Chapter Eight

Collaboration and Services within the Juvenile Justice Population

Expediting Access: A Collaboration of Juvenile Justice, Mental Health and Child Welfare

Richard Hlavacek
Marlyse Benson

Introduction

Union County, New Jersey, has developed a comprehensive system of care incorporating a service approach based on wraparound principles. Components include a Care Management Organization, a Family Support Organization, a Mobile Crisis Team and Youth Case Management services. All services are linked through a statewide database. Two years ago these agencies joined with groups from the juvenile justice system to reduce the number of children in county detention centers and to move children with behavioral problems out of the juvenile justice system into appropriate mental health programs.

The detention center in Union County, New Jersey has been plagued with overcrowding for years. Total admissions reached 782 in 2002, the sixth highest in the state. Recently, the suicide of a teenager and other violence at the site led to extremely negative press coverage and the re-organization of administrative staff at the center. At the same time, New Jersey was facing a Federal takeover of its troubled child welfare system. An independent Child Advocate was appointed who promptly charged that the state was abusing the rights of adjudicated children with mental health problems by keeping them in detention while awaiting placement. In response, Union County created a workgroup called the Union County Juvenile Expediting Team (UJET), which was charged with moving youth out of the detention center to community based probation, residential treatment settings, if indicated, or to commitment in state juvenile justice facilities.

This paper illustrates the outcomes that were achieved by the creation of the UJET to reduce enrollment in the detention center, shorten the length of stay in the detention center, eliminate conditions that led to violence among the youth, and increase access to the mental health system for children with behavioral health needs. Additional outcomes achieved by UJET included improved inter-agency understanding of the various child-serving systems, identification of better treatment alternatives for children and recommended referrals that were more appropriate to the needs of the child in the detention center.

Method

At the time of this writing, UJET has been operational for approximately 24 months. The first year involved the development of a reporting tool to capture the needed information, organizational changes including the hiring of a social worker to manage the system and training of the system partners in a better understanding of the function and mission of each group. During this two year period approximately 1,500 children were admitted to the detention center. The process became fully functional in the second year.

Union County began the project by hiring a consultant who was a senior administrator with extensive state government experience in residential treatment, child welfare and juvenile justice. Her task was to spearhead a work group which had been assembled by the county. She created a model that encourages the participation of various stakeholders in the county, tracks the progress of the decisions that were being made regarding disposition of cases and holds the group accountable for children that fall into their legal and professional area of responsibility. The group also provides feedback to the family court judges who ultimately make the final determination on the cases coming before them. In addition to local interest in improving a troubled juvenile justice system, the reform of the child welfare system and the increased scrutiny of the Child Advocate's office, which had legal standing to sue the state or counties, made the deliberations and the outcomes very public.

Work group participants included members of the newly developed behavioral health care system which was heavily biased toward community based alternatives using a wraparound model and

strength based family orientation. Members included the Executive Director of the Care Management Organization, the Director of the hospital based Mobile Crisis Team and Youth Case Management system, and representatives of the newly formed behavioral health office of the state. Other participants included a court based representative of the child welfare system, the manager and social workers from the detention center, state juvenile justice representatives, probation offices and liaisons from the offices of the family court judges. On occasion, visitors included staff from the state juvenile justice commission, the county judges, mental health providers, prosecutors, defense attorneys and others. The UJET also became a forum for education and advocacy for a wide range of high-level state officials. Other visitors included the Commissioner of the Department of Human Services, staff from the Child Advocate's Office and senior planners from the state Juvenile Justice Commission.

Data were collected for each child in detention on a two-sided form. At each meeting the facilitator distributed a packet of these forms which contained profiles of the youth with an emphasis on his or her psychosocial and criminal justice history. The group reviewed each form and discussed issues that determine sentencing, including previous crimes, special education history, mental health history and family issues.

The UJET process includes a rapid review of the children in the detention center where population varied from an average daily census of 54 in 2003 to 39 as of September 2005. Poorer families in the county and minorities were consistently overrepresented in the population in detention. Union County is about 20% African American and 20% Hispanic. The population in the detention center was 68% African American, 10% Caucasian and 21%Hispanic. In detention, boys outnumbered girls six to one (New Jersey Dept. of Law and Public Safety, 2004).

Cases are reviewed at a weekly meeting and the group then recommends interventions that include a wide range of options. These include, but are not limited to, the following:

- Residential treatment for conduct or behavioral disorders
- Specialized treatment within the juvenile justice system such as residential programs that include drug counseling
- Court ordered county-based day program with a strong counseling component
- Electronic bracelet with a range of collateral requirements including probation and counseling
- Intensive case management through the Care Management Organization including extensive wraparound services such as in home counseling and family team meetings
- Less intensive Youth Case Management which also included service delivery based on wraparound principles

Recommendations of UJET then go to the family court judge a through the newly hired court liaison specialist who also plays a role in monitoring requests for service such as psychological testing and tracking additional charges or legal problems in the case. The weekly meeting, which lasts about two hours, also includes sharing information about system development and has served as a forum to discuss gaps in service and realignment of existing services.

Findings

For this analysis, the Daily Population Report for UJET form was collected and reviewed, individual client summaries were assessed and state reports from the Juvenile Justice Commission were used to give comparative data. All of the children in the sample were detained in the Union County detention center from 2003 to 2005, during which period the UJET became fully functional. Outcomes indicate the changes in the number of children in detention, changes in the average length of stay in detention and the current disposition or placement of the cases. The current population of the detention center ($N = 36$) includes 13 special education students (36%) and 9 (25%) who self-reported a history of mental health treatment.

The outcome of this effort has been the creation of a process that moves children out of detention in an effective and expeditious manner, a reduction in the number of youth in the detention center, closer collaboration with the judges and detention staff when planning for discharge, and more appropriate care for children with behavioral health issues. Challenges include differing views regarding safety and risk among system partners, families that resist engagement in the mental health system and mental health providers that are apprehensive about this population.

The outcomes after two years of UJET includes the following:

- The average daily census in the detention center was 52 in 2003 and is 40.5 for the first nine months of 2005, a reduction of 23% from 2003, when the project began.
- Family Court judges routinely use the UJET recommendations in their deliberations.
- A significant number of children are being referred to alternatives to detention including case management program where extensive wraparound services are being employed for high-risk families. One of the current detainees is enrolled in the Care Management Organization and five are enrolled in the less intensive Youth Case Management service.
- Juvenile justice staff in various facilities have additional options for treatment and are more likely to partner with mental health professionals. Juvenile justice professionals still tend to favor their own residential facilities (many also provide counseling) as an alternative to incarceration even for youth with special education or a history of mental health problems.
- Support from state officials for continuation of the process. Several counties have adopted this model and expanded it with foundation funding.
- Increased access to less restrictive juvenile justice facilities where political pressure has succeeded in relaxing admission standards for children with mental health histories or those on medication.

Conclusion

The development of a system of care with a strong wraparound component can have an impact on other child oriented systems including juvenile justice. By providing a wider range of options for children and input on an administrative level in the decision making process, a mature system of care can reduce transfers of children with mental health and conduct issues into the juvenile justice system. In addition the collaboration of professionals on a local level can improve understanding of the needs of children in the juvenile justice system, potentially reduce recidivism and create a forum to advocate for programs to fill in gaps in service.

The census of the detention center has been reduced through these efforts; those youth who remain tend to have more extensive criminal justice profiles, including some youth whose behavior is viewed as an extreme safety risk to the community (e.g., homicide, manslaughter).

A review of the experience of the UJET for the past two years also reveals that some issues remain that are significant impediments to accessing treatment. These are often based on differing governmental mandates and philosophies of care and treatment.

Community safety is a key factor when a judge decides to release a child into an unlocked facility or return them to their home. These decisions are often influenced by media attention or other events that create a conservative backlash. Recent situations regarding severe abuse or even death to children in the child welfare system have caused caseworkers and others to propose more restrictive environments if the family appears to be unstable or has a history of non-compliance. Families and youth sometimes prefer the less stigmatizing experience of the justice system to that of mental health.

Families may also resist engagement in the mental health system for a variety of reasons. Clinical services are generally based on the voluntary commitment of clients of families to a process of counseling. Some caretakers, due to their own mental illness, addiction problems or resistance to treatment, may be

unwilling to commit to treatment. Sometimes there is an interest and even motivation to participate, but a long history of failed efforts, missed appointments or unrealistic expectations cause professionals to be skeptical about plans that rely too heavily upon voluntary participation in programs.

Reference

New Jersey Department of Law and Public Safety (October 5, 2004). *Statistics on juvenile in detention*, Tables II, VII.

