

# Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System

## *Prepared by*

---

Kathleen R. Skowrya and Joseph J. Coccozza, Ph.D.

The National Center for Mental Health and Juvenile Justice  
Policy Research Associates, Inc.  
Delmar, NY

## *Supported by*

---

The Office of Juvenile Justice  
and Delinquency Prevention

Draft January 2006

National Center for Mental  
Health and Juvenile Justice

NCMHJJ



Blueprint for Change:  
A Comprehensive Model for the  
Identification and Treatment of Youth  
with Mental Health Needs in Contact  
with the Juvenile Justice System

*Prepared by*

Kathleen R. Skowyra and Joseph J. Coccozza, Ph.D.

The National Center for Mental Health  
and Juvenile Justice  
Policy Research Associates, Inc.  
Delmar, NY

*Supported by*

The Office of Juvenile Justice  
and Delinquency Prevention



# Table of Contents

<b>Acknowledgements .....</b>	<b>vii</b>
<b>Executive Summary .....</b>	<b>ix</b>
<b>Section One: The Comprehensive Model.....</b>	<b>1</b>
Overview	1
Purpose of the Comprehensive Model	2
Process	2
Organization of the Model	3
Underlying Principles	5
Cornerstones: The Key Elements of a Comprehensive System	5
Critical Intervention Points	5
Target Audience	7
Boundaries of the Model	7
<b>Section Two: Underlying Principles of the Comprehensive Model.....</b>	<b>11</b>
<b>Section Three: Cornerstones of the Comprehensive Model .....</b>	<b>13</b>
Cornerstone #1: Collaboration	15
Cornerstone #2: Identification	25
Cornerstone #3: Diversion	31
Cornerstone #4: Treatment	37
<b>Section Four: Critical Intervention Points of the Comprehensive Model.....</b>	<b>45</b>
Critical Intervention Point: Initial Contact with Law Enforcement	46
Critical Intervention Point: Intake	48
Critical Intervention Point: Detention	51
Critical Intervention Point: Judicial Processing	54
Critical Intervention Point: Dispositional Alternatives	57
Critical Intervention Point: Re-Entry	60
<b>Section Five: Program Descriptions .....</b>	<b>65</b>
<b>Section Six: Summary .....</b>	<b>99</b>
<b>Appendix A: Key Resources .....</b>	<b>101</b>
National Organizations	103
<b>Appendix B: Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State, Multi-System Prevalence Study .....</b>	<b>127</b>
<b>References .....</b>	<b>131</b>



# Acknowledgements

This document was produced by the National Center for Mental Health and Juvenile Justice (NCMHJJ), in partnership with the Council of Juvenile Correctional Administrators (CJCA), through a grant from the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The development of this document, and the completion of the tasks and activities associated with the project, would have not have been possible without the contributions and assistance of numerous individuals and organizations from across the country. The authors of this document wish to express our sincere appreciation to everyone who helped make the development of the Comprehensive Model possible.

First, we gratefully acknowledge the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and Administrator J. Robert Flores for providing the support to make this project possible. Our deepest gratitude is reserved for Karen Stern, without whom this work would not have been possible. Her leadership, guidance, and flexibility over the four years of the project provided us with the means to complete this challenging task. We thank you for your unwavering support. We also wish to acknowledge Doug Dodge, formerly of OJJDP, for his career-long support of improving the lives of youth in the juvenile justice system and his efforts to see this project materialize.

We would like to acknowledge the support of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Mental Health Services (CMHS) and, in particular, thank Sybil Goldman, Gary Blau, Rolando Santiago, and Pat Shea for their on-going commitment to our work at the NCMHJJ.

The authors wish to express their sincere gratitude to the members of our Model Development Workgroup, including Thomas Grisso of the University of Massachusetts Medical School; Terrence Thornberry of the University of Colorado at Boulder; Eric Trupin of the University of Washington; Karen Stern of OJJDP; and Ned Loughran and Kim Godfrey of CJCA. Your thoughtful guidance and insightful feedback strengthened this document in innumerable ways. We are particularly grateful to each of you for your careful reviews of each iteration of the Comprehensive Model and are deeply indebted to you for your assistance.

The authors wish to acknowledge all of the individuals who assisted us with the mental health prevalence study in the three study states—Washington, Texas, and Louisiana. This was a complex task that would not have been possible without the dedication and help of the following individuals:

**Washington State:**

Eric Trupin  
Sarah Tudor  
Megan DeRobertis

**Texas:**

William Kelly  
Susan Stone

**Louisiana:**

Pam McPherson  
Keith Cruise  
Debra DePrato  
Fabiola Rodericks

We thank the following consultants who provided us with expert guidance during the study design, implementation, and analysis phases, including Gail Wasserman and Larkin McReynolds of the Center for the Promotion of Mental Health and Juvenile Justice at Columbia University; Steve Banks of The Bristol Observatory; and Linda Teplin and Karen Abram of Northwestern University Medical School. We wish to thank the Federation of Families for Children's Mental Health and their affiliates in Washington, Texas, and Louisiana for their assistance in coordinating the Family Focus Groups. We would also like to acknowledge all of the state and local agencies and facilities that agreed to participate in the study and thank the staff within each of these facilities for graciously hosting our data collectors over the course of the study and allowing us to do this work.

The authors wish to thank the staff at Policy Research Associates for their work to organize and oversee the data collection effort and to thoughtfully analyze the results. In particular, we would like to thank Chan Noether, Jennie Shufelt, Tara Agnese, Laura Morris, Sarah McLean, and Margaret Lassiter for their assistance and hard work. We also wish to thank Hank Steadman for his overall guidance and perspective over the course of this project, and Dana Hebert, Jennifer Deschamps, and Janet Mattox for their research and design assistance.

We thank the members of our Expert Review group who provided us with valuable feedback on the final draft of the document. While their review did not constitute a formal endorsement of the document, their comments helped us shape the final version of the Model. These individuals include Richard Dembo, Cathy Foley-Geib, Robert Glover, Kenneth Martinez, Robert Schwartz, Sandra Spencer, Vicki Spriggs, Barry Stoodley, Linda Teodosio, and Janet Williams. We were extremely fortunate to have a number of youth also serve as part of this Expert Review group. Their unique perspective provided us with feedback that we were unlikely to obtain anywhere else. We thank Shane Correia, Flor Mena, Wendy Roman, and Carla Tabb from the Youth Justice Board, and Jimena Martinez of the Center for Court Innovations for her help in coordinating this review. We also thank the youth at Echo Glenn in Washington State for their review of the document and Eric Trupin for his help in coordinating this review.

This document represents the culmination of many years of work and effort, and we are privileged to have had the opportunity to be involved with such an important project. It is our sincere hope that the Comprehensive Model will be of benefit to the field and will result in the development of better policies and services for children and youth with mental health needs in contact with the juvenile justice system.



# Executive Summary

## Background

Every day, hundreds of thousands of youth cycle in and out of state and local juvenile justice systems throughout the country. They are seen in probation offices, juvenile detention centers, juvenile courts, and correctional facilities each day. Many of these youth have lives that have been marred by poverty, violence, substance abuse, academic disadvantage, and delinquent behavior. Further, we now know that the vast majority of these youth, approximately 70 percent, suffer from mental health disorders, with at least 20 percent experiencing disorders so severe that their ability to function is significantly impaired. Their illnesses include major depression, bipolar disorder, conduct disorder, attention deficit/hyperactivity disorder, anxiety disorder, and other potentially debilitating conditions. Frequently, a youth's disruptive or inappropriate behavior is the result or a symptom of a mental health disorder that has gone undetected and untreated. For some youth, contact with the juvenile justice system is often the first and only chance to get help. For others, it is the last resort after being bounced from one system to another. All too frequently, however, the opportunity to intervene early is wasted and youth end up in a system that is ill-equipped to help them, frustrating juvenile justice administrators and leaving youth without access to the treatment they need to get better. The crisis is real and the need to respond is more pressing than ever.

Juvenile justice systems across the country are struggling to take action. Some jurisdictions have formed partnerships with the mental health system to increase accessibility to community-based mental health services for these youth; other jurisdictions have created mental health treatment capacity within their juvenile justice systems; others have done very little simply because there has been a lack of information available about how best to respond.

