



Juvenile Justice & Mental Health

Working Together for the Best Outcomes for Youth With Serious Emotional Disorders

Joyce Burrell



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JUVENILE JUSTICE & MENTAL HEALTH: WORKING TOGETHER FOR THE BEST OUTCOMES FOR YOUTH WITH SERIOUS EMOTIONAL DISORDERS

This guide is intended for family members, non-clinical juvenile justice practitioners, and administrators, as well as other stakeholders in system of care communities who are interested in improving mental health service delivery to all children with serious emotional disorders, including those in the juvenile justice system.

The guide provides an overview of some of the mental health issues facing many of the children and adolescents in the juvenile justice population. It presents how incarceration is used as a frequent response to juvenile crime associated with existing mental health problems among youth. This guide presents information on the prevalence of mental health disorders in the juvenile justice population and information on screening and assessment. Also included throughout the guide are reflective questions to facilitate the use of the information.

As you read through this document, you will come across references to “systems of care.” A system of care is a “comprehensive spectrum of mental health and other necessary services, which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families” (Stroul & Friedman, 1986).

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INTRODUCTION

Identifying and responding to the mental health needs of youth in contact with the juvenile justice system is finally being recognized as a critical issue at the national, state, and local levels (Cocozza & Skowrya, 2000). Increasing numbers of youth entering the juvenile justice system through delinquency arrests and convictions need mental health services during and after their juvenile justice custody. It is estimated that 50% to 75% of youth in detention facilities suffer from mental health problems and are likely, without treatment, to become more vulnerable, volatile, and dangerous to themselves and others. In addition, about half of these youth with mental health problems also suffer from substance abuse disorders.

Historically, juvenile justice systems were not established to deliver mental health care. Traditionally, they emphasized the goals of treatment and rehabilitation of young offenders, while protecting them from punishment, retribution, and stigmatization. However, mounting public pressure to ensure societal protection has challenged the historical underpinnings of the system, resulting in greater legitimacy for community protection through punishment and retribution of young offenders (Tate, Repucci, & Mulvey, 1995). For example, many states are allowing younger juveniles who commit a broader range of offenses to be transferred to adult criminal court, where they usually receive harsher punitive measures. This trend, in conjunction with a greater incidence of mental health disorders, provides daunting challenges for families of youth with mental disorders in the justice system, the youth themselves, and juvenile justice providers and mental health practitioners who must provide appropriate care. Unfortunately, rarely does a single agency or institution have enough resources to resolve all the issues of youth with serious emotional disorders before, during, or after their involvement with the juvenile justice system. Too frequently, youth with serious emotional disturbances have had multiple, uncoordinated interactions with an array of agencies before coming to the attention of the justice system.

Unfortunately, when a child or adolescent becomes involved with the juvenile justice system, all other child-serving systems with the capacity to meet the child's needs withdraw. They assume a "hands-off" approach until the justice involvement ends. As a result, outcome data on youth in the justice system indicate that youth with serious emotional disorders have the highest recidivism rates compared to other youth in the justice system and are often placed in residential settings designed to handle only one of their multiple issues or problems.



These youth present complex issues. When the mental health needs are not addressed in an integrated way, the return on the investment is poor, especially for the children who are often sent away from their homes and communities and for the system and the public that must pay for expensive out-of-home placements (Jones & Harris, 2000). These interventions are not necessarily more effective than home and community-based care. In fact, the recidivism rates for juveniles receiving in-home and community-based interventions are equivalent if not better than those for high-risk juveniles placed in very expensive, restrictive residential programs (Jones, Harris, Fader, Burrell, & Fadeyi, 1999). Clearly, these findings support the case for community treatment interventions and programs.

Mental Health Issues Facing Juvenile Justice Populations

The President's New Freedom Commission Report on Mental Health (2003) states that Americans with mental illness deserve excellent care and emphasizes the importance of working across child-serving systems to meet the needs of youth with mental health problems interfacing with the juvenile justice system. The report states that 50–75% of youth in juvenile detention and correctional facilities have diagnosable, untreated mental disorders (Teplin & McClelland, 1998 and 1999; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). Coccozza and Skowrya (2000) report that at least one out of every five youth in the juvenile justice system has a serious mental health disorder. Rates of mental illness are substantially higher in the juvenile justice system than those detected in the general population (Grisso & Barnum, 2000). Since the de-institutionalization of the mental health system, the reliance on justice systems for the care of the mentally ill has grown (Teplin & McClelland, 1998 and 1999; Northwestern University, 1999; and Teplin et al., 2002).



- Every year, 110,000 children and youth are held in juvenile detention and correctional facilities all over the United States (Murphy, 2003).
- Between 55,000 and 82,500 of those children have diagnosable mental health illnesses that interfere with their daily functioning.
- A large number of juvenile offenders are “sick kids in need of treatment” (Boesky, 2002).

The annual report of the Coalition for Juvenile Justice (2000), titled *Handle With Care: Serving the Mental Health Needs of Young Offenders*, reported that 73% of youth in juvenile facilities reported mental health problems during screening; 57% had previously received treatment; 55% had symptoms associated with clinical depression; 50% had conduct disorders; up to 45% had attention deficit-hyperactivity disorders; and many had multiple diagnoses. At least half of the youth with psychological disorders also experienced a substance abuse disorder.

Human and Financial Costs

Failure to intervene early and effectively treat these youth with mental health disorders results in tremendous human and financial costs. Ironically, effective and evidence-based interventions are available for children and youth involved in the juvenile justice system, but only recently have justice and mental health providers worked collaboratively to begin to identify and treat these youth. Juvenile detention and corrections administrators struggle with under-identification and funding restrictions as they attempt to provide interventions and supports for this rapidly growing population. Untreated, these youth cost juvenile detention center and correctional facilities millions of program dollars in individual supervision and inappropriate programming. Additionally, staff are often not trained to meet the clinical needs of these youth.

According to the Office of Juvenile Justice and Delinquency Prevention, society pays \$1,700,000 to \$2,300,000 annually when one youth leaves school and engages in a life of crime and drug abuse (Juvenile Justice and Delinquency Prevention Act of 2002, Title I, 42 U.S.C. 5601, Section 101, Findings, a.2). The Washington State Institute for Public Policy (2001) conducted a cost-benefit analysis of programs designed to treat and reduce out-of-home placement for youth offenders to determine whether program benefits outweighed costs. The analysis determined that interventions

resulted in significant net taxpayers savings when compared to program costs. For example, the cost of one comprehensive intervention was \$4,743 per participant, resulting in a lifetime net taxpayer savings ranging from \$31,661 to \$131,918.