CONTRIBUTING AUTHORS

Marlyse Benson, R.N.
Director, Behavioral Health, Trinitas Hospital, 655 East Jersey Street, Elizabeth, New Jersey 07206, 908-994-7634, email: mbenson@trinitas.org

Richard Hlavacek, M.S.
Families and Community Together, 3 Monroe Street, Union, New Jersey, 07083,

Symposium

A Multi-State Study of Mental Health Prevalence and Services for Justice Involved Youth: Findings and Implications

Chair and Discussant
Joseph J. Cocozza

Authors
Kathleen Skowyra et al.
Joseph Cocozza et al.
Jennie Shufelt et al.
Trina Osher

Symposium Introduction

Joseph J. Cocozza

Over the past five years, there have been significant steps forward in mental health prevalence research among youth in the juvenile justice system. Despite this, significant questions remain about the generalizability of these results. To answer these questions, a multi-state prevalence study was undertaken by the National Center for Mental Health and Juvenile Justice, through support from the Office of Juvenile Justice and Delinquency Prevention and the Center for Mental Health Services. This study also sought to determine the services provided to these youth and the views of family members regarding their children's needs and treatment. This symposium presented the results of this study and discussed the implications of these results.

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) Multi-State Study: Background, Research Design, and Sample Characteristics

Kathleen Skowyra, Joseph J. Cocozza, & Jennie L. Shufelt

Introduction

National, state, and local policy makers and practitioners are increasingly recognizing the importance of identifying and responding to the needs of youth with mental health disorders in contact with the juvenile justice system (Cocozza & Skowyra, 2000). The increased awareness is the result of a number of factors. First, there has been growing recognition of the mental health needs of youth in general. The Surgeon General's report, *National Action Agenda for Children's Mental Health* (Office of the Surgeon General, 2001), notes that many children with mental health problems end up in the juvenile justice system due to the lack of identification of disorders, prevention, and treatment in the community. Second, recent studies have documented the higher rates of mental disorders among youth in the juvenile justice system. Studies estimate that anywhere from 65% to 100% of youth in the juvenile justice system have diagnosable mental disorders (Otto, Greenstein, Johnson, & Friedman 1992; Teplin, Abraham, McClelland, Dulcan & Mericle, 2002; Virginia Policy Design Team, 1994; Wierson, Forehand and Frame, 1992).

In addition, a recent series of US Department of Justice (2005) investigations into the conditions of confinement in juvenile detention and correctional facilities repeatedly found inadequate access to treatment, inappropriate use of medications, and neglect of suicide attempts in juvenile justice facilities across the country. There is also growing concern on the part of both the juvenile justice and mental health systems over the "criminalization of mental illness." Despite the documented lack of mental health treatment available in many juvenile justice facilities, placement of youth in the juvenile justice system with the hope of obtaining treatment that is unavailable in the community continues. In a recent survey of parents, 36% reported intentionally involving their child in the juvenile justice system in order to access mental health services otherwise inaccessible to them in the community (National Alliance for the Mentally Ill, 2001).

Recently, there have been significant advances in the knowledge base with respect to the mental health needs of youth in contact with the juvenile justice system. Despite this, research on the prevalence and types of mental health disorders among these youth has been scarce, and methodological issues have limited those that have been conducted. Specifically, many of the existing studies focus on populations in large urban centers, leaving many regions of the country understudied. Additionally, many of the existing studies have focused exclusively on youth either within one facility or at one discrete point within the juvenile justice continuum.

In response to the gaps in the knowledge base, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the Center for Mental Health Services provided support to the National Center for Mental Health and Juvenile Justice, within Policy Research Associates in Delmar, New York, to undertake a comprehensive study of the prevalence of mental health problems among youth involved with the juvenile justice system. This study attempted to overcome many of the limitations of prior studies by collecting data on a large number of youth from several understudied regions of the country and, within each region, across multiple levels of care.

Methods

Data on 1,437 currently housed or newly admitted male and female youth, ages 11-18 years, from 29 juvenile justice facilities distributed across three states (Louisiana, Texas and Washington) and three different types of residential placements (community-based programs, juvenile detention centers, and secure juvenile correctional facilities) were collected. All participating youth were administered the Youth Interview. The Youth Interview consisted of: (a) a General Questionnaire for Youth, which included questions about the youth's stay in the facility and living arrangements before coming to the facility; (b) The Massachusetts Youth Screening Instrument – Second Version (MAYSI-2; Grisso & Barnum, 2000); and (c) a Services Questionnaire for Youth (SQY), a newly developed self report services questionnaire.

A 50% subsample of youth whose MAYSI-2 score met the study threshold severity (defined as either two or more cautions on any scale, or one or more warnings on any scale) were identified to take the Diagnostic Interview Schedule for Children – Voice Version IV (Voice DISC-IV; Shaffer, et al, 1996; Shaffer, Fisher, Lucas, Dulcan & Schwab-Stone, 2000). The Voice DISC-IV is a highly structured contingency-based interview designed to assess over 30 psychiatric diagnoses commonly seen in children and adolescents.

Data collection was initiated in May 2003 and ended in April 2004. Efforts were made to oversample for girls and certain ethnic minorities including Hispanic and Native American youth. A total of 1,437 MAYSI-2 interviews and 640 Voice DISC-IV interviews were completed. Data were weighted back to the facility populations at the state level. Estimated rates of disorders were calculated for the full sample based on their MAYSI-2 threshold level.

Finally, in order to supplement and enhance the information collected through the prevalence component of this study, focus groups of parents of justice-involved youth with mental health needs were conducted in each of the three states that participated in the prevalence study. The goal of these focus groups was to obtain the family's views of their children's mental health needs, the adequacy of the services they received, and recommendations for how the juvenile justice system can improve services to these youth.

Conclusion

This research endeavor represents the first ever attempt to collect information on the mental health issues of youth from several regions of the country and, simultaneously, across multiple levels of care. The results of this study fills critical gaps in the knowledge base and will help the juvenile justice system get a better handle on the extent of the problem and better allocate resources. Findings are presented in Cocozza, this symposium summary.

References

Cocozza, J. J., & Skowyra, K. (2000). Youth with mental health disorders in the juvenile justice system: Issues and emerging responses. *Juvenile Justice*, Volume VII, Number 1. Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Grisso, T. & Barnum, R. (2000). *Massachusetts Youth Screening Instrument-Second Version: Users manual and technical report*. Worcester, MA: University of Massachusetts Medical School.

National Alliance for the Mentally Ill. (2001). *Families on the brink: The impact of ignoring children with serious mental illness*. Arlington, VA: National Alliance for the Mentally Ill.

Office of the Surgeon General. (2001). *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington, DC: Department of Health and Human Services.

Otto, R. K., Greenstein, J. J., Johnson, M. K., & Friedman, R. M. (1992). Prevalence of mental health disorders among youth in the juvenile justice system. In J. J. Cocozza (Ed.) *Responding to the mental health needs of youth in the juvenile justice system* (pp. 7-48). Seattle, WA: The National Coalition for the Mentally Ill in the Justice System.

Shaffer, D., Fisher, P., Dulcan, M., Davies, M., Piacentini, J., Schwab-Stone, M., Lahey, B., Bourdin, K., Jensen, P., Bird, H., Canino, G., & Reiger, D. (1996). The NIMH Diagnostic Interview Schedule for Children (DISC-2.3): Description, acceptability, prevalence and performance in the MECA study. *Journal of the American Academy of Child and Adolescent Psychiatry, 59*, 865-877.

Shaffer, D., Fisher, P., Lucas, C., Dulcan, M., Schwab-Stone, M. (2000). Diagnostic Interview Schedule for Children Version IV (NIMH DISC-IV): Description, differences from previous versions, and reliability of some common diagnoses. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*, 28-38.

Teplin, L., Abram, K., McClelland, G., Dulcan, M., Mericle, A. (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry, 59*(12).

United States Department of Justice. (2005). *Department of Justice activities under the civil rights of institutionalized persons act: Fiscal year 2004*. Washington, DC: United States Department of Justice.

Virginia Policy Design Team. (1994). *Mental health needs of youth in Virginia's juvenile detention center*. Richmond, VA: Author.

Wierson, M., Forehand, R. L., & Frame, C. L. (1992). Epidemiology and the treatment of mental health problems in juvenile delinquents. *Advances in Behavior Residential Theory, 14*, 93-120.

Prevalence of Mental Disorders among Youth in the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Multi-State Study

Joseph J. Cocozza, Jennie L. Shufelt, & Kathleen Skowyra

Introduction

Past research that has attempted to determine the exact prevalence of mental health disorders among youth in the juvenile justice system has produced wide variations in prevalence rates. A 1992 comprehensive review of the literature attributed this variation to inconsistent definitions, use of unstandardized and inconsistent measures, and problematic study designs (Otto, Greenstein, Johnson, & Fredman, 1992). Recent research has utilized newly developed standardized screening and assessment instruments, thereby overcoming some of these limitations. However, several issues remain. These studies often draw their sample from one region of the country or from one level of care within the juvenile justice system. Several regions of the country have remained unstudied. The primary goals of this study were to overcome these limitations and comprehensively examine the prevalence of mental health and substance use disorders among youth involved with the juvenile justice system.

Method

Psychiatric diagnoses were identified among a sample of 1,437 male and female justice-involved youth, 11-18 years, from 29 juvenile justice facilities in three states (Louisiana, Texas, and Washington). Within each state, youth were sampled from three types of facilities (secure-correctional, detention, community-based). Females, Hispanics, and Native Americans were oversampled to ensure adequate representation of these subpopulations.