Recognizing the problem, the Federal Office of Juvenile Justice and Delinquency Prevention launched their largest investment ever in mental health research in 2000, aimed at providing the field with guidance to help address this problem, and to ultimately improve the lives and well-being of children and youth with mental health needs who end up in the country's juvenile justice system. The National Center for Mental Health and Juvenile Justice, working in partnership with the Council of Juvenile Correctional Administrators, was awarded the contract for this work in 2001, and set out to complete the required tasks, which included:

- Conducting an extensive review of the research literature to identify issues and gaps in the existing research base;
- Completing a multi-site prevalence study of mental health needs and services for youth in different levels of juvenile justice care;
- Identifying existing promising practices and programs for providing mental health services to youth at critical points of juvenile justice system contact; and
- Using the data and information collected from these tasks to develop a Comprehensive Model for providing a broad range of mental health services to youth in contact with the juvenile justice system.

The results of this effort are presented here. ***Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System*** represents four years of work to develop a conceptual and practical framework for juvenile justice and mental health systems to use when developing strategies, policies, and services aimed at improving mental health services for youth involved with the juvenile justice system. The Model, which sets the highest goals for systems to work toward, summarizes

what we now know about the best way to identify and treat mental disorders among youth at key stages of juvenile justice processing, and offers recommendations, guidelines, and examples for how best to do this.

## Organization of the Model

To develop the Model, it was necessary to establish a framework to guide the effort. First, a set of Core Principles were developed to serve as the underpinning and guide all subsequent efforts to improve the coordination and delivery of mental health screening, assessment, and treatment for youth in contact with the juvenile justice system. These principles represent the foundation on which a system can be built that is committed and responsive to addressing the mental health needs of youth in its care. They include:

1. Youth should not have to enter the juvenile justice system solely in order to access mental health services or because of their mental illness.
2. Whenever possible and when matters of public safety allow, youth with mental health needs should be diverted into evidence-based treatment in a community setting.
3. If diversion out of the juvenile justice system is not possible, youth should be placed in the least restrictive setting possible, with access to evidence-based treatment.
4. Information collected as part of a pre-adjudicatory mental health screen should not be used in any way that might jeopardize the legal interests of youth as defendants
5. All mental health services provided to youth in contact with the juvenile justice system should respond to issues of gender, ethnicity, race, age, sexual orientation, socio-economic status, and faith.
6. Mental health services should meet the developmental realities of youth. Children and adolescents are not simply little adults.
7. Whenever possible, families and/or caregivers should be partners in the development of treatment decisions and plans made for their children.

8. Multiple systems bear responsibility for these youth. While at different times, a single agency may have primary responsibility, these youth are the community's responsibility and all responses developed for these youth should be collaborative in nature, reflecting the input and involvement of the mental health, juvenile justice, and other systems.
9. Services and strategies aimed at improving the identification and treatment of youth with mental health needs in the juvenile justice system should be routinely evaluated to determine their effectiveness in meeting desired goals and outcomes.

From these principles, four Cornerstones emerged that form the infrastructure of the Model and provide a framework for putting the underlying principles into practice. They reflect the most critical areas of improvement to enhance the delivery of mental health services to youth in contact with the juvenile justice system and include:

### Collaboration

The need for improved collaboration between the juvenile justice and mental health systems.

### Identification

The need for improved and systematic strategies for identifying mental health needs among youth in contact with the juvenile justice system.

### Diversion

The need for more opportunities for youth to be appropriately diverted into effective community-based mental health treatment.

### Treatment

The need for youth in contact with the juvenile justice system to have access to effective treatment to meet their needs.

A critical piece of the Model is the inclusion of recommended actions—over 30 detailed suggestions providing guidance and direction to the field on how to address each of the Cornerstones. Examples of efforts that have already been made in the field to address these issues are included as well.

Finally, these Cornerstones were juxtaposed against Critical Intervention Points within the juvenile justice continuum that present opportunities to improve collaboration, identification, diversion, and treatment

strategies for youth with mental health needs. The Critical Intervention Points include:

**Initial Contact with Law Enforcement:** This includes the initial contact a youth has with the police at the time they are suspected of committing a crime.

**Intake (Probation or Juvenile Court):** This includes the point at which a youth is referred by law enforcement to juvenile court. Often, the juvenile court intake function is the responsibility of the local probation department.

**Detention:** This includes the point at which a youth is placed in a secure detention setting.

**Judicial Processing:** This includes the point at which a petition is filed in juvenile court, an adjudication hearing is held, and the judge orders a disposition in the case.

**Dispositional Alternatives (Juvenile Correctional Placement or Probation):** This includes a discussion of two dispositional alternatives—placement in a juvenile correctional facility or placement on probation supervision.

**Re-Entry:** This includes the point at which a youth is released from a juvenile correctional placement and returns home.

Each Critical Intervention Point includes general information on the point of contact, as well as an examination of the mental health issues associated with that particular point in the continuum. Current program and policy examples are included here, as well as throughout the entire document, illustrating how communities across the country have taken steps to develop or enhance services for youth with mental health needs at key stages of juvenile justice system contact. Complete descriptions, with contact information, of every program referenced in the document are included, along with an extensive Resource List of relevant policies, instruments, reports, organizations, websites, and other sources of information pertaining to juvenile justice and mental health.

## Research-Based Knowledge

The Model was informed by the most comprehensive mental health prevalence study conducted to date among youth in the juvenile justice system: 1437 youth in three different states in three types of juvenile justice settings—detention, corrections, and community-based

programs. No single previous mental health prevalence study conducted among youth in the juvenile justice system has examined youth in multiple states and in multiple juvenile justice settings, using standardized instruments to collect data.

The results of the study, which were incorporated into the Model, confirmed that, regardless of level of care or geographic region of the country, the majority of youth in the juvenile justice system meet criteria for at least one mental health diagnosis. Overall, 70.4 percent of youth were diagnosed with at least one mental health disorder, with girls experiencing a higher rate of disorders (81%) when compared to males (66.8%). For many of the youth in the study, their mental health status was complicated by the presence of more than one disorder. Of those youth who were diagnosed with a mental health disorder, 79.1 percent met criteria for at least one other mental health diagnosis. The majority of youth who met criteria for a mental health diagnosis were also diagnosed with a co-occurring substance use disorder. Among those youth with at least one mental health diagnosis, approximately 60 percent also met criteria for a substance use disorder.

## Target Audience

While much of what it is presented in the document will have implications for policymakers, clinicians, and line staff, the Model is primarily oriented to state and county juvenile justice and mental health administrators and program directors who are responsible for establishing, modifying, and overseeing services affecting youth with mental health needs in contact with the juvenile justice system. The Model is not a clinical implementation document; rather, it serves as a “change agent” to spur new thinking and the subsequent development of improved strategies to better identify mental health needs among youth in the juvenile justice system, as well as to improve the delivery of services to these youth.

## Partners

The Comprehensive Model was developed in conjunction with a Model Development Workgroup, which comprised national mental health and juvenile justice experts and researchers, who provided guidance and direction to the National Center for Mental Health and Juvenile Justice as we embarked on this project. This Workgroup met regularly over the four years of the project to provide

feedback, suggestions, and recommendations for how best to approach, implement, and refine every aspect of this project. In addition, the final draft of the Comprehensive Model was circulated to a group of national Expert Reviewers, including mental health and juvenile justice administrators, policymakers, practitioners, advocates, and youth who provided final comments on the draft.

## Summary

This challenging project has culminated in the first ever systematic review of the juvenile justice system in its entirety—from intake to re-entry—to identify ways in which mental health service delivery strategies can be strengthened. The premise, however, is not complicated: stronger partnerships between the juvenile justice and mental health systems can result in better screening and assessment mechanisms at key points of juvenile justice contact, enhanced diversion opportunities for youth with mental health needs to be treated in the community, and increased access to effective mental health treatment. This Model provides a detailed blueprint for how to achieve these goals. What it cannot do, however, is actually effect the change. This can only be accomplished by the leaders in the juvenile justice and mental health fields who have been struggling to develop solutions to meet the needs of these youth. This document provides them the tool to move forward. The energy, hard work and political will to actually make this happen must come from them.