Implications for System of Care Communities

System of care communities involve families, youth, and all relevant service systems to ensure that children's services are appropriate, culturally competent, and, whenever possible, supported by integrated funding streams. **This type of service delivery promises that when accountability is shared by all the systems, outcomes will be improved through a comprehensive strategy for care coordination.** By sharing costs, systems give more children and families access to scarce behavioral health resources.

System of care communities can be found in many of the jurisdictions in which children and youth are incarcerated. However, the juvenile justice agency may not have a strong relationship with the local system of care. Although federally funded system of care communities develop the infrastructure for changes in service delivery, it is important for them to include juvenile justice youth in their calculations of need and prevalence rates for mental health diagnoses. Unless this occurs, the interventions developed may not adequately address this most vulnerable population of children and adolescents.

Exhibit 1. Intake Diagnostic Information by Referral Source

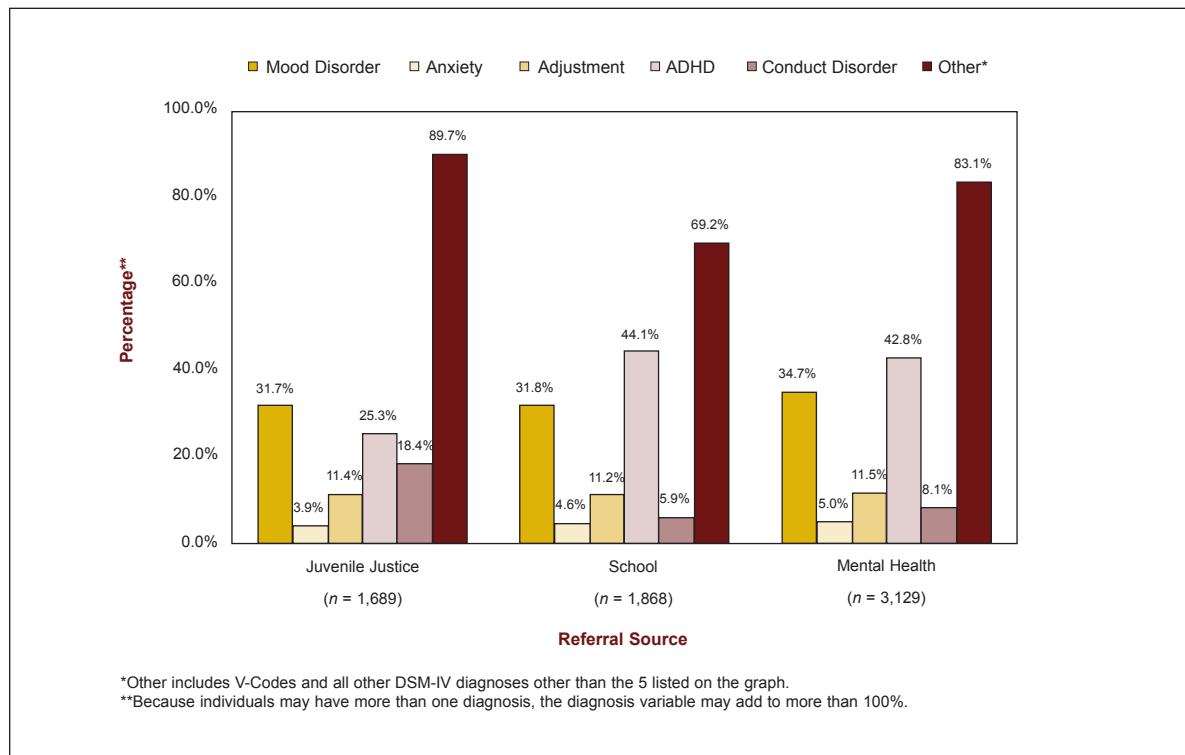
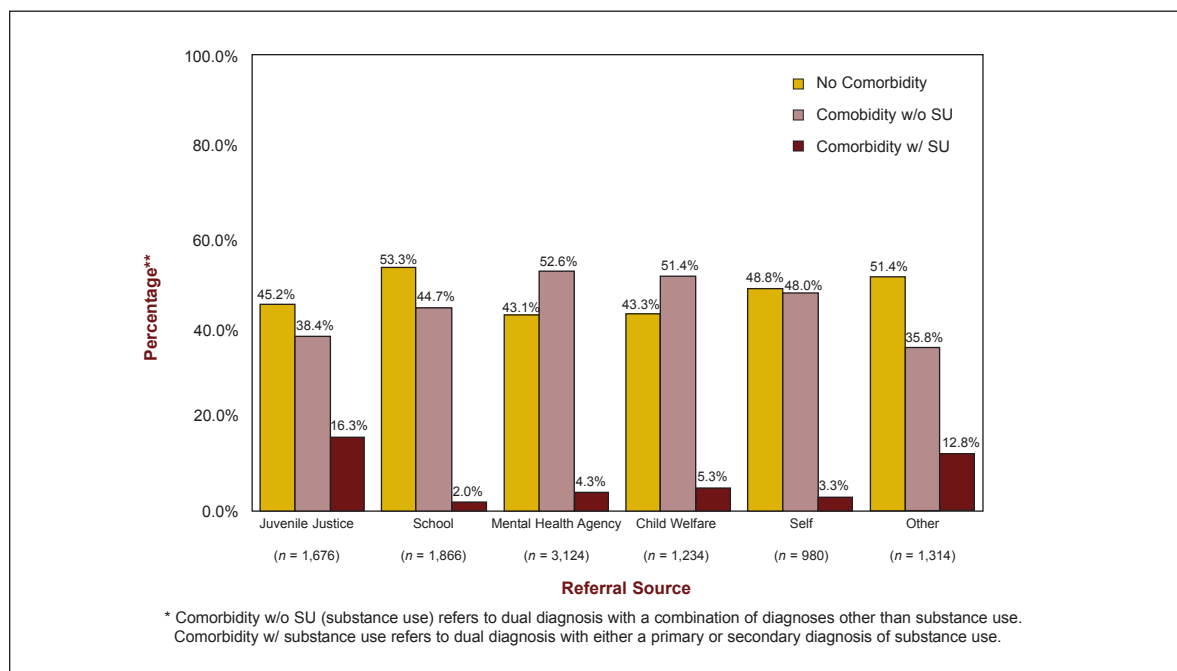


Exhibit 2. Dual Diagnostic by Referral Source



Exhibits 1 and 2 present the enormity of the challenge. The first exhibit shows referrals of youth by diagnosis. The second exhibit shows youth referred who have co-occurring mental health and substance abuse issues. Research indicates that unless these youth receive treatment, the rates of criminal activity will increase.

