first and we'll [parents and clinician] decide what you're going to do."

Participants repeatedly pointed out that having control in life is both an important part of becoming an adult *and* critical to managing mental health problems. This participant eloquently described the importance of respecting youths' autonomy in clinical situations:

[Clinicians should] treat them as adults...not that they're legally adults, but in the sense that their ideas and their feelings are just as important as they would be for an adult.

Theme 3 – Take a Personal Rather than a Diagnostic Approach

Participants also recommended an approach that avoids making young people seeking mental health care feel as if they are somehow "less than human." They advised clinicians to treat youths like "regular human beings" rather than "ill persons." For example:

...don't make them feel like they're really sick, like you wouldn't want to make them feel like they're diseased...

Participants also suggested that a better approach would be collaborative and person-centered:

...Approach them as people, not to approach the *illness* but to approach the *person*, so that you and your client, as two people together, can approach the symptom.

This participant recognized the importance of avoiding approaches that could make adolescents feel shamed or stigmatized.

I think it would be really important [for the clinician] to reassure [youths], and not let...them think they're alone, or that they're defective, or a freak. That actually goes for everybody I think, all ages, but I think an adolescent might be really self-conscious about it...make sure there's no shame...[try] to help remove the sense of shame they might feel.

Similarly, participants suggested that clinicians should foster a sense of being a "regular human" who just happens to have a mental health problem, without introducing or reinforcing negative emotions or perspectives, or treating people as if they *are* their diagnoses.

Theme 4 – Be Empathetic and Authentic

Participants in this study encouraged clinicians to be friendly, but also noted the importance of being authentic about their desire to help youths. They characterized this kind of helpful

approach in various ways—as empathetic, compassionate, honest, and amiable. For example, this participant focused on empathy and compassion:

I think that [clinicians] might approach [youths]...on the same level. They might put themselves in those shoes and actually look into that person's eyes [and] feel where they're coming from in their life...They need to approach them as a friend, they need to approach them as not only this person is coming in for help, but this person might not have no where else to go for help, so you have to help them.

Participants also pointed out that clinicians need to spend time getting to know each young person well if they are to establish relationships based on empathy and authenticity. Some comments suggested the need to go beyond a friendly demeanor and actively cultivate an approach that makes youths feel they are talking with a friend, rather than a professional:

[Clinicians should] approach [youths] like they're your friend...just try to be a straight adult with them, if the person is not mature enough to be an adult, they're just not going to feel comfortable discussing things with you [otherwise].

Theme 5 – Create a Safe and Supportive Environment

Another common theme across participants revolved around creating a safe and supportive environment. These comments addressed a broad range of situations that could affect feelings of emotional safety, including confidentiality policies, clinician demeanor, and modes of interacting. For example, several participants suggested that informing young consumers about confidentiality policies at the beginning of treatment could help mitigate fears or hesitations associated with personal disclosure of thoughts and emotions related to symptoms and other difficulties.

I think that it would be important [for the clinician] to say... “The arrangement is confidential. Whatever you say to me I'm not going to tell anyone else about it. So you can feel free to speak freely with me.”

On the other end of the spectrum, this participant pointed out the value of a gentle demeanor in creating a safe environment.

Be gentle. They're in pain...I know I was when I first saw the doctor. I was going through a lot of questions in my head, [thinking] “What's going on?” Of course a lot of denial too, but you know, be gentle, give space. The person most likely [is] going to be freaked out inside. They're not going to show it but they're scared. They don't know what's going on with them.

The need for careful listening emerged as a distinct subtext in creating these kinds of safe environments, but participants also suggested that approaches should be tempered to address young peoples' sensitivities. In particular, there were different opinions on the extent to which clinicians should listen versus advise, illuminating the tightrope clinicians find themselves walking. For example, this participant suggested clinicians should listen without providing advice.

That they [clinicians] put themselves in their [youths'] shoes, and maybe they can't do it because they haven't been there before, so listening is, listening is great, and maybe suggesting, but never telling, or advising, in my opinion.

Conversely, another participant points to a delicate balance between young peoples' needs to be listened to and understood while still having needs for advice.

...[clinicians] pretty much just listen to you instead of giving you more advice on things you might be doing that would help you, but I notice most of the time when I go in, they just listen to me and don't really give me that much advice...I think it

would be helpful if they would maybe say you could do this, or you could do that, give you new ideas, because I kind of had to think about things for myself.

Theme 6 – Find the Right Diagnosis and the Right Medicine

Only those over age 30 gave advice concerning the link between diagnoses and medications. Some participants discussing this theme emphasized the need for an accurate diagnosis so that the right medication would be prescribed. Others noted that this might involve trying out various medications to find a good fit:

I think...[clinicians] might...have to try various things...With me, they tried probably 3 different medications before they got to the correct one.

Participants over 30 also noted that youths' preferences need to be considered when determining whether a medication is appropriate or if a treatment should continue.