# Section One: The Comprehensive Model

## Overview

There is a growing body of evidence that suggests that large numbers of youth in contact with the juvenile justice system have identified mental health disorders. Until the last decade, however, there was a paucity of research available documenting the degree to which youth in contact with the juvenile justice system were experiencing mental illness. New research, conducted over the last 10 years, has significantly expanded our collective knowledge and understanding of the nature and prevalence of mental health disorders among the juvenile justice population. These new data have provided the field with a more precise assessment of the problem.

For example, we now know that youth in the juvenile justice system experience substantially higher rates of mental disorder than youth in the general population. (Otto, Greenstein, Johnson & Friedman, 1992; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wierson, Forehand, & Frame, 1992). Studies have consistently found that 65 percent to 70 percent of youth in the juvenile justice system have a *diagnosable* mental health disorder (Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002; Wasserman, Ko & McReynolds 2004). Further, it is safe to estimate that approximately one out of every five youth in the juvenile justice system has a serious mental health disorder (Cocozza & Skowrya, 2000).

Many of these youth are detained or placed in the juvenile justice system for relatively minor, nonviolent offenses but end up in the system simply because of a lack of community-based treatment options available to them. A review in Louisiana by the Annie E. Casey Foundation (2003) found that more than 75 percent of Louisiana's incarcerated youth were locked up for nonviolent and drug offenses. Further, a recent study of mental health prevalence among youth in the juvenile justice system

found that of youth with a mental health diagnosis, only 23.5 percent had committed a violent offense as their most serious offense, with the majority of youth involved with the juvenile justice system for property offenses and probation or parole violations (NCMHJJ, 2005). The placement of these youth in the juvenile justice system is part of a growing trend toward the "criminalization of the mentally ill"—placing individuals with mental health needs in the justice system as a means of accessing mental health services that are otherwise unavailable or inaccessible in the community (Bell & Shern, 2002). While this trend has been evident at the adult level for some time, it is now being observed at the juvenile level as well. Thus, the juvenile justice system is viewed as becoming the "public mental health system" for large numbers of youth who are referred there because there is often no other place to seek help.

The growing crisis surrounding these youth is highlighted by a plethora of independent reports and media accounts over the last several years drawing attention to the large number of justice-involved youth who have significant mental health needs but whose needs are not being met. A series of investigations by the U.S. Department of Justice into the conditions of confinement in juvenile detention and correctional facilities repeatedly found a failure on the part of the facilities to adequately address the mental health needs of youth in their care (U.S. Department of Justice, 2005). In addition, media inquiries and reports documenting the mental health crisis within juvenile justice systems in New Jersey, Arizona, California, Michigan, and Pennsylvania, for example, have drawn national attention to an issue that has not traditionally received much consideration from the media. This unprecedented exposure has resulted in elected officials, policymakers, and practitioners struggling to respond and develop more effective solutions for these youth.

This new knowledge serves not only to illustrate the extent of the problem, but provides a solid empirical base for the development of new policies and practices that effectively respond to the needs of these youth. The new research and work that has been done in this area over the last 10 years documents the problem. In order for the field to move forward, there must be recognition, on the part of both the juvenile justice and mental health systems, that many youth in the juvenile justice system are experiencing significant mental health problems and that responsibility for effectively responding lies with both the mental health and juvenile justice systems.

## Purpose of the Comprehensive Model

The increasing awareness and concern about the unmet mental health needs of large numbers of youth in contact with the juvenile justice system has been accompanied over the past few years by the development of improved policies, strategies, and practices for responding to this population. Now, more than ever before, significant energy and resources have been directed to the development of new tools, programs, and resources to help the field better identify and provide appropriate care and treatment to these youth. Yet, despite the pockets of activity that are underway in states and communities throughout the country, to date there has been no attempt made to systematically examine these existing efforts and to comprehensively package this information as a tool that provides guidance and direction to the field. Our goal for this document is to capture this activity and present it in a way that looks at the juvenile justice system as a continuum—from intake to re-entry—summarizing what it is we now know about the best way to identify and treat mental disorders among youth at key stages of juvenile justice processing, and offering recommendations, guidelines, and examples for how best to do this.

## Process

In February 2000, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) issued a solicitation for applications to engage in a series of activities designed to improve knowledge about the nature and prevalence of mental health disorders among youth in the juvenile justice system, and to use this information to develop a Comprehensive Model for providing mental health services to this population. In April 2000, the

National Center for Mental Health and Juvenile Justice (NCMHJJ), working in partnership with the Council of Juvenile Correctional Administrators (CJCA), submitted a proposal to complete this work, and in June 2001 was awarded the grant for the project.

The project included the following key tasks:

- Conducting an extensive review of the research literature to identify and highlight issues and gaps in the existing research base;
- Completing a multi-site prevalence study of mental health needs and services for youth in three different levels of juvenile justice care—juvenile correctional facilities, juvenile detention centers, and community-based facilities;
- Identifying existing promising practices and programs for providing mental health services to youth at critical points of juvenile justice system contact;
- Using the data and information collected from these tasks to inform the development of a Comprehensive Model for providing a broad range of mental health services to youth in contact with the juvenile justice system.

To complete these tasks, the NCMHJJ established a Model Development Workgroup, comprising national mental health and juvenile justice experts and researchers, to provide guidance and direction to the NCMHJJ as we embarked on this project. This Workgroup met regularly throughout the course of this project to provide feedback, suggestions, and recommendations for how best to approach, implement, and refine every aspect of this project.

To conduct the mental health prevalence and services study, we relied on a cadre of researchers from across the country to undertake this challenging task. We identified the sites for the study based on criteria that was included in OJJDP's original solicitation, which specified that the study be conducted in understudied parts of the South, Southwest and rural Northwest. To this end, we selected three states to participate in the study—Louisiana, Texas, and Washington. In each state, we identified a Principal Investigator to serve as the coordinator for the local data collection and as a liaison to the NCMHJJ over the course of the data collection period. Working with the NCMHJJ, each Principal Investigator identified juvenile justice facilities to participate in the study and hired staff to interview youth and collect the data. After numerous

human subject review requirements were satisfied, data collection in all three states began in May of 2003 and ended in April 2004.

The results of the prevalence study confirmed that, regardless of level of care or geographic region of the country, the majority of youth in the juvenile justice system meet criteria for at least one mental health diagnosis. Overall, 70.4 percent of youth were diagnosed with at least one mental health disorder. Among males, Disruptive Disorders were most prevalent, followed by Substance Use Disorders. Among females, Anxiety Disorders were most prevalent, followed by Substance Use Disorders. Rates of mental health disorders are presented in Table I below, both overall and separately for males and females. For many of the youth in the study, their mental health status was complicated by the presence of more than one disorder. Of those youth who were diagnosed with a mental health disorder, 79.1 percent met criteria for at least one other mental health diagnosis.

The majority of youth who met criteria for a mental health diagnosis were also diagnosed with a co-occurring substance use disorder. Among those youth with at least one mental health diagnosis, approximately 60 percent also met criteria for a substance use disorder. Co-occurring substance use disorders were most common for youth with a diagnosis of disruptive disorder; however, significant proportions of youth with anxiety disorders (52.3%) and mood disorders (61.3%) also had a co-occurring substance use disorder. A complete description of the prevalence study and its findings can be found in Appendix B.

Simultaneous to the data collection, the NCMHJJ actively began development of the Model by reviewing the

research literature and identifying existing programs throughout the country that currently provide mental health services to youth involved with the juvenile justice system. Each draft of the Model was shared with the members of our Model Development Workgroup and comments from the group were incorporated into each revised version. Once the data from the prevalence study was analyzed, this information was added to the Model, providing further, quantifiable justification for many of the recommendations included in the document. The final draft of the Comprehensive Model was then circulated to a group of national Expert Reviewers, including mental health and juvenile justice policymakers, practitioners, advocates, and youth for final comment. Comments from the Expert Reviewers were summarized and shared with our Model Development Workgroup, who provided final guidance as to how these comments could best be incorporated into the final document.

## Organization of the Model

To develop the Model, it was necessary to establish a set of core directions to guide our work and to provide a framework for the document. First, a set of **Core Principles** was developed to serve as the underpinning of the comprehensive model and to guide all subsequent efforts to improve the coordination and delivery of mental health screening, assessment, and treatment for youth in contact with the juvenile justice system. From these principles, four **Cornerstones** emerged that form the foundation of the comprehensive model. These Cornerstones provide the necessary infrastructure and reflect key areas where significant improvements can be made to better serve youth with mental health needs. Finally, these key elements were juxtaposed against select, **Critical Intervention Points** within the juvenile justice continuum that present, in our estimation, realistic opportunities to improve collaboration, identification, diversion, and treatment strategies for youth with mental health needs.