Rates of Emotional Disorder Among Youth in the Juvenile Justice System

A significant percentage of children and youth in juvenile detention and correctional facilities has diagnosable, untreated mental illnesses. Despite this knowledge, there have been few empirical studies among juvenile detainees and no large-scale investigations (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). It is reasonable to assert that resources to address the needs of this population will not be made available until the true prevalence rate is determined (Wasserman, Ko, & Jensen, 2002). Universal screening and assessment at every point of admission along the juvenile justice continuum could accomplish this. There is increased risk and liability to communities who do not know the “emotional temperature” of the children and youth in the juvenile justice system. Our current level of information makes not screening a youth for emotional needs as indefensible as not providing medication for a physical condition.

A fairly consistent picture is emerging for the mental health challenges of youth in the juvenile justice system. In a literature review, Kendziora and Osher (in press) cite the following studies:

- The Northwestern Juvenile Project (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002) assessed a random, stratified sample of 1,829 youth (1,172 males and 657 females, ages 10–18) who were arrested and detained in Cook County, Illinois (which includes Chicago). Researchers using a structured interview found that nearly two-thirds of males and

Table 1. Rates of Mental Disorder Reported by Teplin et al., 2002

Type of Disorder	Males (<i>n</i> = 1,170) Prevalence	Females (<i>n</i> = 656) Prevalence
Any listed	66.3	73.8
Any except conduct disorder	60.9	70.0
Disruptive behavior	41.4	45.6
ADHD	16.6	16.4
Any affective	18.7	27.6
Any anxiety	21.3	30.8
Psychotic	1.0	1.0
Substance use	50.7	46.8

three-quarters of females met diagnostic criteria for a mental disorder. Followup interviews are being conducted at 3 and 4½ years post-baseline to address questions about ongoing service needs, pathways to treatment, and experiences in treatment.

- A study of Maryland's 15 juvenile facilities found that 53% of youth met diagnostic criteria for a psychiatric disorder and that 26% indicated a need for immediate mental health services. Additionally, two-thirds of those with a mental health diagnosis had more than one mental or substance use diagnosis, a status called comorbidity.
- A study of 185 youth, ages 13–17, from central South Carolina found that prevalence rates of youth who met criteria for at least one diagnosis were 86% for hospitalized youth, 72% for incarcerated youth, and 60% for youth enrolled in a community mental health center. Comorbidity was common, with youth having an average of 2.4 mental disorder diagnoses.
- A study of two secure juvenile facilities in Toronto, Canada, found that 63% of youth had two or more mental disorders, with an additional 22% meeting diagnostic criteria for one mental disorder (Ulzer & Hamilton, 1998).
- Researchers in Georgia administered structured diagnostic interviews to a random sample of youth admitted to the Regional Youth Detention Centers and found that 61% of these youth had mental disorders, including substance abuse disorders, and 44% had two or more diagnoses (Marsteller et al., 1997).
- Using data obtained from site visits to a nationally representative sample of 95 public and private juvenile facilities, Parent et al. (1994) found that 73% of the children reported mental health problems during screening.

From these studies, Kendziora and Osher concluded that the prevalence of mental disorders among youth in juvenile justice facilities ranges from 50% to 75%. Further, they agreed that youth involved with the juvenile justice system frequently had more than one co-occurring mental or substance use disorder, making their diagnosis and treatment needs more complex.

Although numerous studies have been conducted on youth incarcerated in detention centers and correctional facilities, many of the study samples have been too small to be considered valid. It is important to note that of the 2.5 million children and youth arrested in the United States each year, only about 1.6 million are processed formally by the court systems. Of that 1.6 million, 110,000 are held in juvenile facilities annually (Murphy, 2003).

A large number of children and youth are supervised on probation or through other informal supervision agreements in the community. Most will not receive a mental health screening or assessment. Because there is no legal mandate for such screening or assessment, and jurisdictions are so financially strapped, it is not likely that there will be a precedent for that kind of prevention strategy.

However, the positive impact of behavioral health interventions in situations where screening and assessment occurs is known and well documented. There is convincing evidence that outcomes improve for children who receive community-based treatment and mental health treatment along with supervision from the juvenile justice agency (Jones, Harris, Fader, Burrell, & Fadeyi, 1999). These improved outcomes occur in all domains of these children's lives.

Minority Overrepresentation in Juvenile Detention and Correctional Facilities



Minority youth are referred to system of care communities in much smaller percentages than white children. Instead, these youth are most frequently referred to facilities commonly called training schools, camps, and farms rather than to residential treatment centers or community-based treatment programs. Minority youth with disabilities also are over-represented in juvenile detention and correctional facilities (Burrell & Warboys, 2000).

Minority youth are over-represented and receive tougher treatment than white youth at every decision point in the juvenile justice system. This includes arrest; prosecutorial decision to formally charge or not; decision to detain or release pending court appearance; judicial disposition when the determination is made about placement in a correctional facility, treatment facility, or community program; and the decision to transfer or waive for prosecution by an adult court (Building Blocks for Youth, 2001).

Garfinkle and Drakeford (2000) cite research that documents racial bias in judicial decisions to recommend a mental health residential treatment center versus a juvenile corrections facility for African American boys who commit the same crime and who score similarly to white boys on the Child Behavioral Check List. The research also shows that 63% of the boys in juvenile corrections are African American, compared with 34% in mental health facilities. Many states show similar patterns of disproportionate incarceration of minority youth, whereas white youth are referred more often to mental health placements even though their criminal offenses are the same and their scores on mental health assessments are in the same range.