I would say first of all they have to be understanding, and show they really care for that person, and treat them with the right medication and have a follow-up to make sure they're taking the medication. Of course that would be [the youth's] choice.

Not all participants agreed, however, that medication should be the first or primary approach to helping younger individuals. Two individuals warned against focusing solely on medications: One said, "I would [only] recommend medications as the extreme"; the other: "Don't always respond with medication."

Theme 7 – Don't Use Alcohol or Drugs

Participants age 30 and over also suggested that clinicians should advise youths to avoid alcohol and drugs, while younger participants did not mention this topic. In general, participants who mentioned alcohol and drugs discussed concerns about how substances might interfere with counseling, medication, or the recovery process. This participant noted that alcohol and drug use can interfere with an individual's ability to identify and understand emotions and thoughts:

Helping them stay clean and sober is one [approach], because [substance use] doesn't help. [Help] them to recognize their feelings instead of hiding them from themselves. I speak from experience (laughs).

Similarly, another participant noted that alcohol and drug use interferes with clinical work:

Somehow [clinicians have] got to work with the kids to get off drugs and alcohol, and after [they] get that toned down, then [they] can begin to speak with the person [about what] needs to be dealt with.

Overall, participants suggested that clinicians be straightforward about the kinds of problems that can arise when using alcohol or drugs and trying to manage mental health problems.

Theme 8 – Avoid Isolation

Participants age 30 and over also mentioned that experiencing the symptoms of mental illnesses can produce social isolation at a time when young people are still trying to figure out who they are and how they fit into society and their peer group. They cautioned that social norms of filling time with technological entertainment can further isolate teens from peers and family, and prevent them from having needed and meaningful human interactions.

...I would check the isolation factor. I think in American society today, with the headphones, the cell phones, the internet—these are all self-isolating factors—and we are painting ourselves into a corner, and it's a very lonely place, and you need to

reach out to people and see if they have anybody to talk to, and not gloss it over, but who do you talk to when you have problems?... You have to have some real people, and that's a great angle of attack for a clinician to delve into, because [a clinician will] realize really quick if that person is vulnerable emotionally to being lonely...

Participants also noted that having few interactions with peers with similar illnesses and experiences can contribute to feelings of isolation. Some participants suggested peer support to foster a sense of shared experience and community:

If they had some kind of support group of other kids that were going through the same thing, that might help... if they could talk to other peers.

Others suggested involving family in the healing process as a way to reduce isolation and foster understanding about mental illnesses:

I think get the family involved. Sometimes the clinician and the patient can get isolated doing their own thing, and they understand what's going on but nobody else has a clue. So I think the clinician could do a job of educating the family when you see this going on, "This could be the symptom relating to such and such of their illness," or whatever. A little family education I think.

Overall, these participants suggested that increasing connectivity to peers, friends, and family could reduce the isolation that increases negative emotions, negative thinking, and psychiatric symptoms.

DISCUSSION

Although treatment recommendations for youths with serious mental illnesses do not differ substantially from those for adults (antipsychotic and mood-stabilizing medications with supplemental psychosocial and family interventions, supported education/employment, skills and illness management training (37–41)), consumer recommendations suggest that a youth-specific *approach* to providing these treatments has the potential to improve clinical experiences and engagement.

In particular, these exploratory findings suggest that clinicians who are able to: (1) balance their clinical role with a sensitive and nuanced approach that supports young peoples' developing identities and autonomy; (2) foster a trusting, safe, and understanding environment; and (3) understand *and* appreciate youth culture and prevailing customs, will be more successful as they work to engage young people experiencing mental health problems. This consumer-derived approach differs significantly from approaches that rely on communication with parents as the primary tool for keeping youths in treatment. It is also consistent with other empathic, non-directive, and non-judgmental approaches for working with youths (2) and with Rogers' (22) emphasis on genuineness, congruence, unconditional positive regard, and empathic understanding (42).

The most important themes in our findings—using age- and a youth-culture-sensitive, empowering, approach—are also consistent with recent initiatives and recommendations aimed at improving access to collaborative treatment models for youths (21,43). An excellent example of an innovative model of this type is Australia's Orygen Youth Health program (44).

In addition, consumers' recognition of the strong need for autonomy among adolescents with mental health problems is consistent with developmentally appropriate approaches to youths in this age group (45,46). Similarly, consumers also noted the importance of identity development among young people with mental health problems, cautioning clinicians to

avoid diagnosis-based approaches that make youths feel “less than human” or suggest that their primary identity is as a mentally ill person. This advice is consistent with the mental health recovery movement (47) and with findings showing that teens seeking treatment for depression prefer approaches that give them a sense of normalcy (31). It is also consistent with the reality that teens who have negative attitudes about mental illness discriminate against peers with these problems (48). Thus, for youths, framing mental health problems as *having* a mental illness, rather than *being* mentally ill (49), may have significant long-term implications for recovery (50,51).