This conceptual framework for the comprehensive model is presented in **Figure I** and is described below.

	Overall	Males	Females
Any Disorder	70.4	66.8	81.0
Any Anxiety Disorder	34.4	26.4	56.0
Any Mood Disorder	18.3	14.3	29.2
Any Disruptive Disorder	46.5	44.9	51.3
Any Substance Use Disorder	46.2	43.2	55.1

**Table I Rates of Mental Health Disorder**

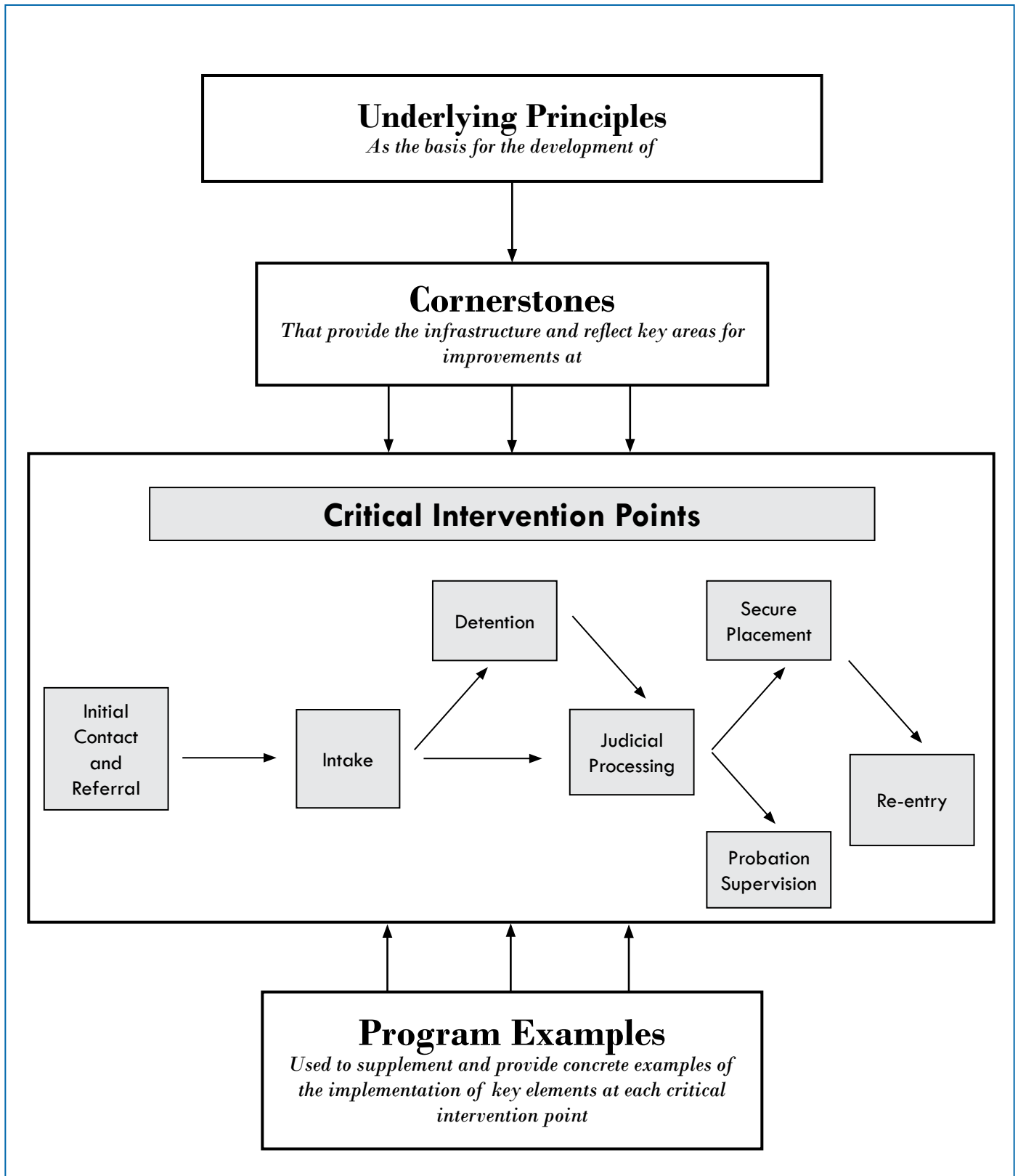


Figure I Conceptual Framework of the Comprehensive Model



## Underlying Principles

The underlying principles guide the model and provide the basis for the recommendations that are put forward in the document. These principles represent the foundation on which a system can be built that is committed and responsive to addressing the mental health needs of youth in its care. The Underlying Principles of the Comprehensive Model include:

1. Youth should not have to enter the juvenile justice system solely in order to access mental health services or because of their mental illness.
2. Whenever possible and when matters of public safety allow, youth with mental health needs should be diverted into evidence-based treatment in a community setting.
3. If diversion out of the juvenile justice system is not possible, youth should be placed in the least restrictive setting possible, with access to evidence-based treatment.
4. Information collected as part of a pre-adjudicatory mental health screen should not be used in any way that might jeopardize the legal interests of youth as defendants
5. All mental health services provided to youth in contact with the juvenile justice system should respond to issues of gender, ethnicity, race, age, sexual orientation, socio-economic status, and faith.
6. Mental health services should meet the developmental realities of youth. Children and adolescents are not simply little adults.
7. Whenever possible, families and/or caregivers should be partners in the development of treatment decisions and plans made for their children.
8. Multiple systems bear responsibility for these youth. While at different times, a single agency may have primary responsibility, these youth are the community's responsibility and all responses developed for these youth should be collaborative in nature, reflecting the input and involvement of the mental health, juvenile justice, and other systems.

9. Services and strategies aimed at improving the identification and treatment of youth with mental health needs in the juvenile justice system should be routinely evaluated to determine their effectiveness in meeting desired goals and outcomes.

## Cornerstones: The Key Elements of a Comprehensive System

The Cornerstones represent the foundation of the model and provide a framework for putting the underlying principles into practice. These Cornerstones reflect the most critical areas of improvement to enhance the delivery of mental health services to youth in contact with the juvenile justice system. These include:

### **Collaboration**

The need for improved collaboration between the juvenile justice and mental health systems.

### **Identification**

The need for improved and systematic strategies for identifying mental health needs among youth in contact with the juvenile justice system.

### **Diversion**

The need for more opportunities for youth to be appropriately diverted into effective community-based mental health treatment.

### **Treatment**

The need for youth in contact with the juvenile justice system to have access to effective treatment to meet their needs.

For each Cornerstone, we offer a policy statement in support of addressing the issue, background information, and a set of recommended actions for addressing the Cornerstone. Examples of efforts that have already been taken in the field to address each of these key elements are included as well.

## Critical Intervention Points

In order to provide guidance around the practical application of the recommended actions included for each key element, we identified a series of critical intervention points within the juvenile justice continuum that offer