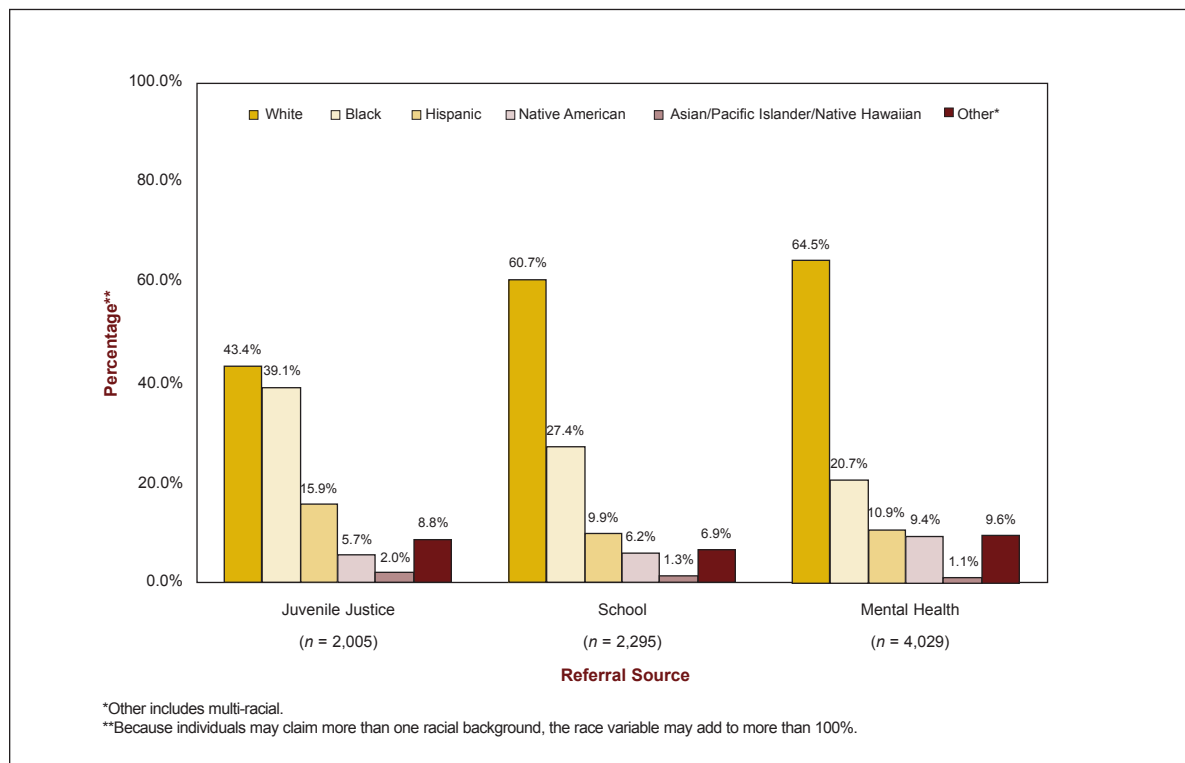
Minority youth do not commit more crimes than nonminority youth. Data show that minority youth commit fewer crimes than their white peers, yet are three times more likely to be incarcerated for

the same offense under the same circumstances as their white peers. Zeidenberg and Schiraldi (1998) reported that white youth ages 12–17 are one-third more likely to have sold drugs than African American youth. In 1998–99, the National Institute on Drug Abuse administered a survey to high school seniors that revealed that white students use cocaine at seven times the rate of African American youth, crack cocaine at eight times the rate, and heroine at seven times the rate of African American youth. Yet, African American youth are three times more likely to be arrested for drug offenses.

The disproportionate percentage of youth with disabilities in juvenile correctional institutions suggests that these youth may be apprehended more frequently because they lack the skills and strategies to avoid detection, avoid apprehension, interact appropriately, and comprehend questions and warnings during police encounters (U.S. Department of Education, 1999). Students with emotional disturbance are 13.3 times more likely to be arrested than those with other disabling conditions (Bullis, Benz, & Benz, 1996).

Minority youth, especially males, are much more likely to be identified as emotionally disturbed because of the prevalence of female teachers who do not understand male behavior (McIntyre & Tong, 1998). Teachers from the majority culture, or who are members of a different class in the minority culture, have greater difficulty understanding minority males. Ellison et al. (2000) suggest that African American students, especially males, display such excitement in their expressions that behaviors can often be interpreted as aggressive, threatening, deviant, or, at the very least, inappropriate.

Exhibit 3. Race by Referral Source



Finally, one of the most detrimental outcomes associated with special education placement is that these students are more likely to be adjudicated into the delinquent system (Osher, Woodruff, & Simms, 2000). **Three to five years after leaving school, more than 50% of students identified as emotionally disturbed have been arrested** (Blackorby & Wagner, 1996).

Exhibits 3 and 4 present data on minority children in the juvenile justice system. The first exhibit presents race by referral source to system of care community services (Burrell, 2004). The second exhibit shows the disproportionate number of minority youth in juvenile corrections. It compares the overall population for youth ages 0–17 to white, non-Hispanic, and minority youth. It also compares the percentage of these populations among youth who are detained juveniles in detention centers waiting for adjudication and disposition and youth from these population groups who are committed and in secure juvenile correction institutions.

Questions to Consider

- What can you do to make sure that family members know the policies regarding youth who have serious emotional disturbances in the juvenile justice system in your jurisdiction?
- Can you access information on the charges of children and youth arrested in your jurisdiction?
- Do you know whether minority children have different outcomes during processing by law enforcement or the prosecutor's office in your jurisdiction?
- Are there any efforts in your jurisdiction to develop and implement plans to address disproportionate minority confinement/contact?
- Are there any special efforts in your jurisdiction to address the need of minority youth with serious emotional disturbances?

Exhibit 4. Disproportionate Minority Youth Confinement Profiles: 1997

Total Population	% White: Non-Hispanic	% Minority
Ages 0–17	66%	34%
Detained Juveniles	38%	62%
Committed and in Secure Juvenile Corrections Institutions	37%	63%

Technical Assistance Partnership for Children's Mental Health

Identifying Mental Health Problems

A focus on the prevalence of mental health and substance abuse problems among youth involved with juvenile justice has resulted in more widespread behavioral health screening within and across states and local communities. The results of these screening initiatives have substantiated the need for assessment and treatment. Although incarcerated youth are typically excluded from Medicaid-funded services, administrators have found other resources to support their treatment (Grisso & Barnum, 2000). Increasingly, many administrators and line staff are recognizing that these are not simply “bad children,” but instead are youth who have emotional problems that need to be addressed.

In many states, the advocacy for and availability of screening and assessment tools have brought a shift in practice. For example, in early 2003, an interview with staff at the National Youth Screening and Assessment Program found that the Massachusetts Youth Screening Instrument, Version 2 (MAYSI 2), was being used in more than 25 states and 8 foreign countries. In comparison, 2 years earlier, fewer than 10 states were using a screening tool. Many who work in juvenile justice were fearful of the implied risk that accompanied the increasing identification of mental health needs among youth in juvenile justice facilities. However, building the capacity to assess and treat became the mandate as more municipalities began to screen for emotional trauma and disorders in a population that had been overlooked and untreated and a strain on the system.