All participating youth were administered the Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2; Grisso & Barnum, 2000) as part of an initial youth interview. Upon completion, the research interviewer examined the participant's MAYSI-2 scores to determine whether the youth met criteria for the second, more-detailed diagnostic interview, the Diagnostic Interview Schedule for Children-Voice Version IV (Voice DISC-IV; Shaffer, et al, 1996; Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000). A random sample of 50% of all youth eligible for the Voice DISC-IV were selected for participation (n = 721). Completed Voice DISC-IV results were obtained for 640 youth. Data were weighted back to the facility populations at the state level. Rates of psychiatric disorders for the 640 youth with a completed Voice DISC-IV were used to estimate prevalence rates for the entire sample.

Findings

Estimated prevalence rates for individual mental health disorders are presented in Table 1, both overall and by gender. A total of 70.4% of the sample met criteria for at least one mental health diagnosis. Some variation was found in terms of type of placement. Mental health disorders were most common among youth in secure correctional facilities (76.4%), followed by detention centers (66.4%) and community-based placements (60.0%). While some state differences were also found, this variation was largely due to differences in the characteristics of the youth in the state samples. Consistent with previous research, disruptive disorders were most prevalent (46.5%), followed by substance use disorders (46.2%), anxiety disorders (34.4%), and mood disorders (18.3%). The prevalence of mental disorder was higher for girls (81.0%) than for boys (66.8%). Girls exhibited especially high rates of internalizing disorders such as anxiety and mood disorders.

Many youth in the sample met criteria for multiple disorders. More than half (55.6%) of youth met criteria for two or more mental health diagnoses, and approximately 33% of males and 49% of females had co-occurring mental health and substance use disorders. Furthermore, a significant proportion of youth in the sample (27%) had a mental illness serious enough to require immediate and significant treatment.

Table 1
Prevalence of Mental Health Disorder, Overall and Stratified by Gender

	Overall %	*Males* %	*Females* %
Any Disorder	70.4	66.8	81.0***
Any Anxiety Disorder	34.4	26.4	56.0***
Agoraphobia	13.5	10.2	22.6***
Generalized Anxiety	6.8	5.3	10.8***
Obsessive-Compulsive	11.1	8.5	18.4***
Panic	6.4	4.9	10.4***
Posttraumatic Stress	8.7	5.5	17.4***
Social Phobia	9.7	7.4	16.0***
Specific Phobia	12.8	9.0	23.1***
Any Mood Disorder	18.3	14.3	29.2***
Manic Episode	3.6	2.6	6.1**
Hypomanic Episode	2.2	1.9	2.8
Major Depression	15.5	11.8	25.4***
Dysthymic	.5	.5	.5
Any Disruptive Disorder	46.5	44.9	51.3*
ADHD	6.6	6.7	6.6
Conduct Disorder	42.4	40.7	47.6*
Oppositional Defiant Disorder	17.4	15.7	22.1**
Any Substance Use Disorder	46.2	43.2	55.1***
Alcohol Abuse	14.4	12.2	20.7***
Alcohol Dependence	16.0	15.5	17.4
Marijuana Abuse	10.5	9.9	12.2
Marijuana Dependence	26.6	24.5	32.5**
Other Substance Abuse	7.3	6.9	8.5
Other Substance Dependence	18.9	15.9	27.8***

*$p < .05$ **$p < .01$ ***$p < .001$

Conclusion

This study was able to overcome the limitations of prior research by sampling a large number of youth from three levels of care and multiple regions of the country. What is clear from the results of this study is that large numbers of youth in the juvenile justice system have mental disorders. Approximately 70% of youth in this study met criteria for at least one mental disorder. This is consistent with previous studies utilizing the Diagnostic Interview Schedule for Children (DISC), which have found rates of disorder between 65% and 70% among youth in residential juvenile justice placement (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002).

Furthermore, it is clear that many of these youth have significant and complex treatment needs. Approximately 27% of the sample met criteria for a severe disorder. In addition, more than half of the sample had multiple disorders. The presence of multiple disorders makes proper identification and treatment more difficult, particularly for the juvenile justice system, which is not equipped for addressing their complex needs.

The results of this study also confirm the finding of previous studies that mental illnesses are more prevalent among justice-involved girls than boys. Approximately 80% of girls in this study met criteria for at least one mental health diagnosis, compared to 67% of boys. In particular, girls were more susceptible to internalizing disorders.

References

Grisso, T. & Barnum, R. (2000). *Massachusetts Youth Screening Instrument-Second Version: Users manual and technical report*. Worcester, MA: University of Massachusetts Medical School.

Otto, R. K., Greenstein, J. J., Johnson, M. K., & Friedman, R. M. (1992). Prevalence of mental health disorders among youth in the juvenile justice system. In J. J. Cocozza (Ed), *Responding to the mental health needs of youth in the juvenile justice system* (pp. 7-48). Seattle, WA: The National Coalition for the Mentally Ill in the Justice System.

Shaffer, D., Fisher, P., Dulcan, M., Davies, M., Piacentini, J., Schwab-Stone, M., Lahey, B., Bourdin, K., Jensen, P., Bird, H., Canino, G., & Reiger, D. (1996). The NIMH Diagnostic Interview Schedule for Children (DISC-2.3): Description, acceptability, prevalence and performance in the MECA study. *Journal of the American Academy of Child and Adolescent Psychiatry, 59*, 865-877.

Shaffer, D., Fisher, P., Lucas, C., Dulcan, M., Schwab-Stone, M. (2000). Diagnostic Interview Schedule for Children Version IV (NIMH DISC-IV): Description, differences from previous versions, and reliability of some common diagnoses. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*, 28-38.

Teplin, L., Abram, K., McClelland, G., Dulcan, M., & Mericle, A. (2002). Psychiatric disorders in youth in juvenile detention. *Archive of General Psychiatry, 59*(12), 1133-1143.

Wasserman, G., McReynolds, L., Lucas, C., Fisher, P., & Santos, L. (2002). The Voice DISC-IV with incarcerated male youths: Prevalence of disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*, 314-321.

Past and Current Service Utilization among Youth in the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Multi-State Study

Jennie L. Shufelt, & Joseph J. Cocozza

Introduction

The recognition that there are large numbers of youth with mental health disorders involved in the juvenile justice system has resulted in heightened awareness of the need to identify those youth requiring immediate attention and to provide appropriate services (Cocozza & Skowyra, 2000). Evidence suggests that, for the most part, the juvenile justice system does not adequately respond to the mental health needs of these youth. A recent series of US Department of Justice investigations into the conditions of confinement in juvenile detention and correctional facilities documented inadequate access to treatment, inappropriate use of medications, and neglect of suicide attempts in juvenile justice facilities across the country (US Department of Justice, 2005).

This presentation discussed the findings from the service utilization component of the OJJDP Multi-State Study. Data were obtained on the extent to which youth with mental health issues report receiving a variety of services during their current placement. In addition, logistic regression was used to identify factors related to the provision of mental health services within the juvenile justice system.

Method

Through support from the OJJDP and the Center for Mental Health Services, the National Center for Mental Health and Juvenile Justice, within Policy Research Associates in Delmar, New York, undertook a comprehensive study of the prevalence of mental health problems among youth involved with the juvenile justice system. As part of the study, information on mental health services provided to youth in the study was collected. Services information was collected from three sources: a survey of the facilities that participated in the prevalence study, a self-report services questionnaire, and a record review.

Findings

The majority of facilities reported providing an array of mental health services to youth in their care. The most common services that the facilities reported providing were medications (94.7%) and screening (89.5%). Significantly fewer facilities reported providing more intensive services such as residential care (36.8%) and hospitalization (47.4%).

In contrast, the results of the record review suggest that while most facilities report providing services, a significant proportion of youth in need do not receive mental health services. For example, while almost 80% of facilities surveyed indicated that they provide emergency mental health services, only 10% of youth with a severe mental disorder had received those services. Similarly, while almost 95% of facilities said that they provide medications to youth in their care, only 44% of youth with a severe mental illness had received medications.

Logistic regression analysis was used to identify predictors of receiving mental health services, using the self-report services data obtained during the Youth Interview (see Skowyra, this symposium). This analysis was limited to those youth who took the Voice DISC-IV and those youth who did not score a caution or warning on the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2; Grisso & Barnum, 2000) (i.e., assumed to have no diagnosis). The results of the logistic regression analysis are shown in Table 1. As expected, youth with severe mental illness were over two times more likely than youth with no disorder to receive mental health services. However, other factors unrelated to a youth's mental health status also predicted service provision. Specifically, Non-Hispanic Caucasian youth were more likely ($OR = 2.01$, $p < .001$) than their Hispanic counterparts to receive services (no differences were found between Hispanic and Non-Hispanic African American youth), and youth in Louisiana were 3.6 times more likely ($p < .001$) to receive services than youth in Washington (no differences were found between youth in Washington and Texas).