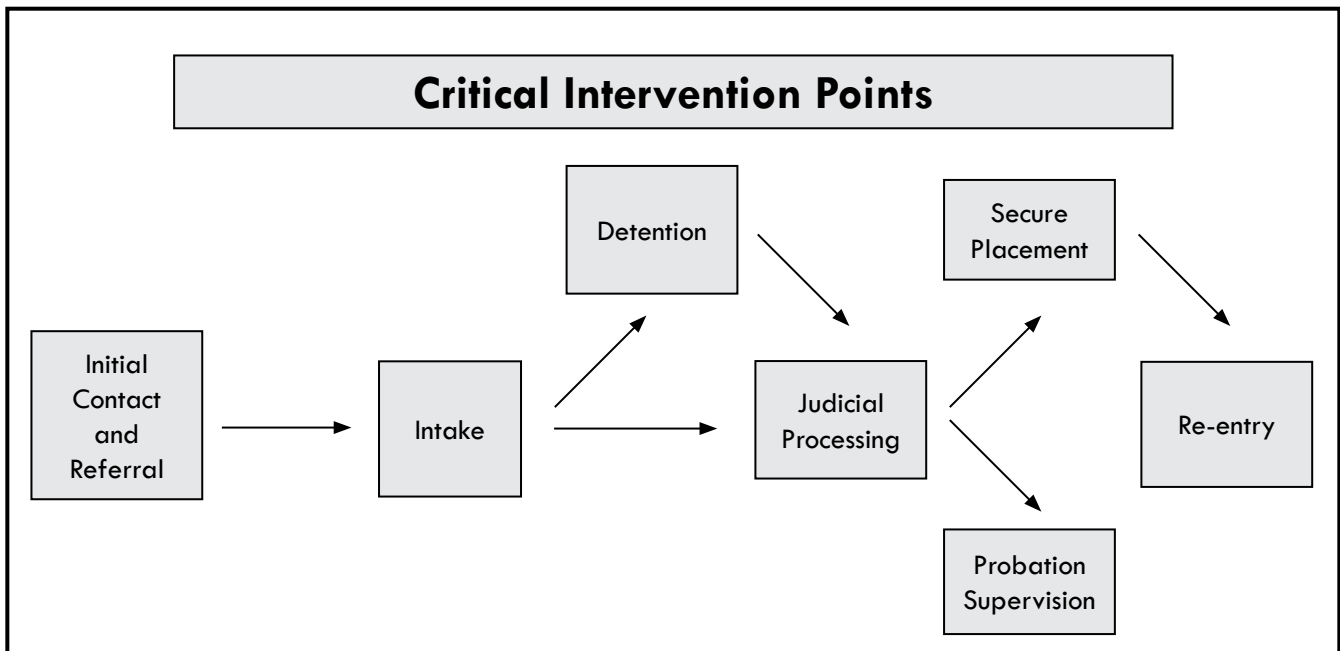
opportunities to make better decisions about mental health needs and treatment. It is recognized that there is tremendous variation across states, and even within states, in how juvenile justice services are organized and provided. Nonetheless, there are some general points in the system where opportunities to improve the delivery of mental health services exist. These critical intervention points are initial contact with law enforcement, intake, detention, judicial processing, disposition (including probation and juvenile correctional placement) and re-entry, as depicted below in **Figure II**.

The critical intervention points in **Figure II** represent the primary opportunities for mental health interventions in at least three ways. First, they are points where youth with mental health problems can be identified through various procedures such as the training of law enforcement officials in identifying mental health symptoms at initial contact, the use of standardized screening and assessment instruments at intake and other points, and the use of psychiatric assessments and diagnostic tests. Second, each point also represents an opportunity to divert youth from further penetration into the justice system and into community-based services and programs. This is particularly true at the pre-adjudication stages between initial contact and judicial processing. Third, for youth identified with mental health disorders who are not diverted, these stages represent key points for the provision of mental health services either by the

juvenile justice system alone or in conjunction with the mental health treatment system.

For each of the critical intervention points, the Model provides a general description of that stage in the context of the larger juvenile justice continuum, an examination of relevant mental health issues, and case examples of promising programs that respond to the mental health needs of youth at that point in the system. In some instances, the program examples reflect evidence-based interventions, that is, interventions for which there is a strong research base indicating positive outcomes. In other instances, the examples represent promising programs that are consistent with the cornerstones of the Model, and reflect, in a general sense, what is considered to be best practice in the field.

Cross-referencing the Cornerstones against individual points of contact within the juvenile justice system offers a comprehensive approach to improving mental health identification and treatment across the entire continuum. However, it also presents an opportunity to consider how improvements can be made in smaller, more incremental steps, for instance within detention settings or as part of a plan to improve aftercare services for all youth leaving a juvenile correctional placement. In essence, the model serves a dual role. It offers a comprehensive blueprint for how mental health issues can be better addressed within the juvenile justice system as a whole, offering communities a plan for re-tooling the



**Figure II Key Points in the Juvenile System for Mental Health Intervention**

entire system. At the same, the model also effectively compartmentalizes the system into discrete points of contact, allowing communities to consider implementing individual components of the model as a first step in an effort to improve their system.

## Target Audience

While much of what is presented in this document will have implications for policymakers, clinicians, and line staff, the model is not primarily oriented to these groups. Rather, it is targeted to state and county juvenile justice and mental health administrators and program directors who are responsible for establishing, modifying, and overseeing services affecting youth with mental health needs in contact with the juvenile justice system. The model is not a clinical implementation document, but serves as a “change agent” to spur the development of improved strategies to better identify mental health needs among youth in contact with the juvenile justice system, as well as to improve the delivery of services to these youth. The model provides state and county juvenile justice administrators and program directors, and their counterparts in the mental health system, with a blueprint for how to affect positive change, recognizing that certain limitations exist and that any modifications or improvements to the system must be made in the context of current political and economic realities.

## Boundaries of the Model

While this document represents the most comprehensive attempt to date to describe and provide guidelines for how mental health screening, assessment, and treatment can best be provided to youth in contact with the juvenile justice system, there are a number of remaining issues that go beyond the scope of the Model presented here. These issues are important to highlight because they present challenges to the field and, at some point, will need to be more thoroughly addressed. This model does not attempt to solve these issues. Rather, the model offers recommendations for comprehensive improvement in key areas that could positively affect some of the larger and remaining “systems” issues.

**A. Existing tension between the juvenile justice and mental health systems.** First, it is recognized that there is a great deal of underlying tension between the juvenile justice and mental health systems when it comes to determining responsibility for this population of youth.

Despite the fact that existing prevalence data suggest that the vast majority of youth involved with the juvenile justice system have mental health problems, the reality is that the existing juvenile justice system is not designed, nor does it have the capacity or specific mandate, to respond to all youth with mental health problems. This issue gets at the heart of the conflict between the juvenile justice and mental health systems. There is general agreement that the juvenile justice system should not become the designated mental health provider to the large numbers of youth who enter the system with mental health needs. Yet, the juvenile justice system is very often where many of these youth end up, and their needs cannot be ignored. This “responsibility by default” has led to a high degree of tension (and sometimes resentment) between the juvenile justice and mental health systems. This reality is recognized by the authors of this document, and it was within this context that we set out to begin the process of outlining the most critical ways the two systems can work together to develop more collaborative strategies and partnerships for responding to these youth. In this document, we identify a set of recommendations for improving coordination between the juvenile justice and mental health systems. At the same time, however, we recognize that resolving the existing tension will require much more work in the future to successfully address this complex issue.

### **B. The lack of available mental health services.**

A second reality facing both the juvenile justice and mental health systems is the fact that all youth who may need services cannot get services. The 2000 Surgeon General’s report on children’s mental health found that approximately 20 percent of children and youth in the general population experience a diagnosable mental health disorder, with 10 percent of youth experiencing illness severe enough to cause impairment (USDHHS, 2000). It is estimated that as few as 10 percent of youth with severe mental illness will receive the treatment that they need (USDHHS, 2000). There simply are not enough mental health services available to treat all of the youth who need such services, including youth in the juvenile justice system. Further, the juvenile justice system simply does not have the resources to respond to every child who may need services. There are numerous practical reasons for placing some limits on the obligation to respond to every youth’s mental disorder, including the enormous financial and professional resources necessary to do this, as well as the potential risk for net-widening and longer sentences or periods of confinement for youth (Grisso, 2004). The current reality is that the juvenile justice and mental health systems use their existing (and

often limited) resources to identify and treat only a small proportion of those children who need services.

### **C. Determining levels of mental health need.**

Increasing the supply of mental health services available to youth would only solve part of the problem. Research indicates that anywhere from 67 to 70 percent of youth in the juvenile justice system have a diagnosable mental health disorder (Teplin et al., 2002; Wasserman et al., 2002; Wasserman et al., 2004). While not all of these youth require a high level of service, clearly all could benefit from some type of mental health treatment or intervention, with some requiring more intense services than others. The question becomes, how do you identify those youth who are most seriously disordered and who are in greatest need of services? Attempts to estimate the exact prevalence of severe mental illness within the juvenile justice population are difficult given the lack of consensus on how best to measure this. Some measures limit the definition to certain psychiatric diagnoses; others focus on the degree of impairment; while others use service utilization as an indication of severity (Narrow, Reiger, Goodman, Rae, Roper, Bourdon, Hoven & Moore, 1998). It has been estimated, based on extrapolations from the prevalence of severe mental illness in the general youth population, that approximately 20 percent of justice-involved youth experience illness severe enough to require immediate and significant treatment (Cocozza & Skowrya, 2000). Using data collected as part of the study to develop this Model, the prevalence of severe mental illness was examined using each of the above approaches. The results suggest that the rate of severe mental illness may be even higher, with 17–27 percent of youth meeting criteria for serious mental illness, depending on the definition used (NCMHJJ, 2005).