Question to Consider

- Are screening and assessment available to all children who have contact with the juvenile justice system at the following decision points?
 - At the police station or processing center at the time they are arrested
 - When the decision is being made whether to charge them, detain them, or release them
 - Before the initial detention hearing
 - At the time of admission to a detention center
 - Prior to the adjudication hearing
 - Prior to going to a juvenile corrections or residential treatment facility

Screening Tools

Understanding a child’s or adolescent’s emotional status when developing a treatment plan is as important as knowing his or her physical condition and education level. Treatment outcomes and placement decisions are enhanced when decision-makers have access to comprehensive information (Trupin & Boesky, 1999). Screening instruments are intended to identify potential mental health problems and assist others in making objective referrals to clinicians, as well as identifying children and youth who may need closer supervision by staff while they are in facilities. For example, without these processes, judges may continue to order one-on-one supervision (a much more costly alternative to assessment and appropriate treatment) in their efforts to protect those who they think are the most vulnerable children.

Some screening tools currently being used in the juvenile justice system include:

- **Children’s Depression Inventory—Self Report.** This measure screens for suicide and mental health issues (Kovacs, 1981).
- **Massachusetts Youth Screening Instrument 2 (MAYSI-2)—Self Report.** This measure screens for emotional and mental health issues, and substance use and abuse needs.
- **Voice Version of the Diagnostic Interview Schedule for Children (V-DISC)—Computer Administered.** This structured interview is designed to identify the presence of psychiatric disorders.
- **Problem Oriented Screening Instrument for Teenagers (POSIT).** This 20–25 minute, self-administered screening questionnaire is designed to identify potential problem areas that require further in-depth assessment. POSIT was designed to identify problems and potential treatment or service needs in 10 areas, including substance abuse, mental and physical health, and social relations. The POSIT followup questionnaire was derived from items on POSIT to screen for potential change in 7 out of the 10 problem areas represented on POSIT.

<http://www.nida.nih.gov/ICAW/ICAWTeen1.html> or
<http://silk.nih.gov/silk/niaaa1/publication/insposit.htm>

More than 25 states are currently using the MAYSI-2 to screen for the “emotional temperature” of a child or youth transitioning to different parts of the juvenile justice system. As a screening tool, the MAYSI-2 is intended only to identify those children who could benefit from a clinical interview to determine whether a diagnostic assessment is appropriate (Grisso & Barnum, 2000). When it is determined that a diagnostic assessment is necessary, many juvenile justice and mental health



professionals become extremely concerned because they know that most systems lack the capacity to meet the identified needs. Until the true prevalence of the behavioral health issues and disorders is determined in this population, availability of and access to resources will continue to be fragmented and insufficient. The MAYSI-2 and V-DISC are free to jurisdictions and offer hope that we can begin to identify critical issues that prevent youth from developing their full potential across all life domains.

Assessment Process

Once a child or a youth has been screened and the results reviewed, clinicians can refer those they determine appropriate for a more extensive assessment. These assessments identify strengths as well symptoms and disorders. Some of the commonly used assessments include (Grisso & Underwood, 2003):

- Child Behavior Checklist (CBCL)
- Child and Adolescent Functional Assessment Scale (CAFAS)

- Diagnostic Interview Schedule for Children (DISC)
- Milan Adolescent Clinical Survey
- Adolescent Substance Abuse Subtle Screening Instrument (Adolescent SASSI)
- Suicide Probability Scale (SPS)
- Beck Depression Inventory Childhood Depression Inventory
- Behavioral Events Rating Scale

This list of screening and assessment tools is not intended to be exhaustive or to suggest that these are the best tools but to provide a list of some frequently used tools.

Questions to Consider

- What screening tools are being used when children or youth are arrested in your jurisdiction?
- What assessment tools are available to clinicians who determine that screened children need further assessment?

Treatment

An increasing number of demonstrably effective interventions exist for treating mental disorders among youth in contact with the juvenile justice system. Several of these treatment options are described below. Clinical interventions are described first, followed by collaborative models of care.



Medications. According to Dr. Gayle Porter, Senior Mental Health Advisor for the Technical Assistance Partnership, medication can be an appropriate intervention, depending on the youth's symptoms and the parents' acceptance of medication. This question is of particular importance to adolescents who have reached an age when they can decide whether they want to take medications. Adolescence is a very difficult time for all teens, and it is much harder if the teen's perception is that everyone thinks the he or she is "crazy."

Cognitive-Behavioral Therapy. Cognitive-behavioral therapy includes various strategies to help people change negative or inappropriate thoughts and behaviors into more rational and productive ones. This type of therapy is usually short-term (i.e., 50 minutes a week for 10 to 20 weeks), structured, and goal-oriented. The symptoms and the diagnosis determine the particular cognitive and behavioral techniques that are most appropriate for each youth. These interventions may include such tactics as thought-stopping, role-play, systematic desensitization, visualization, anger management, deep breathing and assertiveness, self-control, and relaxation trainings (Hagopian & Ollendick, 1997).

Interpersonal Therapy. Interpersonal therapy focuses on improving current significant relationships (with family members, friends, supervisors, teachers, etc.) and can help youth and adults work through issues related to grief, role disputes, and transitions and interpersonal deficits.

Treatment can last 4 to 6 months. Sessions usually occur once a week for 50 minutes. A major focus of this treatment is improving current relationships through role-playing and assertiveness and relaxation training. Interpersonal therapy is regarded as an effective treatment for adolescent girls and women because of the great significance they often place on relationships. Studies have documented personal relationships as a greater source of stress for females.



Multisystemic Therapy (MST). Multisystemic therapy is a home and community-based intervention developed for adolescents. It addresses their conduct-related mental health needs by intervening in all the systems, institutions, and groups that affect the youth. These may include family, school, after-school programs, church, peer group, and community. MST often includes family therapy, structured family therapy, behavioral parent training, and other cognitive behavioral interventions. MST usually consists of about 60 hours of direct service over a 4-month period (Henggler, 1998; Henggler, Schoenwald, Borduin, Rowland, & Cunningham, 2000).

Functional Family Therapy. Functional family therapy is a home and community-based intervention designed for 11- to 19-year-old youth who have disruptive behavior disorders, conduct disorder, oppositional defiant disorder, and delinquency. The intent of the intervention is to reduce risk factors and enhance protective factors. The intervention usually consists of 12 to 26 hours of direct service over 3 months (Alexander & Parsons, 1982).

In addition to these clinical interventions, there has been increasing focus on promising collaborative models.

