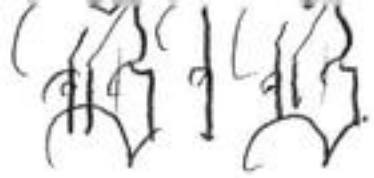

This class is really riling me ire!

Youth With Mental Health Disorders: Issues and Emerging Responses

by Joseph J. Cocozza and Kathleen R. Skowyra

Tragic mass homicides by juveniles, documented cases of neglect and inadequate services, and Federal policy initiatives focusing on providing systems of care for at-risk juveniles have propelled mental health issues among juvenile offenders into the headlines.

As the former Administrator of the Office of Juvenile Justice and Delinquency Prevention (OJJDP) has observed (Bilchik, 1998):

> It is crucial that we deal not only with the specific behavior or circumstances that bring them [youth] to our attention, but also with their underlying, often long-term mental health and substance abuse problems.

Recognition of the Mental Health Needs of Youth

The mental health needs of youth in the juvenile justice system have received more attention at the Federal level in the past 2 years than in the past three decades combined. During the past 2 years:

- The Civil Rights Division of the U.S. Department of Justice undertook a series of investigations that documented the consistent inadequacy of mental health care and services in juvenile correctional facilities in a number of States (Butterfield, 1998).
- The U.S. Department of Health and Human Services' Center for Mental Health Services initiated the first national survey of juvenile justice facilities to identify available mental health services (Center for Mental Health Services, 1998).
- Congress considered several bills and amendments that mandated comprehensive mental health and substance abuse screening and treatment programs for youth in the juvenile justice system (Manisses Communications Group, Inc., 1999).

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The importance of the mental health issue is also recognized at the State level, for example, in the response given recently by the Secretary of the Florida State Department of Juvenile Justice when asked about the most challenging issue facing juvenile corrections at the beginning of this century. His answer was not funding, sufficient beds, or security. Rather, the most challenging issue he identified was "providing specialized services such as mental health and substance abuse services within the juvenile correctional continuum" (Bankhead, 1999).

Our jails have once again become surrogate mental hospitals.

The current level of concern about the mental health needs of youth in the juvenile justice system stands in stark contrast to past neglect (Knitzer, 1982). A comprehensive review of the last several decades of research (Cocozza, 1992) concluded:

> We still know very little about the mental health needs of youth who are involved in the juvenile justice system. There are no good national studies on the number of such youth who come in contact with the juvenile justice system. Systematic information on how services are organized and delivered across the country, or on how the mental health and juvenile justice systems coordinate their efforts, does not exist. Moreover, we have no adequate information on what services are provided, their quality and whether or not they make a difference.

What has led to this dramatic change? A number of different factors are involved, including the following:

◆ **Growing recognition of the mental health needs of youth in general.** As noted by a number of authors, children's and adolescents' mental health needs have historically been addressed inadequately in policy, practice, and research (Hartman, 1997; Burns, 1999). Only recently have the number of youth with mental illness and their level of unmet need been recognized (Burns, 1999). Recent estimates place the rate of serious emotional disturbance among youth in the general population at 9 to 13 percent (Friedman et al., 1996), much higher than the 0.5- to 5-percent range previously used by State policymakers (Business Publishers, Inc., 1996).

◆ **Increasing reliance on the justice system to care for individuals with mental illness.** This trend has been clearly documented for the adult population. A report to Congress (Center for Mental Health Services, 1995:iii) found: "As jail and prison populations increased, and the number of persons with mental illness living at the fringe of their communities rose, the absolute number of persons with mental illness in jails and prisons also increased." The survey-based study *Criminalizing the Seriously Mentally Ill* (Torrey et al., 1992:iv) also concluded: "Our jails have once again become surrogate mental hospitals." Various other studies have confirmed that large proportions of individuals in the Nation's jails and prisons are seriously mentally ill. For example, Teplin (1990) reported prevalence rates of 6.4 percent for male jail inmates and 15 percent for female jail inmates. The most recent study released by the U.S. Department of Justice reported that 16 percent of State prisoners were identified as mentally ill (Ditton, 1999). Such findings buttress the view that "[j]ails and prisons have become the nation's new mental hospitals" (Butterfield, 1998a). As suggested

above, policymakers, practitioners, and advocates now recognize that the same trends and issues exist in the juvenile justice system.