Currently, there is no clear, objective, scientifically based formula to distinguish between the different levels of need or seriousness in order to determine which youth should receive services. This document does not attempt to resolve the issue. Until there is some objective measure to determine a youth's level of need, it is our recommendation that triage decisions be based on sound clinical judgment, with consideration given to a youth's diagnosis, level of impairment, and receptivity to treatment.

**D. Focus on mental health.** There is emerging empirical evidence to support the assertion that large numbers of youth in the juvenile justice system have co-occurring mental health and substance use disorders. The results of the prevalence study undertaken as part of the

development of this model found that of those youth with a mental health diagnosis, 58.5 percent of males and 65.6 percent of females also had a co-occurring substance use disorder. Despite significant gains that have been made on this issue recently, the knowledge and research base on the extent of the problem within the juvenile justice population, and how best to treat co-occurring disorders among justice-involved youth, is generally less available. More research and work on the development of effective identification and treatment strategies for youth with mental health and co-occurring substance use disorders is necessary. While this document begins to address some of the issues associated with co-occurring mental health and substance use disorders, the document focuses more heavily on mental health and does not address issues pertaining to youth with only substance use disorders in the juvenile justice population. There has been much work done to develop a strong research base on substance abuse among juveniles, and many programs and interventions have been developed to effectively treat substance abuse among youth. However, per the terms and specifications put forward by the Office of Juvenile Justice and Delinquency Prevention, the clear focus of the work was to develop a Comprehensive Model for addressing the mental health needs of the juvenile justice population. As a result, this document does not directly address the issue of youth with substance use disorders.

### **E. Recommendations targeted to the juvenile justice and mental health systems.**

It is explicitly recognized that youth in contact with the juvenile justice system often have interactions and contact with a number of systems, not simply the mental health system. Minimally, many of these youth are simultaneously known to the education system and to the child welfare system as well. Youth typically “flow” through these systems and as such, different agencies have different responsibilities at varying points in time. The authors of this document recognize that any effective and sustainable collaboration between the juvenile justice and mental health systems should include representatives from other child-serving systems as well as families. These “extended collaborations” can help to ensure that efforts to improve services and linkages are as holistic and coordinated as possible. However, for the purposes of the Comprehensive Model, it was necessary for the authors to target the majority of the discussion and recommendations to the two primary systems in question—juvenile justice and mental health. This is not meant, in any way, to minimize the role that other child serving systems should play in the development and implementation of strategies to improve the delivery of

mental health services to this population of youth. It is meant to underscore the fact that any meaningful and positive changes that take place within a community to improve the way youth in contact with the juvenile justice system are identified and treated for mental health needs must begin, at a minimum, with the juvenile justice and mental health systems.



## Section Two: Underlying Principles of the Comprehensive Model

The Underlying Principles provide the foundation for the Comprehensive Model. These statements reflect the philosophy and values behind the Model and communicate our beliefs for the development of a system that is respectful of children, youth, and families, and committed and responsive to improving mental health services for youth in its care.

1. Youth should not have to enter the juvenile justice system solely in order to access mental health services or because of their mental illness.
2. Whenever possible and when matters of public safety allow, youth with mental health needs should be diverted from the juvenile justice system into evidence-based treatment in a community setting.
3. If diversion out of the juvenile justice system is not possible, youth should be placed in the least restrictive setting possible, with access to evidence-based treatment.
4. Information collected as part of a pre-adjudicatory mental health screen should not be used in any way that might jeopardize the legal interests of youth as defendants
5. All mental health services provided to youth in contact with the juvenile justice system should respond to issues of gender, ethnicity, race, age, sexual orientation, socio-economic status, and faith.
6. Mental health services should meet the developmental realities of youth. Children and adolescents are not simply little adults.
7. Whenever possible, families and/or caregivers should be partners in the development of treatment decisions and plans made for their children.
8. Multiple systems bear responsibility for these youth. While at different times, a single agency may have primary responsibility, these youth are the community's responsibility and all responses developed for these youth should be collaborative in nature, reflecting the input and involvement of the mental health, juvenile justice, and other systems.
9. Services and strategies aimed at improving the identification and treatment of youth with mental health needs in the juvenile justice system should be routinely evaluated to determine their effectiveness in meeting desired goals and outcomes.





## Section Three: Cornerstones of the Comprehensive Model

In order to provide a framework for improving the way the juvenile justice and mental health systems respond to youth with mental health needs in contact with the juvenile justice system, four issues are presented that identify the most critical areas for improving the system. These issues, or Cornerstones, form the basis for the subsequent discussion and recommendations included in the Model. They include collaboration, identification, diversion, and treatment. For each Cornerstone, background information is presented, along with series of specific, recommended actions.



## Cornerstone #1: Collaboration

**1. In order to appropriately and effectively provide services to youth with mental health needs, the juvenile justice and mental health systems should collaborate in all areas, and at all critical intervention points.**

### Background

The increasing number of youth in the juvenile justice system with identified mental health needs is placing a strain on the juvenile justice system in ways never seen before. The growing awareness of the needs of this population, and the concern over their care and treatment while involved with the juvenile justice system, documented in numerous advocacy, media, and government reports, has created a “mental health crisis” for juvenile justice administrators across the country. The Executive Director of the Coalition for Juvenile Justice (CJJ) has called mental health “the number one emergent issue as far as juvenile justice is concerned” (Coalition for Juvenile Justice, 2000). Further, mental health was cited as the single most pressing issue facing juvenile justice administrators in a recent meeting of state juvenile justice agency directors.

Despite the large numbers of youth with mental health needs in the juvenile justice system, the current landscape of service delivery for these youth is often fragmented, inconsistent, and operating without the benefit of a clear set of guidelines specifying responsibility for the population. In the search for better responses, it is important to stress that no one system bears sole responsibility for caring for these youth. Full responsibility for meeting the complex needs of juveniles with mental disorders cannot fall to any one system or agency. An effective response must include the development of collaborative approaches involving both mental health and juvenile justice systems.

The juvenile justice system was never intended to serve as the primary provider of mental health services for youth. The system lacks the necessary resources, expertise, and training to be able to do this on its own and is not interested in “transforming” itself into the mental health provider for youth. What distinguishes the juvenile justice system from other child serving systems, such as mental health or education, is the fact that the juvenile justice

system cannot say “no”—they cannot refuse to accept a child. This responsibility to serve and protect places the juvenile justice system in a very difficult situation when a large proportion of the youth that they are responsible for serving and protecting are mentally ill.

The juvenile justice system is not looking for new mental health business. Nor would it be reasonable to suggest that the mental health system is solely responsible for addressing this issue as well. Instead, a more balanced solution is required, one that involves both the juvenile justice and mental health systems as partners in all efforts to identify and respond to the mental health needs of these youth. Recognition of the problem on the part of both systems is the crucial first step. Taking joint responsibility for addressing the problem is the next and equally, if not more, important step.

Recent Federal efforts have resulted in the creation of a national climate that is increasingly supportive of collaboration between the juvenile justice and mental health systems. The Comprehensive Community Mental Health Services for Children and their Families Initiative (referred to as the Systems of Care model) was created in 1992 by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a way to promote more effective ways to organize, coordinate, and deliver mental health services and supports to youth and their families (SAMHSA, 2005). The program encourages the development of multi-agency partnerships involving the mental health, juvenile justice, child welfare, and education systems to provide services using a strength-based approach that is driven by the individual needs of the youth and family. Some communities have used this funding to create and enhance service delivery strategies for youth in the juvenile justice system, including such well-known programs as WrapAround Milwaukee, the Dawn Project in Indiana, and Project Hope in Rhode Island.