Table 1
Results of Logistic Regression—
Predictors of Current Mental Health Services (SR)

Mental Health Status (ref: None)	*OR*
Mild Mental Health Disorder	1.68*
Severe Mental Health Disorder	2.38**
Substance Use Disorder	1.02
Race/Ethnicity (ref: Hispanic)	
Non-Hispanic Caucasian	2.01**
Non-Hispanic African American	0.994
Female Gender	0.915
Age (ref: 11-13 years)	
14-15 years	0.929
16-18 years	0.689
State (ref: Washington)	
Louisiana	3.55***
Texas	1.18
Facility Type (ref: Detention)	
Secure	5.29***
Community-Based	2.26**
Most Serious Charge is Violent	1.56
Length of Stay (days)	1.002**

*$p < .05$ **$p < .01$ ***$p < .001$

Conclusion

The results of this study raise significant concerns about the extent to which the juvenile justice system is providing these youth with the treatment they need. A significant proportion of youth with a severe disorder were not receiving services. Furthermore, although there is some indication that the presence of severe mental illness plays a role in determining service allocation, other factors unrelated to a youth's mental health status, including race, geographic region, and type of facility emerged as predictors of service provision.

References

Cocozza, J. J., & Skowyra, K. (2000). Youth with mental health disorders in the juvenile justice system: Issues and emerging responses. *Juvenile Justice*, Volume VII, Number 1. Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Grisso, T. & Barnum, R. (2000). *Massachusetts Youth Screening Instrument-Second Version: Users manual and technical report*. Worcester, MA: University of Massachusetts Medical School.

United States Department of Justice. (2005). *Department of Justice activities under the civil rights of institutionalized persons act: Fiscal year 2004*. Washington, DC: United States Department of Justice.

The Family Perspective: Results of the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Multi-State Study Family Focus Groups

Trina Osher

Introduction

Increasingly, the importance of developing interventions for youth with mental health needs involved in the juvenile justice system that address the social context of youth development, including the family, is being recognized (MacKinnon-Lewis, C., Kaufman, M., & Frabutt, J., 2002). Families represent a valuable resource for the juvenile justice system. They can contribute background information and insight into their child's condition, provide support and assurance to their child, and play a vital role in carrying out transition plans (Osher & Hunt, 2002). Unfortunately, parents often find themselves isolated and confused by the complexities of the juvenile justice process and, as a result, this vital resource is often overlooked and underutilized.

Given the importance of the family perspective to the juvenile justice system's ability to appropriately respond to the needs of this population, an additional component of the OJJDP Multi-State Study involved conducting family focus groups. The goal of these focus groups, convened by the Federation of Families for Children's Mental Health, was to obtain the family's views of their children's mental health needs, the adequacy of the services they received, and to solicit recommendations for how the juvenile justice system can improve services to youth with mental health needs. The results enhance the information obtained through the OJJDP Multi-State Study.

Method

Focus groups of parents of justice-involved youth with mental health needs were conducted in each of the three study sites (Louisiana, Texas, and Washington). The target population for the focus groups consisted of family members of children with mental health disorders currently or previously involved with the juvenile justice system in the three sites. A total of 31 parents or caregivers of justice-involved youth participated. Consistency between the focus groups was maintained through the use of a discussion guide, predetermined focus group questions, and facilitation of the group by two or three members of the research staff. Each focus group lasted approximately three hours.

Findings

Beneficial Services

Parents repeatedly said that the availability of a support system was extremely helpful. They spoke frequently about the complexity of the juvenile justice system and the difficulties this imposed on parents. Many participants felt confused and frustrated as they tried to understand what was happening to their child. As several members pointed out, there is no time when the juvenile justice system explains the juvenile justice process or parental rights and options. The failure of the system to offer this support made navigation and understanding of the process almost impossible for the focus group participants. Some parents also reported satisfaction with wraparound services provided to their child.

Barriers

A resounding theme of the focus groups was disappointment over the failure of the juvenile justice system to involve families. Many parents reported feeling blamed or looked down upon by the juvenile justice system, as if they were responsible for their child's behavior. Most parents reported that they had tirelessly tried to get their child help prior to juvenile justice system involvement. The failure of their efforts was typically attributed to inadequate community mental health resources, and not to a lack of effort on their part. As a result, the negative reception of parents by the juvenile justice system, often the system of last resort, was extremely frustrating.

Many parents also indicated that the incredible burden placed on families is magnified by the lack of collaboration and communication between the mental health, juvenile justice, and school systems. Parents revealed that treatment and medications were often interrupted during transitions between systems. They attributed this disconnect to the failure of any one agency to take responsibility for the treatment of youth with mental health needs. This forces parents to take responsibility for their child's care. In an environment that views parents as part of the problem and that isolates and ignores parents, such a task can be overwhelming and discouraging.

When asked about the quality of mental health services, most parents in the focus groups felt that the quality was poor. This was primarily attributed to inadequately trained providers and high turnover in the facilities. Parents also expressed their frustration with the "one-size-fits-all" approach to treatment typical in the juvenile justice system. Such an approach was not only viewed by parents as ineffective, but as time consuming and costly.

The majority of parents in the focus groups felt that their children did not receive adequate treatment for mental health issues while involved with the juvenile justice system. A number of parents actually reported involving their child in the juvenile justice system with the hope that they would finally be able to access services that were unavailable to them in the community. Therefore, the failure of such services to materialize was very troublesome.

Parents consistently brought up the inadequacy of screening for mental health and substance abuse issues at entry into the juvenile justice system. According to these parents, youth are not screened until they are already immersed in the system. Furthermore, once a mental health issue was identified, most parents thought that the juvenile justice system focused on addressing the behavioral manifestation of the mental illness in a punitive way instead of addressing the underlying mental illness in a therapeutic way.

According to some of the focus group participants, the juvenile justice system did not create or implement any transition plan for their children. Other parents reported that although their child was given a transition plan, the plan was unrealistic. This was attributed to the failure of the system to involve parents in transition planning. However, despite the lack of parental involvement in transition planning, the system expected parents to carry out the plan once the youth had been released. This typically involved coordinating and arranging services, providing transportation, supervision of their child, and other expectations nearly impossible for a parent to carry out.

Conclusion

The participants in the three focus groups had several recommendations for improving the delivery and effectiveness of mental health and substance abuse services within the juvenile justice system. Many of their recommendations focused on increasing family involvement. In particular, participants felt that providers and administrators should be encouraged to look at families as a potential resource. Most of them felt that families are perceived as part of the problem, resulting in reluctance by providers to involve them in the care of their child.

Parents in these focus groups also advocated strongly for the implementation of family support mechanisms. These sources of support were sometimes formal (support groups, advocacy organizations), but often consisted of informal conversations with parents in similar situations. Specific support mechanisms mentioned by parents include the provision of information on parental rights, the juvenile justice process, and available options; formal support groups; and facilitation of good relationships between parents and probation officers.

References

MacKinnon-Lewis, C., Kaufman, M., Frabutt, J. (2002). Juvenile justice and mental health: Youth and families in the middle. *Aggression and Violent Behavior, 7*, 353-363.

Osher, T., Hunt, P. (2002). *Research and program brief: Involving families of youth who are in contact with the juvenile justice system*. Delmar, NY: National Center for Mental Health and Juvenile Justice.

Symposium Conclusion

Joseph J. Cocozza

This research endeavor represents the first ever attempt to collect information on the mental health issues of juvenile justice-involved youth from several regions of the country and, simultaneously, across multiple levels of care. The availability of this information represents a significant step forward for the field. Equipped with a better understanding of the prevalence and types of disorders and service needs, the ability of the juvenile justice system to plan effectively and utilize resources more efficiently is significantly enhanced. This, in turn, can improve the response of the juvenile justice system to the mental health needs of the youth in its care.

CONTRIBUTING AUTHORS

Joseph J. Cocozza, Ph.D.
Director, National Center for Mental Health and Juvenile Justice, Policy Research Associates, Inc., 345 Delaware Avenue, Delmar, NY 12054, 518-439-7415, fax: 518-439-7612, email: jcocozza@prainc.com

Trina Osher, M.A.
Federation of Families for Children's Mental Health, 1021 Prince Street, Alexandria, VA 22314, 301-434-4071, fax: 703-836-1040, email: tosher@ffcmh.org

Jennie L. Shufelt, M.S.
Division Manager, National Center for Mental Health and Juvenile Justice, Policy Research Associates, Inc., 345 Delaware Avenue, Delmar, NY 12054, 518-439-7415, fax: 518-439-7612, email: jshufelt@prainc.com

Kathleen Skowyra
Senior Consultant, National Center for Mental Health and Juvenile Justice, 333 Rector Place, Apt. 7F, New York, NY 10280, 212-945-4049, email: kathyskowyra@ncy.rr.com

Juvenile Justice and Mental Health in Rural and Urban Tennessee

Michael D. Pullmann
Craig Anne Heflinger
Carolyn S. Breda

Introduction

Youth living in rural areas have comparable rates of mental health problems to youth in suburban and urban areas, but the availability and quality of behavioral health care in rural areas may be more limited (Fox, Merwin, & Blank, 1995). Estimates of the rates of youth with mental health problems in the juvenile justice system are high. The rate of youth in the juvenile justice system who qualify as having a *serious* mental health disorder is estimated at 20% (Cocozza & Skowyra, 2000; Goldstrom, Jaiquan, Henderson, Male, & Mandersheid, 2000), which is double the estimated rate in the general youth population (Friedman, Katz-Leavy, Mandersheid, & Sondheimer, 1996).