Recent changes in the juvenile justice system. The juvenile justice system has largely shifted away from treatment and rehabilitation and toward retribution and punishment as the "get tough" movement swept the Nation during the 1990's. The decade has seen more youth transferred to criminal court, longer sentences, and lower minimum ages at which juveniles can be prosecuted in the criminal justice system as if they were adults—all part of the "adultification" of juvenile justice (Altschuler, 1999). This trend toward criminalizing the juvenile justice system has raised questions about its role (Schwartz, 1999). The trend has also forced courts and the juvenile corrections system to address mental health-related issues for youth that had been previously restricted primarily to adults, such as the constitutional right to mental health treatment (Woolard et al., 1992), the applicability of the "not guilty by reason of insanity" defense (Heilbrun, Hawk, and Tate, 1996), and mental competency guidelines (Woolard, Reppucci, and Redding, 1996).

Prevalence of Mental Health Disorders Among Youth

Despite the growing concern, there is a paucity of adequate research on the prevalence and types of mental health disorders among youth in the juvenile justice system. A comprehensive review of the research literature (Otto et al., 1992) found the research to be scarce and methodologically flawed. Other reviews have reached similar conclusions (Wierson, Forehand, and Frame, 1992). Methodological problems include inconsistent definitions and measurements of mental illness; use of biased, nonrandom samples; reliance on retrospective case report data; and use of nonstandardized measurement instruments.

Despite these problems, some general conclusions can be drawn:

◆ **Youth in the juvenile justice system experience substantially higher rates of mental health disorders than youth in the general population.** This is a major conclusion drawn from a review of 34 studies (Otto et al., 1992) and is also consistent with the finding that mental illness prevalence rates in adult corrections populations are two to four times higher than the rates in the general adult population (Teplin, 1990).

There is a paucity of adequate research on mental health disorders among youth in the juvenile justice system.

◆ **A high percentage of youth in the juvenile justice system have a diagnosable mental health disorder.** One difficulty in addressing mental health issues in the juvenile justice system centers around the varying uses and definitions of the terms "mental health disorder" and "mental illness." One critical distinction is between youth with a diagnosable mental health disorder and youth with a serious mental health disorder or serious emotional disturbance (SED). Youth with a diagnosable mental health disorder are those that meet the formal criteria for any of the disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition, DSM–IV* (American Psychiatric Association, 1994) such as psychotic, learning, conduct, and substance abuse disorders. The terms "serious mental health disorder"

and "SED"—defined and measured in a number of different ways—are used to identify youth experiencing more severe conditions that substantially interfere with their functioning. The term "serious mental health disorder" often refers to specific diagnostic categories such as schizophrenia, major depression, and bipolar disorder. "SED," a term used for youth, includes those youth with a diagnosable disorder for whom the disorder has resulted in functional impairment affecting family, school, or community activities. With regard to diagnosable mental health disorders in general, research has found that most youth in the juvenile justice system qualify for at least one diagnosis. It is not uncommon for 80 percent or more of the juvenile justice population to be diagnosed with conduct disorder (Otto et al., 1992; Wierson, Forehand, and Frame, 1992; Virginia Policy Design Team, 1994). Given the broad definitional criteria for conduct disorder, Melton and Pagliocca (1992) point out that such a finding is not surprising, although many of these youth qualify for more than one diagnosis (Virginia Policy Design Team, 1994).

◆ **It is safe to estimate that at least one out of every five youth in the juvenile justice system has serious mental health problems.** Estimates of the prevalence of serious mental health disorders among these youth are particularly unreliable because of the problems with research and, as mentioned above, the varying definitions and measures of serious mental illness. If the prevalence rate of SED for youth in the general population is estimated at 9–13 percent (Friedman et al., 1996) and the prevalence rate of disorders for youth in the juvenile justice system is consistently found to be at least twice as high (Otto et al., 1992), one can reasonably expect the prevalence rate of serious mental health disorders for youth in contact with the juvenile justice system to be at least 20 percent. This estimate is consistent with the findings other researchers have reported (Schultz and Mitchell-Timmons, 1995). A more accurate estimate will require further research. It is clear, however, that while most youth in the juvenile justice system have a diagnosable mental illness and could benefit from some services, there is a sizable group of youth who critically need access to mental health services because they are experiencing serious problems that interfere with their functioning.