The President’s New Freedom Commission on Mental Health, in their report released in July 2003, called for the transformation of the nation’s mental health system, and included numerous recommendations for improving the organization and delivery of mental health services. The report also references the need for the wide adoption of diversion and re-entry strategies to avoid the unnecessary criminalization of adult and juvenile offenders with

mental illness. Building on these recommendations, SAMHSA and other Federal agencies, such as the Department of Justice, followed up with the release of an action agenda for putting the recommendations in the report into action. The Federal Mental Health Action Agenda, released in July 2005, includes five principles to guide the mental health transformation process, along with specific action steps detailing immediate activities that the Federal government will initiate to begin this process. Principle B calls for increased “focus on community models of care that effectively coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services” (SAMHSA, 2005). One action step for this principle includes building on and expanding criminal and juvenile justice and mental health collaborations by establishing a new cooperative agenda between the Federal Department of Health and Human Services and the Department of Justice. This cooperative agenda directs the Office of Justice Programs (OJP) and SAMHSA to continue to develop and support juvenile justice diversion and reintegration programs for youth.

The push for more collaboration can be seen not only on the mental health side, but also on the juvenile justice side. The 2003 reauthorization of the Juvenile Justice and Delinquency Prevention (JJDP) Act puts into place new provisions that allow for and encourage the use of funds to support mental health treatment to delinquent youth or youth at risk of delinquency. Guidelines concerning the use of Juvenile Justice Delinquency Prevention Block Grant program funds were broadened to allow for the support of projects that provide mental health treatment to juvenile offenders or youth who are at risk of becoming juvenile offenders, and their families, to reduce the likelihood that youth will commit violations of the law. Funds may also be used to support comprehensive juvenile justice and delinquency prevention projects that meet the needs of youth through collaboration with other local systems, including, among others, the mental health system. Changes made to the Juvenile Accountability Block Grant (JABG) program call for the establishment of interagency information-sharing systems that enable the juvenile justice system to make more informed decisions regarding the early identification, supervision, and treatment of juveniles. JABG purpose areas also call for the establishment of programs to conduct risk and need assessments of juvenile offenders that allow for effective early intervention and the provision of comprehensive services, including mental health screening and treatment. These changes reflect the growing awareness of the

importance of addressing mental health needs among youth in the juvenile justice system and providing support for the establishment or expansion of juvenile justice and mental health system collaboratives.

## Wider Multi-System Collaboration

While the juvenile justice and mental health systems must clearly be involved in any attempt to improve the coordinated response to youth in the juvenile justice system with mental health needs, there are other systems that also play a critical role in responding to the multiple needs of justice-involved youth. The substance abuse system is a stakeholder system that has a responsibility to provide treatment services to youth. There is a significant body of evidence indicating that large numbers of youth in the juvenile justice system have substance use disorders, with studies suggesting that about 50 percent of justice-involved youth meet DSM-IV criteria for a substance use disorder (NCMHJJ, 2005; Teplin, 2002; Wasserman, 2002). In many states, the mental health agency is responsible for providing both mental health and alcohol and other drug services (National Association of State Mental Health Program Directors, 2004). In other states, the substance abuse agency is a separate, standalone entity. Under either scenario, it is critical that the substance abuse system be involved in any attempt to improve services for youth involved with the juvenile justice system, particularly given the documentation of the frequency of co-occurring mental health and substance use disorders.

The term co-occurring disorder refers to co-occurring substance-related and mental disorders (Center for Substance Abuse Treatment, 2005). While the research base on co-occurring disorders is still emerging, existing studies suggest that the rates of co-occurring mental health and substance use disorders among the juvenile justice population are high (Abram, Teplin, McClelland, & Dulcan, 2003; Jensen & Potter, 2003; Neighbors, Kempton, & Forehand, 1992). The prevalence study conducted as part of the development of this Model found that among youth with a mental disorder, 60.9 percent also met criteria for a co-occurring substance use disorder. An earlier study of youth in the Cook County, Illinois detention center found that among juvenile detainees with major mental disorders, 58.4 percent of females and 73.8 percent of males also had a substance use disorder (Abram, et al., 2003). Youth with co-

occurring mental health and substance use disorders are best served through an integrated screening, assessment, and treatment planning process that addresses both substance use and mental disorders, each in the context of the other (CSAT, 2005).

The education system is a key stakeholder whose participation should be sought when developing improved strategies for identifying and treating mental health disorders within the juvenile justice population. The need for strong linkages between the juvenile justice system and the education system is compelling. First, evidence suggests that large numbers of youth involved with the juvenile justice system have education-related disabilities, and as many as 20 percent of students with emotional disabilities are arrested at least once before they leave school (Burrell & Warboys, 2000). The majority of youth who enter juvenile correctional facilities come into the system with a broad range of intense educational, mental health, medical, and social needs (National Center on Education, Disability and Juvenile Justice, 2005), and many of these youth are marginally literate or illiterate and have frequently experienced school failure and grade retention (Center on Crime Communities and Culture, 1997). Zero tolerance policies, instituted in school districts across the country, have resulted in schools referring more youth to the juvenile justice system for behaviors that used to be handled by school administrators (Rimer, 2004). Many of these referrals involve students with special education needs whose behavior is often related to their disability (Lynagh & Mancuso, 2004). Information about a youth's disability may be relevant at every stage of juvenile justice processing, and can help determine whether formal juvenile justice processing should proceed or if other strategies should be employed (Burrell & Warboys, 2000). Many of these youth are eligible for special education and related services (which can include psychological services) as part of an Individualized Education Plan (IEP) under the Federal Individuals with Disabilities Education Act (IDEA). It is important for probation officers, judges, juvenile correctional staff, mental health professionals, and families to be knowledgeable about special education issues and processes to ensure that youth receive the services they need, both in community settings, as well as institutional settings, such as detention and corrections (Burrell & Warboys, 2000).

Second, the education system plays a crucial role for youth who are transitioning from juvenile correctional placement back to their homes and communities. Many

youth re-entering the community perform below grade level and have histories of truancy and suspension (Roy-Stevens, 2004). Partnerships between the juvenile justice system and education system are critical to help youth transition back into appropriate community education settings.

The child welfare system is another key system whose clients frequently overlap with those in both the juvenile justice and mental health systems (Wiig & Tuell, 2004). A National Institute of Justice study indicated that being abused or neglected as a child increased the likelihood of arrest as a juvenile by 59 percent (Widom & Maxfield, 2001). Not only are there behavioral consequences for children and youth who have been abused or neglected, there are also psychological consequences. Studies have found abused and neglected children to be at least 25 percent more likely to experience problems such as delinquency, teen pregnancy, low academic achievement, drug use, and mental health problems (Kelly, Thornberry, & Smith, 1997). One long-term study found that as many as 80 percent of young adults who had been abused met diagnostic criteria for at least one psychiatric disorder at age 21, exhibiting problems, including depression, anxiety, eating disorders and suicide attempts (Silverman, Reinherz & Giaconia, 1996). Given the increasing body of evidence suggesting links between child abuse and neglect, involvement in the juvenile justice system, and the development of psychological problems stemming from abuse, the child welfare system should be a key partner in any collaborative effort designed to strengthen and improve mental health service delivery for youth in contact with the juvenile justice system.

## How to Collaborate

The basic goal of improving services to a population of youth is sometimes not enough of an incentive to embark on multi-system collaboration. Often, the creation of an interagency task force or coalition is in direct response to a crisis in the community, a lawsuit in which a facility or system is sued, or new funding opportunities that require systems to blend funding in order to receive new funding (National GAINS Center, 1999). Whatever the motivator, there are some first steps that a jurisdiction can take to establish multi-system collaborations. These include:

- Organize a coordinating body or task force that includes representatives from the involved systems as well as consumers, family members, and advocates.