Advocates are apprehensive as to whether the system is prepared to address the needs of the young people being served. A recent study of juvenile offenders referred to any of the 98 courts in Tennessee (Breda, 2001) found that about 7% are referred either to mental health or substance abuse services by the court. This rate of treatment referral is substantially lower than even conservative estimates of service need (Otto, Greenstein, Johnson, & Friedman, 1992). This suggests the juvenile court system is missing an opportunity to respond to the service needs of youth. This may be even more of a problem for rural youth, given the lack of available services. However, there is a lack of research available on the juvenile justice system in rural areas. The purpose of this study is to compare rural and urban counties in Tennessee on their need for mental health service through juvenile justice facilities and juvenile courts.

Method

Data Sources

This is a secondary analysis of two datasets. The first was from a survey of juvenile justice facilities in Tennessee between October and December of 2003 (Tennessee, 2004). Sixteen questions were asked about identifying and providing services to youth with mental health and substance use problems. Additionally, a "one-day census" asked facilities to report on all of the youth in their facility during a high-census day of their choosing. Forty (91%) of the forty-four juvenile justice facilities in Tennessee responded to this survey. A report from this survey is currently available (Tennessee, 2004). The second dataset was created from survey results addressing Tennessee juvenile court judges' beliefs about mental health services (Breda, 2001). Seventy-three of the ninety-eight juvenile courts in Tennessee responded to this survey.

There are four research questions for the current study. First, what are the differences between juvenile holding facilities located in rural or urban counties in screening, referral, and provision of services? Second, do the youth served in juvenile holding facilities located in rural or urban counties differ in respect to demographics, mental health need, and substance use need? Third, what are the differences between rural and urban juvenile court judges' reports on the adequacy and quality of mental health services in their county, and on their beliefs related to mental health? Finally, how do the findings from the juvenile court judges differ when using different definitions of rural?

Definition of Rural

Compounding the lack of rural mental health research is the lack of consensus on an operational definition of rural. This study used five different definitions in order to compare the findings (all definitions are available at http://www.ers.usda.gov/Briefing/Rurality/). First, a categorical measure from the Office of Management and Budget defines *nonmetropolitan* (rural) as all counties that were not metropolitan (urban). Metropolitan is defined as an area that has at least one central county with either a place with a minimum population of 50,000, or a census bureau defined urbanized area and a

total metropolitan area population of at least 100,000. Second, the Economic Research Service (ERS) *Rural-Urban Continuum Code* classifies counties into nine increasingly rural categories by urbanization and nearness to a metropolitan area. Third, the ERS *Urban Influence Code* classifies counties into ten increasingly rural areas by adjacency to metropolitan counties and the size of the largest urban settlement within the county. Fourth, counties are classified as "percent rural" by the US Census Bureau, which included areas that had a population density of less than 500 people per square mile as rural. The fifth and last definition was a simple continuous measure of persons per square mile in the county.

Juvenile Justice Facilities

The analysis of juvenile facilities focuses on Juvenile Detention Centers (JDCs) and Temporary Holding Resources (THRs), two of several different types of facilities in Tennessee used to hold pre-adjudicated delinquent youth. All eighteen of the JDCs and eight of the nine THRs responded to the statewide survey; these represent 26 of the 40 juvenile facilities that responded. The number of youth detained in JDCs and THRs was 396, with 82% being male and 54% African-American. Four percent of the youth were identified as Hispanic or Asian-American. The average age was 15.6 years.

Results

The first research question sought to uncover the differences between rural and urban holding facilities in screening, referral, and provision of services, and the second research question examined differences between rural and urban youth served in those facilities. Table 1 answers the first two questions using the survey of JDCs and THRs, with findings based on the first definition of rural (OMB, nonmetropolitan). There were significant differences in the race of the detained youth. In rural areas, the youth were approximately one fourth African-American, while in urban areas this increased to 77%. This difference generally reflects the differences in population in these regions, however, it demonstrates a disproportionately high rate of minority youth confinement in both settings. Youth in rural settings were significantly more likely to be reported as having mental health problems ($\chi^2(1) = 7.6$, $p = .006$), more likely to have a mental health diagnosis ($\chi^2(1) = 10.8$, $p < .001$), and more likely to be on a suicide watch ($\chi^2(1) = 12.9$, $p < .001$). There were no differences between youth in the rates of receiving mental health services in the facility, or receiving mental health medications while in facility. Facility resources for identifying and treating behavioral health issues were also examined. The JDC facilities' activities in screening and referral for mental health and substance abuse were not related to rurality.

The third research question explored the differences between rural and urban juvenile court judges' reports on the adequacy and quality of mental health services in their county, and in the judge's beliefs related to mental health. The fourth research question examined how the findings from the juvenile court judges differ when using different definitions of rural. Table 2 presents the findings for questions three and four from the survey of juvenile court judges. In all tests that were significant (see Table 2), judges in urban counties rated the item higher (i.e. they rated with more agreement, as more important, of higher quality, or of higher adequacy) than judges in rural counties. Rural judges tended to report significantly less contact with mental health providers, significantly less adequate mental health services, and significantly lower quality mental health services. This was especially true for the adequacy and quality of outpatient mental health services. There were few differences in reports on inpatient residential treatment centers or community mental health centers.

Rural judges were no more or less likely to think delinquency was related to youths' emotional disturbance, to believe that the court should take mental health factors into account in making dispositions, or to think that a psychiatric evaluation was important prior to making a disposition. In three of the five definitions of rurality, urban judges were significantly more likely to think that mental health services can rehabilitate offenders with mental health needs, and this approached significance in the other two definitions.

The variables *persons per square mile* and *percent rural* were each significantly related to eight of the variables completed by the judges. The *Rural-Urban Continuum Code* was significantly related to three of the variables completed by the judges.

Table 1
Descriptive Information on Juvenile Demographics, Mental Health Services, and Mental Health Training in Juvenile Facilities

	JDC-Urban (n = 5)	*JDC-Rural (n = 13)*	*THR-Rural* (n = 8)*
Demographics			
Number of youth	209	163	24
Youth is male (%)	83	80	71
Youth race (%)			
African American	77	26	13
Hispanic	2	2	0
White	20	70	88
Youth average age	15.5	15.7	16.3
Youth MH problems			
Youth has MH probs—staff ID (%)	8	19	-
MH medication (%)	4	10	-
MH diagnosis (%)	2	7	-
MH service received in facility (%)	18	17	-
Youth on suicide watch (%)	0	4	-
Any of the above (%)	24	29	-
Services and training in facilities			
Information collected at intake (%)			
MH problems	60	69	38
Past MH services	100	100	100
Current MH services	60	69	38
Services offered in facilities (%)			
Crisis intervention	20	31	13
MH counseling	20	8	0
Staff training in the facilities (%)			
Mental health	80	77	75
Psychiatric medication	60	69	50

* The THRs did not identify any of their youths with having any mental health problems.

Table 2
Relationships Between Juvenile Court Judges' Survey Responses and County Rural/Urban Classifications

	Definition of urban or rural				
	Metro/ non-metro	*Rural-urban continuum code*	*Urban influence code*	*Persons per square mile*	*Percent rural*
Think delinquency is the result of emotional disturbance	NS	-.008	.015	.137	-.058
Think court dispositions should be made with regard to the mental health status of the youth	NS	-.057	-.072	.142	-.042
Think mental health services can rehabilitate offenders with mental health needs	U>R*	-.213	-.229*	.239*	-.210
How often is a clinical MH evaluation available before a disposition is made	NS	.144	.150	.132	.031
How important is clinical/ psychiatric evaluation before a disposition is made	NS	-.013	-.007	.088	-.102
How often are the court's work group members in contact with others regarding mental health	U>R*	.364**	.283*	-.416**	.439**
How is the quality of the work group's relations with others outside the group who handle mental health	NS	-.115	-.101	.168	-.151
What is the overall *adequacy* of mental health services in your community (sum score of 12 different services)	U>R*	.237*	.303*	-.379**	.342**
What is the overall *quality* of mental health services in your community (sum score of 12 different services)	NS	.156	.158	-.287*	.306**
Adequacy of outpatient MH services	U>R*	.185	.246*	-.289*	.377**
Quality of outpatient MH services	U>R*	.265*	.304*	-.315**	.323**
Adequacy of inpatient residential treatment centers	NS	.015	-.029	-.243*	.134
Quality of inpatient residential treatment centers	NS	.220	.114	-.305*	.321*
Adequacy of community mental health centers	NS	.103	.168	-.196	.295*
Quality of community mental health centers	NS	.124	.211	-.180	.270*

Note: In all significant cells, judges in urban counties rated the item higher than judges in rural counties
*$p < .05$; **$p < .01$

Discussion

There has recently been a push by U.S. federal agencies to pay more attention to rural areas. Rural residents have been designated as special populations for increasing focus on health, mental health, drug and alcohol abuse (NIH, 2004) issues and service delivery for those concerns. The President's New Freedom Commission on Mental Health (2003) specifically addressed the need to improve access to quality care in rural areas (Recommendations 3.2 and 6.1).