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◆ **Many of the youth in the juvenile justice system with mental illness also have a co-occurring substance abuse disorder.** Over the past several years, there has been greater recognition and documentation of the high level of co-occurring substance abuse disorders among individuals with mental health disorders. Kessler et al. (1996) found that 50.9 percent of the general adult population with serious mental health disorders have a co-occurring substance abuse disorder, while Teplin, Abram, and McClelland (1991) found that 73 percent of adult jail detainees with serious mental health disorders had a co-occurring substance abuse disorder. Although research has just begun to focus on youth, Greenbaum, Foster-Johnson, and Petrila (1996:58) found that "approximately half of all adolescents

receiving mental health services" in the general population are reported as having a dual diagnosis. Among the juvenile justice system population, the rates may be even higher (Otto et al., 1992; Milin et al., 1991).

Emerging Strategies and Models

Given these findings, it is not surprising that juvenile justice officials regard the care of youth with serious mental health problems—and the multiple and complex issues surrounding the treatment of these youth—as among their greatest challenges. Efforts to address these problems confront numerous barriers, including the following:

- The confusion across multiservice delivery and juvenile justice systems, at both the policy and practice levels, as to who is responsible for providing service to these youth.
- Inadequate screening and assessment.
- The lack of training, staffing, and programs necessary to deliver mental health services within the juvenile justice system.
- The lack of funding and clear funding streams to support services.
- The dearth of research that adequately addresses the level and nature of mental health disorders experienced by these youth and the effectiveness of treatment models and services.

If one considers other complicating trends, such as managed care, the privatization of services, and the diagnostic and treatment issues surrounding particular populations such as youth of color (Issacs, 1992) and girls (Prescott, 1997), one quickly gets a sense of how great a challenge any change will be.

At the same time, a clear set of comprehensive strategies that appear to be critical to any progress is emerging. These strategies are consistent with many of the actions recommended by leading national experts (Whitbeck, 1992), State officials (Virginia Policy Design Team, 1994; Ohio Department of Rehabilitation and Correction, Youth Services, Mental Health, and Alcohol and Drug Addiction Services, 1995), and advocates (National Mental Health Association, 1999). They are being implemented—often in a less than ideal manner—for a limited number of youth and in only a few locations. Described below are some of these strategies and examples of supporting policies, programs, and services that are developing across the Nation as systems and communities begin to better address the needs of the growing number of youth with mental health disorders entering the juvenile justice system.

A clear set of comprehensive strategies is emerging.

Collaborating Across Systems

Cross-system collaboration must form the basis for all solutions. The field is beginning to understand that the needs and issues surrounding individuals with mental health disorders cannot be placed at the doorstep of any single agency or system (Steadman, McCarthy, and Morrissey, 1989). Systematic efforts to examine and improve the response to these youth, whether at the national (Whitbeck, 1992) or State level (Virginia Policy Design Team, 1994), reach the same conclusions. Although an individual system can help to improve the care and treatment of youth with mental illness in the juvenile justice system, effective solutions require that multiple relevant agencies coordinate and integrate strategies and services.

Collaborative efforts can include coordinated strategic planning, multiagency budget submissions, implementation of comprehensive screening and assessment centers, cross-training of staff, and team approaches to assessment and case management. Further, such efforts can be employed at varying points in the juvenile justice process—from intake through adjudication, disposition, and aftercare.

Whenever possible, youth with serious mental health disorders should be diverted from the juvenile justice system.