More problematic findings, for clinicians, were related to differences in suggestions based on consumer age. More experienced, older consumers suggested that clinicians emphasize abstaining from alcohol and other drugs, of getting the right diagnosis and right medications, and of avoiding isolation, while younger participants did not mention these topics. These vexing issues may be the most difficult for clinicians to address. For example, accepting diagnoses and medications may be seen by young people as accepting a mentally ill identity and lead to social isolation and discrimination. In addition, medication side effects, such as acne and weight gain, may produce psychological distress and medical problems, and reduce willingness to continue taking them as prescribed. For these reasons, and because untreated symptoms can lead to worse long-term outcomes (52), close monitoring of medication use, side effects, and young peoples’ feelings about their medications become even more important (22). Moreover, peer pressure, combined with the need to fit in and not be isolated, may make it much more difficult for young people with mental illnesses to abstain from using substances. An alternative may be groups composed of peers experiencing similar problems who can provide non-stigmatizing, sober, support. Such an approach is consistent with consumer empowerment approaches, particularly if they are designed to empower youths to become more active and more focused on developing their strengths (53).

Limitations

This was an exploratory study, thus should be considered the first step in a research program designed to understand the processes that facilitate treatment engagement for young people. In addition, the STARS study population was drawn from a private not-for-profit health plan and may differ from populations with similar diagnoses obtaining services in public systems. In particular, study participants were more likely to be white, married, have higher education levels, and were more likely to be working than those in public systems (54). Participants were also well enough to take part in the study interviews, and the sample has been characterized as having long-term continuity of care with the same mental health provider and high satisfaction with their care (26). In addition, we have only a proxy for age of onset of mental health problems and thus no corresponding duration of illness. At the same time, most participants had worst year GAF scores indicating significant illness severity, and had experienced care in other systems, including publicly funded mental health care clinics. For these reasons, it is difficult to know whether differences in outcomes in this system, compared to public systems, are a result of the care provided or represent selection into the different systems based on differential illness severity. Thus, the extent of applicability of our findings to other populations with serious mental illness is unknown, and our results should be viewed as exploratory and hypothesis-generating.

CONCLUSIONS

Our findings suggest that clinicians who approach youths with serious mental illnesses using a person-centered, age- and youth-culture sensitive approach may be able to develop stronger, more effective relationships with young people and enhance treatment engagement. Educating youths about medications and the dangers of drugs and alcohol may

also be important aspects of an age-appropriate approach, although it may be difficult to negotiate these territories given the threats to identity and risks of social isolation they may pose.

Acknowledgments

This work was supported by the National Institute of Mental Health's grant R01 MH062321 (Recoveries from Severe Mental Illness). The authors would like to thank Shannon Janoff, MPH for her help with coding interview transcripts and all study participants who gave so generously of their time in telling us their stories.

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Table 1**Baseline Demographic Statistics**

	<i>n</i>	Percent
Education		
Less than high school graduate	173	8%
High school graduate		19
Some college or technical school		39
College graduate		34
Diagnosis		
Schizophrenia or schizoaffective disorder	177	42%
Bipolar disorder		48
Affective psychosis		10
Age first felt "different" from others (proxy for age of onset)		
Always		6%
Grade School	167	25
High School		20
Adult		49
Number of mental health hospitalizations (self-report)		
Never		19%
1–2 times		41
3–4 times	167	20
5–6 times		7
7–9 times		4
10 or more times		10
Worst-year GAF score (rated at baseline, range 10–70)	177	
Mean ± sd	38.8 ± 10.5	
Marital status		
Never married	173	22%
Widowed		8
Divorced		17
Separated		3
Married		45
Living with partner		9
Prior year household income		
<\$10,000	166	10%
\$10–20,000		20
\$20–30,000		16
\$30–40,000		14
\$40–50,000		10
\$50–60,000		9

	<i>n</i>	Percent
\$60–80,000		5
\$80,000+		5
Source of income (all that applied, total > 100%)		
Paid employment	173	48%
Disability		25
Spouse, partner, family		28
Retirement, pension, investments, savings		26
General assistance, Medicaid, TANF		2
Unemployment, alimony, child support		2
Other		13
Primary activity		
Paid employment	173	40%
Volunteer/unpaid work		8
School		5
Treatment/rehabilitation program		2
Craft/leisure/hobbies		15
No structured activity		15
Homemaking		9
Other		7
Had comorbid mental health diagnoses in 12 months prior to study recruitment	177	41%
Had comorbid substance abuse diagnoses in 12 months prior to study entry	177	27%
Colorado Symptoms Inventory Score ¹	173	
Mean ± sd	16.63 ± 10.7	
SF-12 Mental Component Summary Score ²	171	
Mean ± sd	40.80 ± 12.7	

¹Possible scores range from 0 to 56 with higher scores indicating more psychiatric symptoms. Means in a homeless population were 20.8 at baseline and 17.0 at 12 months following treatment (55).

²Possible scores range from 0 to 100 with higher scores indicating better mental health; The U.S. norm for healthy individuals = 52.3 ± 7.9 (56).