Wraparound Milwaukee. This program provides comprehensive psychiatric services to children and adolescents, many of whom are involved with juvenile justice. It sustains itself by pooling funds with its system partners and utilizing an integrated, multiservice, outcome-focused approach build on a vast array of community-based providers and a mobile crisis team.

Mobile Mental Health Teams. This is a collaboration between the New York State Office of Mental Health and the Office of Children and Family Services designed to enhance the provision of onsite mental health services to youth in the state's juvenile correctional facilities.

PINS Diversion Program. This is a probation-based diversion program for status offenders that offers comprehensive assessment and treatment services to referred youth and their families.

Mental health professionals are at a premium in juvenile justice settings and often have many restrictions on who they can see and for how long. For example, a psychiatrist in one system of care community, who also works in the secure juvenile corrections program in her state, is concerned that she is not permitted to spend more than 30 minutes with any child in that setting. She gives much of her own time to compensate for that shortcoming and is seeking ways to get appropriate services for children in secure juvenile correctional settings. Current legislation pending before Congress supports funding to train more mental health professionals to serve children and adolescents in the settings where they spend the majority of their time. This training will enable workers to address the critical need for more assessment and treatment of troubled youth. They will be trained to deliver effective, evidence-based interventions identified from the literature and research.

Questions to Consider

- Are there any effective, evidence-based interventions, whether medical or nonmedical, that might work for my child, who is involved with juvenile justice?
- Do any effective, evidence-based psychosocial interventions work for children and youth with the same diagnosis as my child?
- What are some of those interventions?
- How long will it be before we can expect to see improvement in his or her behavior?
- What kind of supervision and support will youth need from their parents during and after therapy?
- What are the advantages and disadvantages?

What Parents Need to Know if Their Child With a Mental Health Problem Is Arrested

First and foremost, as a family member, you should know that you are not alone. Each year in the United States, 2.5 million youth are arrested, and more than half (55–75%) of those youth have at least one diagnosable mental health disorder. However, it is important to keep in mind that the behavioral health needs of youth in the juvenile justice system are not as well understood by probation officers, judges, or other officials making decisions as they are by the families of the youth involved. Input from families is critical, starting at the earliest point when decisions are made—at the local police station. This information must be available to judges and magistrates as they decide about the appropriateness of detaining a child or adolescent. For those youth who have had prior mental health treatments, the therapist can also be a reliable source of information.

Judges are committed in their desire for improved outcomes for children, including reduced problems at home, improvement in school, and reduced law-enforcement contact. They pay close attention to the research findings regarding the outcomes from community placement or treatment compared with the outcomes for youth transitioning from expensive out-of-home residential placements. Many judges are engaged in problem-solving courts, where specialized and ongoing training is provided to support better outcomes for youth who are often caught in what they describe as “the revolving door.” It is troubling to judges how often critical information about mental health issues that could come from a pediatrician, educators, family members, or friends is left out of the information-gathering process for these hearings.



Because parents are the best informed adults on the child’s team, it is critical that they attend every court proceeding and provide the attorney representing the child or adolescent with information about the youth’s mental health so it can be included in reports and plans. President Bush’s *New Freedom Commission Report on Mental Health* recommends that parents lead the treatment planning process. The family and all relevant providers (e.g., probation officer, clinical team) must develop a partnership that will ensure an appropriate and comprehensive treatment plan and sustained progress for the youth.

In a system of care community, staff members may provide cross-system training for probation staff. This means that probation staff experience training alongside mental health professionals. Many of the probation personnel usually have a law enforcement orientation and background and find it difficult to understand various mental health disorders and interventions. To improve their understanding, these staff members may shadow mental health professionals in their jobs. Such training can help a probation officer understand the impact of mental health disorders on the youth's ability to comply with his or her probation plan. The probation officer who knows which interventions are available and appropriate is much better equipped to make appropriate recommendations to the court. The probation or parole officer is an invaluable member of the child and family team and is a critical link to integrating and sustaining effective and needed services for court-involved youth.

It is important for parents to understand the key decision-making points in the juvenile justice system. Parents and other community leaders can be more effective if they know when critical decisions are made. Exhibit 5 shows how a case flows through the justice system.

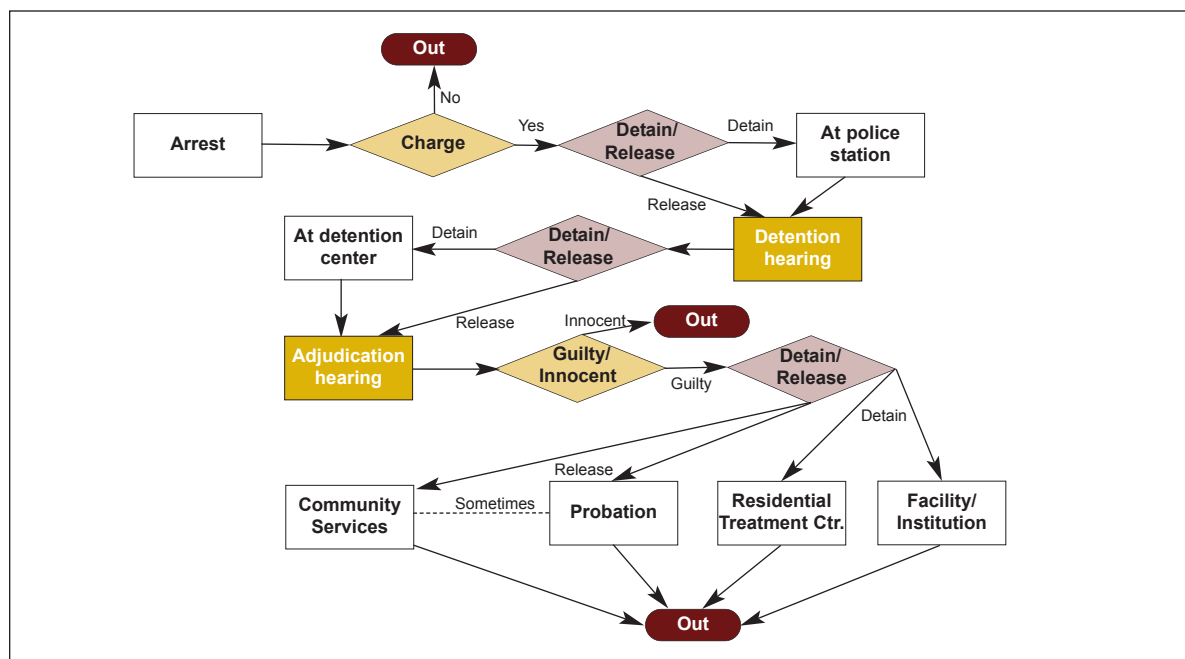
Question to Consider

- Can you match the names of the individuals and offices in your jurisdiction to the decision points in exhibit 5? Doing so can make this graphic representation more useful because it will reflect your local juvenile justice system.