At the Federal level, the systems of care concept developed by the Center for Mental Health Services (CMHS) has encouraged the coordination of services for youth with SED in a number of communities across the Nation (Center for Mental Health Services, 1996). Most sites have not focused heavily on the juvenile justice population, but those that have, such as the Wraparound Milwaukee program, have observed positive results. Wraparound Milwaukee is a collaborative county-operated health maintenance organization that provides comprehensive care to youth referred from both the child welfare and juvenile justice systems and their families. The program is designed to provide community-based alternatives to residential treatment and psychiatric hospitalization (Wraparound Milwaukee, 1998; see Bruce Kamradt's article on Wraparound Milwaukee on pages 14–23). In addition, OJJDP and CMHS have collaborated for the past 2 years to increase juvenile justice system involvement in systems of care. Under this interagency agreement, OJJDP has provided funds to the CMHS technical assistance grantee to promote inclusion of youth with mental health needs involved in the juvenile justice system in other systems of care.

At the State level, there also have been attempts to foster more coordinated approaches. In Ohio, four State agencies—the Ohio Departments of Alcohol and Drug Addiction Services, Mental Health, Rehabilitation and Correction, and Youth Services—allocated funds for the Linkages Project. This project supports local efforts to improve the coordination of the criminal and juvenile justice, mental health, and substance abuse service systems to reduce incarceration and improve offender access to mental health services. One funded county, Lorain, used the funds to create the Project for Adolescent Intervention and Rehabilitation (PAIR), which targets youth placed on probation for the first time for any offense. Youth are screened and assessed for mental health and substance abuse disorders, and individual treatment plans are developed. Youth are then supervised by probation officers/case managers in conjunction with treatment providers. An evaluation of the PAIR program found that it provides an important service and coordinating function for youth, the courts, and the service systems involved (Cocozza and Stainbrook, 1998).

Diverting Youth From the Juvenile Justice System

Whenever possible, youth with serious mental health disorders should be diverted from the juvenile justice system. Given community concerns about safety, there are youth who, regardless of their mental health needs, will need to be placed in the juvenile justice system because of their serious and violent offenses. For other youth, however, their penetration into the juvenile justice system and placement into juvenile detention and correctional facilities will serve to further increase the number of mentally ill youth in the Nation's juvenile facilities who are receiving inadequate mental

health services. At the adult level, efforts to stem this tide have begun to focus on developing collaborative programs to divert individuals with serious mental illness into community-based services (Steadman, Morris, and Dennis, 1995).

Diverting appropriate youth from the juvenile justice process—whether at first contact with law enforcement officials, at intake, or at some other point prior to formal adjudication—can reduce the growing number of these youth entering the juvenile justice system and reduce the likelihood that their disorders will go untreated. Diversion to services, however, requires a multidisciplinary partnership involving the justice and treatment systems and a comprehensive range of services to which youth can be diverted.

The Persons in Need of Supervision (PINS) Diversion Program in New York is an example of how to implement such a diversion initiative. In 1985, the New York State PINS Adjustment Services Act was enacted on behalf of persons alleged to be in need of supervision in order to prevent inappropriate or unnecessary court intervention. Counties participating in the PINS Diversion Program must submit a plan containing interagency strategies for diverting youth from court and providing youth with community-based services. Upon State approval of the plan, the county is authorized to deny access to family court and to divert potential PINS and their families to assessment and adjustment services. Participating counties are required to create a multiagency Designated Assessment Service (DAS) to provide comprehensive assessments of the service needs of PINS youth and their families and to develop treatment plans based on assessment results. An interagency planning process encourages collaboration among the local and State agencies whose programs and resources target this population.

Mental Health Screening

One of the major obstacles in recognizing and treating youth with mental health disorders in the juvenile justice system is the lack of screening and assessment. All youth in contact with the juvenile justice system should be screened and, when necessary, assessed for mental health and substance abuse disorders. The screening should be brief, easily administered, and used to identify those youth who require a more comprehensive assessment to further define the type and nature of the disorder. The screening also should occur at the youth's earliest point of contact with the juvenile justice system and should be available at all stages of juvenile justice processing.