While there was only one statistically significant difference found in the urban v. rural facilities' screening, training, services, and referral, the rate of behavioral health resources varies widely and few of the facilities provided a full range of behavioral health screening, referral, or treatment services. Juvenile court judges in rural counties reported that the quality and adequacy of mental health facilities were lower than judges in urban counties reported and that mental health services were less effective for juveniles with mental health needs; however, they did not report any differences in beliefs about the interaction between mental health and juvenile delinquency or the importance of incorporating mental health needs into dispositional hearings.

A last note is needed on the varying definitions of rurality. The "correct" definition of rural is dynamically related to the research question; this study revealed some differences in findings depending on the definition that was used. In this study, *persons per square mile* and *percent rural* were predictive of the most variability in judges' responses, the *Rural-Urban Continuum Code* was predictive of the least, and the last two definitions fell in the middle. It is important to remember that regardless of definition of rurality, rural areas are unique, each with its own special populations, resources, health problems, and patterns of caring for its members (Bushy, 1997) and large variations in the demographic, cultural, economic, and environmental characteristics (Hart, Larson, & Lishner, 2005). This study is a first step in examining the needs of youth in rural areas.

References

Breda, C.S. (2001). The mental health orientation of juvenile courts. *Journal of Behavioral Health Services and Research, 28*(1), 89-95.

Bushy A. (1997). Case Management: Considerations for coordinating quality services in rural communities. *Journal of Nursing Care Quality, 12*(1), 26–36.

Cocozza, J. J., & Skowyra, K. R. (2000). Youth with mental health disorders: Issues and emerging responses. *Juvenile Justice, 7*(1), 3-13.

Fox, J., Merwin, E., & Blank, M. (1995). De facto mental health services in the rural south. *Journal for the Poor and Underserved*, 6, 434-468.

Friedman, R. M., Katz-Leavy, J. W., Mandersheid, R. W., & Sondheimer, D. L. (1996). Prevalence of serious emotional disturbance in children and adolescents. In R. W. Mandersheid & M. A. Sonnenschein (Eds.), *Mental Health, United States, 1996* (pp. 71-89). Rockville, Maryland: U.S. Department of Health and Human Services.

Goldstrom, I., Jaiquan, F., Henderson, M., Male, A., & Mandersheid, R. W. (2000). The availability of mental health services to young people in juvenile justice facilities: A national survey. In R. W. Mandersheid & M. J. Henderson (Eds.), *Mental health, United States, 2000*. Washington, DC: Substance Abuse and Mental Health Services Administration.

Hart, L. G., Larson, E. H., & Lishner, D. M. (2005). Rural definitions for health policy and research. *American Journal of Public Health, 95*(7), 1149-1155.

National Institutes of Health (NIH). (2004). *Research on rural mental health and drug abuse disorders (PA-04-061). Bethesda, MD: NIH. Available at http://grants2.nih.gov/grants/guide/pa-files/PA-04-061.html.*

Otto, R. K., Greenstein, J. J., Johnson, M. K., Friedman, R. M. (1992). Prevalence of mental disorders among youth in the juvenile justice system. In J. J. Cocozza (Ed.), *Responding to the Mental Health Needs of Youth in Juvenile Justice System*. Seattle WA: The National Coalition for the Mentally Ill in the Criminal Justice System.

President's New Freedom Commission on Mental Health (2003). *Achieving the promise: Transforming mental health care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

Tennessee Juvenile Justice/Mental Health Work Group. (2004, June). Tennessee's youth in juvenile justice facilities. Mental health, substance abuse, and developmental disability issues. Nashville, TN: Tennessee Department of Mental Health. Available online at: http://www.state.tn.us/mental/specialpops/cj/jjmhreport061104.pdf.

CONTRIBUTING AUTHORS

Michael D. Pullmann, M.S.
Center for Evaluation and Program Improvment, Vanderbilt University, Peabody 151, 230 Appleton Place, Nashville, TN 37203, 614-343-1652, email: Michael.D.Pullmann@Vanderbilt.edu

Craig Anne Heflinger, Ph.D.
Vanderbilt University, Peabody 151, 230 Appleton Place, Nashville, TN 37203, 615-322-8275, email: C.Heflinger@Vanderbilt.edu

Carolyn S. Breda, Ph.D.
Center for Evaluation and Program Improvement, Vanderbilt University, Peabody 151, 230 Appleton Place, Nashville, TN 37203, 615-343-8723, email: Carolyn.S.Breda@Vanderbilt.edu

Factors Related to Mental Health Referral among Juvenile Detention Staff

Denise Richardson
Shanta Powell
Kristy Tomlin
Kenneth M. Rogers

Introduction

It has been estimated that as many as 60% of youth who enter the juvenile justice system suffer from an emotional or behavioral disability (Cocozza, 1991). Despite this high level of identified need, most juvenile detention facilities do not have adequate screening procedures to detect psychopathology in youthful offender populations. The burden of identifying youth in need of mental health treatment and referring these youth for treatment is often placed on juvenile corrections staff members who have little training in mental health or developmental issues.

Unfortunately, knowledge about factors that motivate these gatekeepers' judgment is minimal. Currently, the decision to refer a youth for treatment once in the justice system is highly variable and dependent upon a complex interaction of youth factors (age, race, crime committed, past criminal record, etc.), decision maker characteristics (attitudes about incarcerated youth, experience in the system, feeling about mental health treatment, mental health training, etc.), and organizational context characteristics (barriers to referral, lack of available services, etc.).

Knowledge about mental illness may be associated with mental health care. However, there are few identified studies examining factors associated with referral in individuals with no clinical background or training. Furthermore, many of these individuals have been trained in disciplines with models that appear more punitive and less rehabilitative in nature.

The goal of this study is to (1) describe the sociodemographic characteristics of juvenile corrections staff, (2) explore the attitude of corrections staff toward mental illness and mental health treatment, and (3) explore reasons for referral or lack of referral of youth for mental health treatment by juvenile corrections staff.

Methods

Focus groups were convened with four groups of staff members at a long term juvenile corrections facility housing adjudicated youth including: front line officers, supervising officers, facility administrators, and mental health and nursing staff. The data from the focus groups were used to develop two questionnaires: The Staff Attitude Survey and the Youth Referral Survey. The Staff Attitude Survey is a 22 item questionnaire focusing on four domains: (1) the role of mental health in detained youth, (2) benefits of mental health treatment, (2) barriers to mental health referral, and (4) indicators of referral for mental health treatment (see Table 1). The Staff Referral Survey is a 40 item instrument which assesses the reasons for mental health referral and has five domains: (1) youth likeability, (2) likelihood that the youth would have a positive future, (3) aggression toward staff, (4) aggression toward others, and (5) indicators of mental illness.

All staff members were recruited to complete the Staff Attitude Survey including direct care staff, supervising staff working on each unit, facility administrators, and mental health and nursing staff. Additionally, primary assigned staff members for 120 youth referred for mental health services and a control group of 120 youth not referred for services were asked to complete the Staff Referral Survey.

Clinical and demographic data was obtained for a randomly selected group of 100 youth referred for mental health care and a group of 100 matched youth. The matched factors include age, type and severity of charges, gender, and length of time in the detention prior to referral. Sources of information included the Child Behavior Checklist (CBCL; Achenbach, 1991a), Youth Self Report (YSR; Achenbach, 1991b), and a clinician reported diagnosis.

Table 1
Component Questions of the Staff Attitude Survey

Domain: Discipline	α = 0.73
Q1. Discipline for the youths in juvenile hall is too strong.	
Q2. All that juveniles here need is a good spanking.	
Q3. Encouraging and supporting troubled youths is more important than strict discipline.	
Q4. Detention in juvenile hall is not enough punishment for most of the crimes youth commit.	
Q5. The main purpose of juvenile hall is to punish offenders.	
Q6. Most youth who seek mental health treatment are trying to avoid punishment.	
Domain: Role of Mental Health	α = 0.74
Q1. Adequate evaluation for mental health problems should be a high priority in juvenile hall.	
Q2. I would seek mental health treatment myself if I thought that I needed help.	
Q3. I feel I can help youths under my care just as much as a mental professional can.	
Q4. Having a mental health professional to talk to is very helpful for youths in juvenile hall.	
Q5. Youth with emotional problems are reluctant to be evaluated by mental health professionals.	
Q6. Youth who are referred to mental health by staff members are usually troubled youth.	
Domain: Barriers to Mental Health	α = 0.62
Q1. Most staff in SFV juvenile hall are aware of the mental health services offered here.	
Q2. The last thing that staff members need is another training session.	
Q3. It is easy to make a mental health referral at SFV juvenile hall.	
Q4. I am concerned about what youths might say about me or my co-workers to the metal health staff.	
Q5. I fee SFVJH should receive more training in how to deal with youths with possible mental problems.	
Q6. I feel that my co-workers will think negatively of me for making a mental health referral.	
Domain: Indicators for Mental Health	α = 0.76
Q1. Juveniles who attack other juveniles should be referred to mental health.	
Q2. Kids who are fearful or anxious should be referred to mental health.	
Q3. Juveniles who attack staff members should be referred to mental health.	
Q4. Juveniles who try to hurt themselves should be referred to mental health.	
Q5. Youth who are sad and cry a lot should be referred to mental health.	
Q6. Kids who hear voices when no one is speaking should be referred to mental health.	
Q7. Kids who ask to be referred to mental health should be sent.	