The Importance of High-Quality Legal Representation

The role of the defense attorney in a juvenile justice proceeding is very important. It is reasonable to expect the defense attorney representing a youth with a serious emotional disturbance to know something about the disability and how to best work with the youth being represented. It is also

Exhibit 5. How a Case Moves Through the Juvenile Justice System



important for the lawyer to know something about child and adolescent development to recommend appropriate sanctions. One of the attorney's primary responsibilities is to advocate for what is best for his or her client: your child.

The American Bar Association's Model Rules of Professional Responsibility say that the role of the attorney includes determining whether the youth

- is competent to stand trial;
- has the capacity to understand what is going on throughout the court proceedings;
- has the ability to make decisions about his or her future; and
- can express a reasoned preference and defend it if questioned.

Another role of the defense attorney is to abide by the wishes of the client (the youth alleged to have committed a delinquent act), as long as what the client wants is legal. This charge assumes that the client knows and can express what he or she wants. The juvenile justice system, like the adult criminal justice system, is adversarial in nature. Therefore, the attorney representing a youth with serious emotional disturbances needs special skills to do the best job possible.

Any defense attorney who undertakes representing an alleged delinquent with special needs, especially youth who have severe emotional disturbances, must understand the signs and symptoms of the presenting mental illness. That attorney must also know how to effectively engage the child or adolescent so that he or she can have the best possible legal outcome, along with appropriate access to interventions within the least restrictive setting. Since the level of mental functioning and the presence of disabilities can affect what happens at every decision point in juvenile justice processing, it is critical that the youth's counsel be well informed by family members, well trained, and skilled at putting on the best defense possible for the youth. The better the training of the legal counsel representing the child or youth, the more likely counsel will be able to rely on assistance from the client as he or she represents the client in court. If nothing else, the attorney should be familiar with and use the checklist in Rosado's curriculum for attorneys representing children and youth with mental health problems (Rosado, 2002). Another curriculum available to train attorneys representing youth with mental health disorders is Navigating Behavioral Health (Juvenile Law Center, August 2004).

In system of care communities, a defense attorney who represents alleged delinquents (or already adjudicated delinquents) with serious emotional disturbances can usually bring the voice of legal advocates to the discussion of how to approach the needs of the child or adolescent. Having the lawyer's involvement gives other members of the team an opportunity to understand the mandates under which attorneys operate. These lawyers can often shed light on other work they are doing with stakeholders such as judges, educators, and other school personnel, as well as probation practitioners. Defense lawyers can be the bridge to improve the connection between mental health and juvenile court. For the youth's counsel, participation in the work of the system of care community also increases the awareness of and access to resources and other advocates. Although bar associations and professional organizations have made tremendous strides in improving training under continuing legal education, many members of the public and indigent defense bar do not have time, funds, or inclination to seek access to the training because they cannot afford the time away from their caseloads.

Questions to Consider

- What questions should you ask of any attorney assigned to represent your child?
- What should you do if the attorney says she or he represents your child and not you as the parent also?
- What resources can you suggest to an attorney who is assigned to your child?

Avoiding Custody Relinquishment

For many parents, the issue of custody relinquishment looms very large. This is especially true when their child has mental health needs that they do not have the means or resources to address. If the need for treatment cannot be addressed because their insurance coverage is exhausted or other resources are unavailable, another plan must be developed.

There are numerous stories of families who have taken second mortgages on their homes and sold personal valuables to ensure continuity of treatment for their child with a serious emotional disturbance. Although many of the children in juvenile justice are temporary wards of the state and will return to their families eventually, a small percentage are at risk of being placed outside their homes to continue or access treatment. The Adoption and Safe Families Act (ASFA), which requires a permanent placement for a child within 15 months of being placed outside the home, has had a profound impact on how business is conducted in the juvenile justice system. ASFA affects youth in the juvenile justice system and their families in the same way it does children in the child welfare system. It requires that the family to which the child is returning meet safety, well-being, and accountability standards. Parents of delinquents did not have this added risk of losing custody of their child prior to 2000.



With the closing of many mental health programs and institutions, juvenile justice agencies have become the “mental health placements of last resort” since the late 1980s. This has resulted in an increasing number of children and youth with mental health histories having no choice except to enter juvenile justice agencies for treatment. When the juvenile justice placement ends, these youth usually return to their communities, and their families are left to determine how to continue treatment. When private insurance coverage is exhausted, a few states provide support to fill the gaps. In some states, Medicaid may be an option. It is critical that families understand their state Medicaid plan, and if there are gaps in coverage, find out why state officials are not implementing solutions.

Individuals who are residents of correctional facilities (whether adults over age 21 or youth) cannot utilize health insurance, including Medicaid, State Children’s Health Insurance Program (SCHIP), and, in general, private health insurance. In the case of Medicaid and SCHIP, the Federal Match, known as Federal Financial Participation (FFP), is not available to state Medicaid agencies, and thus Medicaid and SCHIP coverage is not available during the period of incarceration. However, when youth are discharged, they may be eligible for Medicaid or SCHIP and should be discharged ideally with a Medicaid or SCHIP card. State Medicaid and SCHIP programs vary greatly in who is

covered and have flexibility as to the services that are provided. However, states are mandated to cover certain individuals and provide certain services (including mental health services) that are generally more comprehensive and extensive than private insurance. Medicaid coverage is mandatory if the youth is eligible for Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI). A number of youth who are being discharged from correctional facilities may be eligible for SSI because of a disabling mental health condition. Both TANF and SSI may enable access to mental health coverage through Medicaid. Youth who are not eligible for Medicaid because their family's income exceeds the eligibility standards may be eligible for SCHIP. It is important for families and staff of correctional facilities to acquaint themselves with Medicaid and SCHIP programs.



An additional option that states can offer is TEFRA, the Medicaid option that allows the state to cover home and community-based services for children with disabilities living at home with their families. The family should tell the social services or Medicaid agency that they are applying for TEFRA (often referred to as the Katie Beckett Act). If the child meets all eligibility criteria for TEFRA, the child receives a Medicaid card and is viewed as a family of one for the purpose of medical treatment. The biggest advantage to knowing about this option is that the child can qualify without regard to family income (Koyanagi & Gilberti, 2002).