A major obstacle has been the absence of reliable, valid, and easy-to-use screening tools to help the juvenile justice system identify signs of mental illness. Grisso and Barnum (1998), however, recently developed a new tool, the Massachusetts Youth Screening Instrument (MAYSI). It is a short, easily administered inventory of questions that has been normed and tested on a number of juvenile justice populations and appears to provide a promising, standardized screen for use in juvenile justice settings (i.e., probation intake, detention, correctional facilities).

Community-Based Alternatives

Effective community-based alternatives should be used whenever possible. Over the past decade, a number of community-based approaches have been developed as alternatives to institutional care for children with serious mental health disorders, which is often more costly. These approaches are designed to keep youth in their homes, schools, and communities while providing a comprehensive set of services that respond to their mental health needs and related problems.

Standards should provide the field with meaningful guidance in providing effective mental health services.

A number of communities have implemented the systems of care initiatives noted previously and related efforts such as Wraparound services (Clark and Clarke, 1996). One approach that has demonstrated positive outcomes is Multisystemic Therapy (MST) (Henggeler, 1997; Henggeler and Borduin, 1990). Developed by Scott Henggeler and his colleagues, MST is a family- and community-based treatment model that provides services in the home and community settings and addresses a range of family, peer, school, and community factors. Research, most of which has been conducted on youth with serious antisocial behavior, has found that MST is a successful and cost-effective clinical alternative to out-of-home placements. The use of this therapy has resulted in positive outcomes in a number of dimensions, including the prevalence of recidivism, psychiatric symptomatology, and drug use (Henggeler, 1999).

Appropriate Treatment

It is critical that youth with mental health disorders who are placed in juvenile correctional facilities receive appropriate treatment. Even with greater emphasis on diversion and increased reliance on community-based alternatives, many such youth will be placed in juvenile correctional facilities because of the nature and severity of their acts. Clearly, for youth assessed as being seriously disordered, it is reasonable to expect that a mental health treatment plan will be developed and implemented by qualified, trained staff. Investigations by the U.S. Department of Justice's Civil Rights Division, as has been noted, indicate that this is not always the case.

With funding from OJJDP, the Council of Juvenile Correctional Administrators (1998) is developing and testing new performance-based standards for these youth that include treatment guidelines promulgated by a group of mental health and substance abuse experts. These standards should provide the field with meaningful guidance in providing effective mental health services.

Part of the difficulty in providing mental health services to incarcerated youth centers around larger issues concerning the relative responsibilities of the juvenile justice and treatment systems for these youth. Some jurisdictions have responded to the increasing number of youth with mental health disorders by making more secure beds available within the mental health system and transferring the more seriously disturbed youth back and forth between the two systems. Other jurisdictions have created a continuum of mental health services within the juvenile corrections system itself to address the needs of these youth (Underwood, Mullan, and Walter, 1997).

Although empirical data on the relative success of different approaches is lacking, a collaborative approach that involves both systems in planning, cross-training, and the delivery of services appears to be preferable. Such an approach builds on the strengths of each system and helps to establish connections that are critical to aftercare and community reintegration following release. In New York, for example, Mobile Mental Health Treatment Teams, supported by State juvenile justice and mental health agencies, serve youth with identified mental health needs in juvenile correctional facilities. Six regional teams provide onsite assessments, training, counseling, and other clinical services to youth in these facilities.

Conclusion

These are just some of the topics and issues that are relevant to a discussion on how to improve the field's understanding of and response to the mental health needs of youth in the juvenile justice system. There are many more that merit examination. For example, given what the field is learning about the high prevalence of co-occurring mental health and substance abuse disorders, emerging directions and strategies should emphasize approaches that rely on more integrated mental health and substance abuse treatment approaches. Although this review has dealt with youth in the juvenile justice system as a whole, research on variations in prevalence, needs, and types of treatment services must also consider issues surrounding particular populations such as minority youth and females in the juvenile justice system.

Nonetheless, several critical points emerge from the preceding review. First, a large number of youth who come in contact with the juvenile justice system require mental health treatment. Second, there is growing recognition of these needs and of the inadequacies of current assessments and services. Third, a set of clear strategies and useful models and tools are emerging. Much more is needed—funding, social and political will, and further research—but the foundation of a recognition of the problem and the development of promising practices appears to be in place as we enter the new millennium.

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