Results

The study included 301 participants which represented 80% (301/375) of individuals working at the facility. The most common reasons for refusal were (1) negative information getting back to administration (n = 50) and (2) working on an intermittent basis and thus not available during the study period (n = 24). These individuals did not differ demographically from subjects agreeing to participate.

The mean age of subjects was 35 years with line staff being younger than nursing staff (mean age = 42) and administration (n = 51). Most staff members had a post high school education with associates degree (25%), bachelor's degree (37%), master's degree (12%), and doctoral degree (1%). Twenty-five percent only had a high school diploma, but many had taken college classes. The most common areas of study were criminal justice, sociology, and psychology. Most direct care staff had been at the facility for a long period (6 years). Mental health professionals and nurses had the longest average tenure (7 years).

Most staff members endorsed positive feelings about mental health treatment, but felt that mental health practitioners did not focus enough on consequences for behavior problems. Survey results showed that staff members were able to identify symptoms of psychosis and suicide risk factors, but were less likely to identify symptoms of depression or anxiety as reasons to refer youth for mental health treatment. Most staff members reported that they did not feel that there were system barriers preventing mental health referral; however, many felt that fellow staff members may view the decision to refer the youth for mental health treatment negatively.

Juvenile justice staff members were able to identify appropriate youth for referral. Youth referred for mental health care were more likely to have clinically significant scores on both the CBCL (Mean = 65) and YSR (Mean = 71) than youth in the comparison sample (p = .005 for CBCL; p = .002 for YSR).

Results indicated that youth were more likely to receive a mental health referral if they were seen as likeable, χ^2 = 5.67, p = .017. This included joyfulness, positive self statements, and ability to engage. Youth were most likely to be referred for services if they asked to be referred for services, χ^2 = 7.65, p = .006. Youth who were more verbally aggressive were more likely to be referred for mental health services, but youth with physical aggression toward staff or peers were less likely to receive a referral, χ^2 = 15.52, $p \leq .001$. Youth who were seen as possibly having a bright future were more likely to receive a referral, χ^2 = 65.59, p = .01.

Sociodemographic factors also influenced referral status. Youth who were of a different race from the primary staff member were less likely to receive a mental health referral. This was more prominent for Latino youth than for African-American or Caucasian youth. Gender differences between primary staff member and youth did not impact referral status. Direct care staff members were less likely to make a mental health referral than supervisors. Nursing staff were more likely than corrections staff to recognize symptoms of mental illness and refer the youth for treatment.

Conclusions

This study does not support the common assumption that juvenile corrections officers do not recognize psychopathology and are unwilling to refer for mental health services. The findings do suggest that more subtle symptoms of anxiety and depression are more difficult for individuals with little mental health training to identify. As corrections personnel gain more experience in dealing with youth, the ability to identify and refer youth appears to improve. The findings also suggest that cultural differences may impact the ability of staff members to recognize mental health problems. This is especially true when language barriers may also be present with a Latino youth and a non-Latino staff member. These problems do not appear as pronounced with African-American and Caucasian youth.

This study has several limitations that prevent its generalizability. First, the study was completed in a single juvenile facility in a metropolitan area. Secondly, the staff members in this juvenile facility may have been more educated than staff in most juvenile correction facilities. Thirdly, mental health service are more prominent and available in this facility than in most. Despite its limitations, this study is an initial step into understanding the referral patterns of juvenile corrections staff.

References

Achenbach, T. M. (1991a), *Manual for the Child Behavior Checklist/4-18 and 1991 Profile*. Burlington, Vermont: University of Vermont Department of Psychiatry.

Achenbach, T. M. (1991b), *Manual for the Youth Self-Report and 1991 Profile*. Burlington Vermont: University of Vermont Department of Psychiatry.

Cocozza, J. (1991). *Responding to the mental health needs of youth in the juvenile justice system.* Seattle, WA: National Coalition for Youth in the Juvenile Justice System.

CONTRIBUTING AUTHORS

Corresponding Author: Kenneth M. Rogers, M.D.
410-328-3522, Email: krogers@psych.umaryland.edu

Shanta Powell, M.D.
410-328-3522

Denise Richardson, M.D.
410-328-3522

Kristy Tomlin, B.A.
410-328-3522

All Authors:
University of Maryland, Baltimore, 701 West Pratt Street, Baltimore, MD 21201,

Topical Discussion

The New "Unclaimed Children"— Linking Systems of Care and Best Practices for Intervention with Youth Who have Caused Sexual Harm

Karen A. Fredricks
Jane Nunez
Joann Schladale

Introduction

During the last fifteen years clinicians and researchers have been grappling to make sense of the complex dynamics involved in the development of sexually abusive behavior (Hermann, 1992; Ryan & Lane, 1997), ways to prevent recidivism (Knight & Prentky, 1993; Prentky, Harris, Frizzell & Righthand 2000; Minor & Crimins, 1995) and curb the tide of sexual abuse. Literature now includes comprehensive, multidisciplinary models addressing a full continuum of care (Bengis, 1986; Henggeler, Schoenwald, Broduin, Rowland & Cunningham, 1998; Trepper & Barrett, 1989). Agencies intent on providing a therapeutic response to juvenile sexual offending based upon best practice strategies can now integrate core effective components into a broad range of settings.

A therapeutic framework embracing evidence based research on juvenile sexual offending, trauma, affect regulation, resiliency and family therapy can inform interventions with sexually aggressive youth and their families. This important research can easily be integrated into systems of care in order to enhance service provision and impact successful treatment outcomes.

Research indicates that multisystemic family therapy (MST) is an empirically tested approach that influences successful treatment outcomes with delinquent youth and is cost effective. A study using MST with sexually aggressive youth shows promise with this population (Borduin, Henggeler, Blaske & Stein, 1990). Concepts derived from family systems theory, which provide the foundation for multisystemic treatment, can be integrated into all service provision. Family focused interventions need not be limited to the intensive home-based approach created by Henggeler and his colleagues (Borduin et al., 1990; Henggeler et al. 1998). Programs do not have to struggle with the dilemma of either providing MST, or limiting interventions to traditional responses based primarily on outdated conventional wisdom.

Challenges in Systems of Care

Comprehensive therapeutic protocols for youth who exhibit sexually harmful behaviors do not exist in many systems of care, and identification and early intervention are not widespread. Families are often scared and have no idea where to obtain help, and systems of care staff do not always know where a family might get help. There is also inadequate specialized training for service providers. Further, referrals are made without adequate specialized assessment which puts other children at risk of sexual harm.

Goals for Best Practice

In keeping with the President's New Freedom Commission on Mental Health (2003), we are proposing a family driven response to youthful sexual harm that encompasses essentials for living, working, learning, and participating fully in the community. Best practices for responding to youthful sexual harm include the following goals for integration into mental health settings:

- Freedom from sexual harm is essential to overall health.
- Family driven services are critical to successful treatment outcomes that stop youthful sexual harm.
- Disparities in mental health services are eliminated through a seamless continuum of care.
- Mental health screening, assessment and referral to services specifically designed to address sexual harm are needed.
- Data and research drive best practice for mental health care delivery that is empirically based.
- Technology enhances access for mental health care and information.

While experts in the field of youthful sexual aggression acknowledge that a collaborative, multi-system approach is required for successful treatment outcomes, it is the system of care approach that can

operationalize the Child and Adolescent Service System Program (CASSP) principles, making them the driving force in policy formulation, program planning, service delivery, training and evaluation. The enhanced core values of system of care work (based upon the New York Statewide Workgroup on Child and Adolescent Sexual Abusers) provide the foundation essential for integrating specialized services for youngsters who are sexually aggressive. See Table 1 for a list of identified best practices for this population.

Providing comprehensive services for youth who have caused sexual harm and their families requires that a range of service options, at varying levels of intensity, be made available to them, (Stroul & Friedman, 1986). Such services should meet their multiple needs across all relevant domains, including physical, emotional, social, educational and justice domains. Specifically, youth identified as experiencing learning, conduct, and psychiatric problems need individually tailored treatment plans to remediate these difficulties (Becker, 1990), as well as treatment programs which conform to their developmental abilities (Stroul & Friedman, 1986).