Out-of-home placement is a temporary intervention for children and youth in the juvenile justice system. If the services provided through the temporary placement cannot be met in the home, the family may think that they have to relinquish custody in order to continue the level of care the youth needs. Although some states honor voluntary placements for youth in juvenile justice who need treatment, it is often time-limited. In many states, the limit is 180 days. If the level of care needed requires out-of-home treatment for more than 180 days, the family must go back to court. The court can decide on continued placement through the issuance of a waiver to the permanency requirement, or the court must take another action. Whether custody relinquishment is considered depends on the state and the court of that jurisdiction. In making its decision, the court will also take into account whether any other provisions are available to support the level of care the child or adolescent needs.

Public policy alternatives exist that can assist families with the difficult choice of giving up custody to the state or seeing their child go without needed care. The federal government gives states several ways for these families to access services through the federal-state Medicaid program, but to date most states have failed to utilize them. Examples include programs like the TEFRA option, also known to some as the Katie Beckett option, of the Medicaid law, which allows states to cover home and community-based services for children with disabilities living at home. Eligibility is based on the child's disability and care needs, not on his or her family's income. This is a huge finding for juvenile justice because many children are placed in institutions for treatment because their family could not afford or access appropriate community-based treatment. In some cases their personal resources had run out and the parents felt the only option was to place the youth with the juvenile court. There is also the home and community-based waiver option under section 1915(c) of the federal Medicaid law. Neither of these options is a quick fix and both require coordination and collaboration with the state and regional Medicaid authorities.

Questions to Consider

- If your child is returning from residential placement and your insurance does not pay for community treatment because your benefits are exhausted, do you know your rights?
- Do you know how to access other resources?
- Is the provision under TEFRA that makes your child a “family of one,” and therefore able to access or continue medical treatment for a specific period of time while living with his or her family, a possible resource for your child?
- Is the option available in your state?
- Is this a policy issue you can advocate for with your system of care community?

Making the 8th and 14th Amendments Work for These Youth

Due process and the right to be free from cruel and unusual punishment are guaranteed constitutional rights for everyone, including youth in the juvenile justice system. If the judge or the probation officer preparing the report do not have information that identifies a youth’s mental health needs, then the court cannot be held responsible for providing appropriate services. If the court had this information and knew that locking up a child in a secure detention or correctional facility could worsen the youth’s mental health condition, the judge or probation officer would have to develop a plan to place that youth in a setting appropriate to address both the behavioral health needs and the criminal justice matter. Lack of capacity in facilities and treatment services is a major concern of judges and has recently become a concern for some probation officers.

Widespread training on the needs of children with serious emotional disturbance with multi-agency involvement and how to use existing constitutional protections to ensure access to more appropriate services has resulted in better-informed clients, law enforcement, courts, and juvenile personnel. Steinberg and Kaufman’s (2000) research on a youth’s competency to stand trial provides insight into major problems with the way decisions are made about the placement of youth. Arrendondo (2001; 2003), of the Children’s Center at the National Council of Juvenile and Family Court Judges, describes the developmental needs of children and youth in the juvenile justice system and highlights the two constitutional protections of due process and freedom from cruel and unusual punishment. The development of the first juvenile mental health court in Santa Clara County, California, grew out of concern that the courts not violate the rights of youth.

The juvenile justice system must have knowledgeable attorneys to ensure that the least restrictive, therapeutic community-based interventions are provided for their clients under the 8th and 14th Amendments.

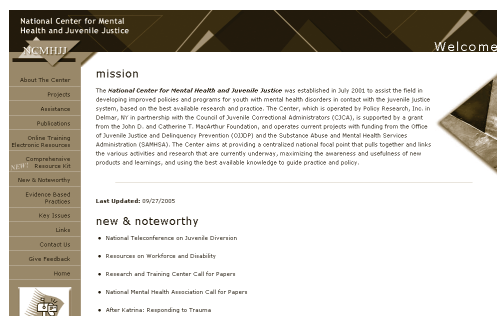
Questions to Consider

- Do local attorneys consider 8th Amendment rights when they are representing youth with serious emotional disorders or children who have not been diagnosed?
- How is the 14th Amendment applied in a juvenile matter in your jurisdiction?

Engaging the Advocates

Many advocacy organizations have published position papers and briefs and have made public pronouncements regarding the mental health needs of children and adolescents in the juvenile justice system. Their research and well-crafted position papers can provide significant ammunition to build the case for treatment and community-based interventions for youth with serious emotional disturbance. Here are some of the advocacy organizations that can provide this information:

- The National Association of State Mental Health Project Director's Policy
- Federation of Families for Child and Family Mental Health (www.ffcmh.com)
- National Mental Health Association Initiatives that Support Improved Mental Health Delivery Systems for Delinquent Youth
- National Center for Mental Health and Juvenile Justice (www.ncmhjj.com)
- The National Association for the Mentally Ill (NAMI)
- The Council of Juvenile Correctional Administrators' Best Practices Committee (www.cjca.net)
- The National Juvenile Detention Association (www.njdasis.com)
- Center for the Promotion of Mental Health in Juvenile Justice (www.promotementalhealth.org)



www.ncmhjj.com



www.promotementalhealth.org

CONCLUSIONS

Youth in the juvenile justice system who have mental health challenges have often been overlooked and unfairly treated by multiple child-serving agencies. This guide has addressed some of the topics and issues relevant to understanding the system, program, and clinical needs of these youth and their families. Some of the emerging issues include:

- A large number of youth who come in contact with the juvenile justice system require mental health treatment.
- There is a growing recognition of these needs and the lack of services and supports to address mental health problems in juvenile justice.
- Yet a set of clear clinical and comprehensive community interventions are emerging.

And some of the pressing future strategies include addressing:

- The lack of funding for treatment and the absence of community awareness of the prevalence of mental health disorders in the juvenile justice population, as these are major barriers to the development and implementation of treatment models
- The insurance issues related to reimbursable treatment in juvenile justice
- That professionals in the juvenile justice system have not been trained to identify, refer, or treatment mental health difficulties
- The tensions between treatment and punishment in justice systems
- The need to provide culturally competent, accessible, and effective treatments to youth to address the disproportionate representation of culturally, racially, and ethnically diverse youth with mental health disorders in the juvenile justice system
- The need for communities to develop an infrastructure that is family and child driven, that ensures that families, youth, providers, and other stakeholders are aware of existing resources and models of intervention

This guide has addressed the challenging and growing crisis for mental health and juvenile justice. By highlighting key issues and posing targeted questions, this guide will hopefully encourage stakeholders to ask the hard questions and do the “right thing” for these most vulnerable children and youth.

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