Table 1
Best Service Practices for Youth with a History of Sexual Aggression

1. The system of care must address community safety. While we believe in advocacy for the rights of the client, these must be balanced against concerns for community safety, with safety taking priority if a choice is forced.
2. Individualized treatment of sexually abusing children and adolescents, which uses a strength-based approach, can be effective in curtailing the offending behaviors and increasing community safety.
3. There should be cooperative inter-agency planning and integrated service delivery at the state and local level. Coordinated services maximize community resources, reduce duplication, and address the complex needs of clients.
4. The system must have measurable and accountable outcomes routinely monitored and reported to a centralized oversight group. The system of oversight and standards, whether at the local, state or peer level, must exist independent of program administration and be charged with the responsibility for formative evaluation and continual quality improvement.
5. Sustainable funding needs to follow the client.
6. The system should include case coordination: a person or entity that ties together services and insures continued oversight.
7. The system must include a comprehensive continuum of care including early intervention and continuing care, to prevent recidivism and to maintain community safety.
8. All services must be culturally sensitive, respecting ethnic and cultural backgrounds of youth and families.
9. Individualized services should be provided to abusers, their families, victim, and victim's families.
10. Services should be available close to the child and family's home community. Agencies should provide equal access to services with an individualized monitoring plan consistent with the risk of reoffending.
11. Adjudicated youth need to complete specialized sex offender treatment. Length of treatment should not be dictated by sentence length. Treatment should continue regardless of sentence completion.
12. Inclusion of families, surrogate families, and significant others identified by the child or family for full participation (as appropriate) in all levels of service planning and delivery.
13. A sex abuse-specific, culturally competent needs and risk assessment is an essential component of care.
14. Perpetrators accept responsibility and accountability for their behavior(s).
15. All staff working with this population must complete a core training that establishes a minimum level of competence, and receive regular, on-going training thereafter.
16. The system should insure a smooth transition to the adult system of care/support as clients reach maturity.

A service use model such as the system of care provides a context for organizing and delivering a broad array of community-based services necessary to successfully treat and maintain youth in their communities (Holden et al., 2001). Essential elements of the system of care model, applied to the treatment and management of sexually aggressive youth include service providers offering a comprehensive array of individualized, integrated services in the least restrictive environment, making families full participants in all aspects of treatment planning, as well as providing case management services, early intervention, and culturally sensitive care (Rosenblatt, 1998; Stroul & Friedman, 1986).

Youth arrested for sexual crimes may be viewed by community-based social service agencies as being under the aegis of the juvenile justice system, and therefore seen as not appropriate for inclusion in certain service networks. However, no single agency or service domain should be expected to assume responsibility for the treatment of youth receiving services across service domains (Stroul & Friedman, 1986). Rather, a multi-modal, cross-systems treatment approach that involves multiple agencies and multiple modalities is required to provide services that increase the chance of youths improving over time (Stroul & Friedman, 1986). Integrated, multi-agency networks of services are needed to blend services across multiple domains including mental health, education, juvenile justice, social services, and substance use. Active involvement of community and social service agencies (Borduin et al., 1990; Henggeler et al., 1998), school-based support services (Borduin et al., 1990), and family treatment resources (Ryan & Lane, 1997) are key to the success of treating sexually aggressive youth. Optimal multi-system service delivery requires communication and collaboration among agencies.

The Discussion

Because this presentation followed a research-based presentation, the audience consisted primarily of researchers who had little first hand knowledge about working with families with a child who has serious emotional disturbance and sexual aggression issues. Although audience members had other backgrounds, they were very receptive and asked questions about the statistics that were presented as well as the number of children that were thought to have these problems. The comments and suggestions that were made during the discussion and presentation suggested that the Substance Abuse and Mental Health Service Administration (SAMHSA) might consider adding the following types of questions to all systems of care (SOC) research projects related to youth with serious emotional disturbances (SED) who are sexually aggressive:

- How many children/adolescents within the SOC have sexually aggressive issues?
- Are these youth treated within the community or routinely sent into residential care?
- If they are sent into residential care does that residential care facility offer treatment for their sexually aggressive behaviors?
- When these children/youth return from care, are there treatment providers within the SOC who can address (with some sense of expertise) their sexually aggressive behavior issues?
- Does the SOC community have protocols or standards to address the needs of youth with SED who are also sexually aggressive?
- Does the SOC have professionals who are trained specifically in the area of youth who are sexually aggressive?
- If so, what does that training consist of, and how often is it updated?
- If there is not an expert on staff, do SOC professionals receive consultation from an expert?
- Are there programs that work seamlessly with families and youth where sexual aggression is an issue?
- Does the SOC believe they are doing an adequate job of addressing the needs of families with youth who have SED and ar also sexually aggressive?

The discussion was short and decidedly had more questions than answers. However, we are of the opinion that researchers in the field of children's mental health who investigate the problems of sexually

aggressive youth need more time to adequately explore the current research and to move forward with designing new reseach tools to help address the needs of youth and their families faced with these troubling issues. In past presentations when we have spoken with audiences that were mixed in terms of therapists, line staff, Social Services, teachers etc., they brought issues relevant to working with these youth to the table. Yet they too had experienced frustration when trying to find experts in their communities who could help them address the needs of the youth and family.

Conclusion

We believe providing a therapeutic response to youthful sexual harm is trauma work. Empirical evidence increasingly reveals that trauma influences dysregulation that includes sexually harmful behavior. Resiliency or protective factors have the power to mitigate such influence. Integrating important empirical findings from these areas of research can enhance successful treatment outcomes and create safer communities.

The importance of service coordination among service systems dealing with sexually offending youth is especially pertinent because of the seriousness of their sexual and nonsexual behavior problems, as well as because of the large number of youths who receive services across multiple systems of care, and pervasive problems with service fragmentation across service systems (Cocozza & Skowyra, 2000; President's New Freedom Commission, 2003).

References

Becker, J. (1990). Treating adolescent sexual offenders. *Professional psychology: Research and practice, 21*(5), 362-365.

Bengis, S. (1986). *A comprehensive service delivery system and continuum of care*. Brandon, Vermont: Safer Society Press.

Borduin, C., Henggeler, S., Blaske, D. & Stein, R. (1990). Multisystemic treatment of adolescent sexual offenders. *International Journal of Offender Therapy and Comparative Criminology, 34*, 105-113.

Cocozza, J. & Skowyra, K. (2000). Youth with mental health disorders: Issues and emerging responses. *Juvenile Justice, 7*(1), 3-13.

Henggeler, S., Schoenwald, S., Broduin, C., Rowland, M., & Cunningham, P. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents*. New York: The Guilford Press.

Hermann, J. (1992). *Trauma and recovery*. New York: Basic Books.

Holden, W., Friedman, R., & Santiago, R. (2001). Overview of the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program. *Journal of Emotional and Behavioral Disorders, 9*, 4-12.

Knight, R., & Prentky, R. (1993). Exploring characteristics for classifying juvenile sex offenders. In H. Barbaree, W. Marshall, & S. Hudson (Eds.), *The juvenile sex offender* (pp. 45-83). New York: Guilford Press.

Minor, M. & Crimmins, C. (1995). Adolescent sex offenders: Issues of etiology and risk factors. In B. Schwartz & H. Cellini (Eds.), *The sex offender: Vol. 1. Corrections, treatment and legal practice* (pp. 9.1-9.15). Kingston, New Jersey: Civic Research Institute.

Prentky, R., Harris, B., Frizzell, K., & Righthand, S. (2000). An actuarial procedure for assessing risk with juvenile sex offender. *Sexual Abuse: A Journal of Research and Treatment, 12*, 71-94.

President's New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* U.S. Dept of Health and Human Services, Pub. No. SMA-03-3832, Rockville, MD.

Rosenblatt, A. (1998). Assessing the child and family outcomes of systems of care for youth with serious emotional disturbance. In M. H. Epstein, K. Kutash, & A. J. Duchnowski (Eds.), *Outcomes for children and youth with behavioral and emotional disorders and their families: Programs and evaluation best practices* (pp. 329-362). Austin, TX: Pro-Ed.

Ryan, G. & Lane, S. (Eds.). (1997). *Juvenile sexual offending*. San Francisco: Jossey-Bass Publishers.

Stroul, B. A., & Friedman, R. M. (1986). *A system of care for children and youth with severe emotional disturbances*. (Revised edition). Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center

Trepper, T., & Barrett, M.J. (1989). *Systemic treatment of incest*. New York: Brunner Mazel.

CONTRIBUTING AUTHORS

Karen A. Fredricks, M.S.W.
Fredricks & Denison Educational Consultants and Trainers, 111 Ritter Road, Stormville, NY 12582, 914-469-2323, email: Pfsa1@aol.com

Jane Nunez, M.A., L.P.C.
Parkside Family Counseling, LLP, 738 S Main St, Adrian, Michigan, 49221, 517-266-8880, email: ljanienunez@sbcglobal.net

Joann Schladale, M.S., L.M.F.T.
Resources for Resolving Violence, 207-865-3111, email: schladale@aol.com