## Connecticut Case Study

Over the last several years, the state of Connecticut has significantly transformed its approach to providing mental health care to youth involved with the juvenile justice system. The impetus for these changes stemmed, in large measure, from the terms of a 2002 Federal court ruling (*Emily J. vs. John G. Rowland et al.*) in which Connecticut was found to be out of compliance with a 1997 consent decree that called for significant improvements in mental health care for youth in the juvenile justice system (Kids Counsel, 2005). As a result, Connecticut's Court Support Services Division (CSSD) of the Judicial Branch and the Department of Children and Families embarked upon a three year court-ordered plan to develop and implement a comprehensive system of care for screening, assessing, and providing a broad range of behavioral health services to detained youth. Connecticut used this challenge as an opportunity to engage in a strategic planning process that would result in measurable and positive outcomes. Working with the National Center for Mental Health and Juvenile Justice as part of the Comprehensive Systems Change Initiative, (CSCI) (NCMHJJ, 2005) they formed a multi-system team, comprising representatives from:

- CSSD, which is responsible for juvenile probation and detention services in the state,
- DCF, which is responsible for services provided to youth in juvenile correctional facilities and aftercare services,
- AFCAMP—a parent advocacy group,
- The Tow Foundation, a private foundation with an interest in behavioral health and juvenile justice reform; and
- The Center for Effective Practice, which was created to promote the use of evidence-based behavioral health treatment interventions with Connecticut youth.

It is important to note that shortly after the 2002 ruling, DCF closed its Juvenile Justice Bureau and shifted responsibility for juvenile correctional programs and services to DCF's Bureau of Behavioral Health, Medicine and Evaluation, emphasizing the need for treatment rather than merely confinement for delinquent youth in the custody of DCF. DCF representatives brought this broadened perspective to the interagency team.

The team began by developing a mission statement that clearly articulated the goals of its work: to develop a coordinated and continuous system of care with sufficient capacity, assessment capability, and program variety to fully address the mental health needs of children involved with the juvenile justice system. They then developed a workplan with clear action goals, including:

- Implement a system-wide, uniform mental health screening process
- Redesign the juvenile court mental health evaluation process
- Match assessment outcomes to appropriate intervention
- Expand evidence-based treatment programs available to youth in the juvenile justice system
- Develop a system to monitor outcomes of screening, assessment, and treatment

- Designate a strong leader with good communication skills who understands the systems and related informal networks.
- Decide on a common goal or goals for the work and develop clear objectives and strategies for meeting the identified goals.
- Emphasize strategic planning that is aimed at producing immediate but sustainable results.
- Recruit political support from community leaders, such as judges or legislators.
- Develop a financing plan to support the group's proposed objectives and strategies, and refer back to this plan frequently to update it or modify it based on the availability of existing or new funding. Explore multiple funding opportunities at the local, state, and Federal levels. (National GAINS Center, 1999).

## Connecticut Case Study *continued*

Over three years, the team met regularly, involved other interagency groups in their work, and received technical assistance arranged by the NCMHJJ. Through these efforts, the CSCI team was able to accomplish several major goals. These accomplishments include:

- **System-wide implementation of the MAYSI-2 in all juvenile detention centers and probation departments.** Probation officers and detention staff were extensively trained on the use and interpretation of the MAYSI-2, and CSSD agreed to provide clinical consultation to probation staff in situations where clinical clarification on MAYSI-2 results was necessary. In addition, in response to concerns raised by the Public Defender around client self-incrimination and confidentiality, negotiations occurred between CSSD, DCF, the Office of the Chief Public Defender, and the Office of the Chief State's Attorney. These discussions resulted in the passage of legislation that ensures the confidentiality of information collected as part of a mental health screen and limits the use of this information for planning and treatment purposes only.
- **The creation of a court-based assessment model for providing expedited mental health evaluations to youth, and the use of clinical coordinators within the courts to foster linkages with community-based service providers.** This model was based on the Cook County, Illinois, Juvenile Court Clinic Model, and representatives from Cook County provided on-site technical assistance to the Connecticut team to help them develop their approach.
- **The creation of Multi-Disciplinary Case Review teams who review youth mental health assessment outcomes and match these to the most appropriate interventions.** Since their inception in May 2004, over half of all cases presented to the Case Review teams were diverted from residential placement and referred to community-based care.
- **The significant expansion of evidence-based treatment services throughout the state for youth involved with the juvenile justice system.** From 2002 to 2005, the state of Connecticut increased the number of Multi-Systemic Therapy (MST) slots from 92 to 398, and expanded MST into all juvenile courts as a dispositional alternative to incarceration. They also introduced other evidence-based treatments, such as Multi-Dimensional Treatment Foster Care, Functional Family Therapy, and Brief Strategic Therapy, and designated treatment slots specifically for juvenile justice youth.
- The Connecticut experience highlights several critical elements important to successful juvenile justice and mental health collaboration:
  - ◆ It is necessary to examine all components and elements of the juvenile justice continuum, not just individual points.
  - ◆ A broad group of stakeholders working together can provide a large and diverse perspective, and offer innovative solutions and ideas.
  - ◆ Parents and advocates are critical to the process and must be part of the stakeholder group.
  - ◆ The team must agree on a joint mission and vision in order to move forward.
  - ◆ A long-term work plan provides enhanced opportunities for innovation.

Creating multi-system partnerships should be viewed as a fluid process that evolves and intensifies over time. One way of approaching this is within the context of a continuum, with points on the continuum representing the different levels (and intensity) of interagency work. Konrad (1996), in a paper that provides a framework for viewing such interagency efforts, identifies a series of benchmarks on a continuum for defining the different

levels and strengths of interagency partnerships. Konrad's benchmarks include:

**Information Sharing and Communication:** This represents a very informal relationship in which entities share general information about programs, services, and clients. Communication may or may not occur on a regular basis and is largely dependent on the functions and authority of the staff involved. Examples include sharing

of newsletters, brochures, educational presentations, and joint staff meetings.

**Cooperation and Coordination:** This level is still largely informal representing a loosely organized attempt by autonomous agencies and programs to work together or change procedures or structures to make all affected programs successful. Examples include reciprocal client referral and follow-up processes between agencies and programs, verbal agreements to conduct joint staff meetings, mutual agreements to provide priority responses or joint lobbying for legislation.

**Collaboration:** This level is usually formalized and activities are shared. Still autonomous agencies and programs work together as a whole with a common goal, product, or outcome. Partners are equal. Examples include partnerships with written agreements, goals, formalized operational procedures, and possibly joint funding, staff cross-training, and shared information systems.

**Consolidation:** A consolidated system is often represented by an umbrella organization with single leadership in which certain functions are centralized but line authority is retained by categorical divisions. Often, there is a high degree of cross-program collaboration, coordination, cooperation, and information sharing. Examples include government agencies with responsibility for numerous human service programs.

**Integration:** A fully integrated system has a single authority, is comprehensive in scope, operates collectively, addresses client needs in an individualized fashion, and is multi-purpose and cross-cutting. Categorical lines are transparent, activities are fully blended, and funding is pooled. Eligibility requirements for all services are simple and uniform. Examples include one-stop shops in which unified intake, assessment, case management, and services are provided in one location, and one entity has sole responsibility for management and operational decisions.

This continuum, and the defined benchmarks, can be used to help systems realistically assess their readiness for multi-agency partnerships, and offers concrete examples of the kinds of activities that are associated with the different levels of multi-system work.

## Recommended Actions

**1.1 The juvenile justice and mental health systems must recognize that many youth in the juvenile justice system are experiencing significant mental health problems and that responsibility for effectively responding to these youth lies with both the mental health and juvenile justice systems.**

**1.2 The juvenile justice and mental health systems should engage in a collaborative and comprehensive planning effort to thoroughly understand the extent of the problem at each critical stage of juvenile justice processing, and to identify joint ways to respond.** Once there is a recognition of the problem and a commitment to change, the juvenile justice and mental health systems must engage in a comprehensive and strategic planning process and develop key goals, objectives, and strategies for addressing the identified problems. Many states have conducted their own mental health prevalence studies among youth in the juvenile justice system to document the extent of the problem in their own state, to set the stage for the development of a strategic plan or the implementation of new interventions, and to generally draw attention to the issue. Often, these reports are the result of an interagency task force or committee that is charged with examining the situation and developing recommendations for improvement. States such as Virginia, Texas, Ohio, Nebraska, Minnesota, and Delaware have all conducted their own mental health studies among youth in the juvenile justice system and used the results to call for changes and improvements in the way the state identifies and responds to these youth. Jointly collecting data and using the data to document the extent of a problem and justify why improvements and new resources are necessary can be an effective way of bringing about necessary change. Frequently, these efforts increase the visibility of this population of youth and serve as a catalyst for change.

**1.3 Any collaboration between the juvenile justice and mental health systems should include family members and caregivers.** Families are a critical stakeholder who should be involved in any collaboration designed to improve mental health identification and treatment services for youth in contact with the juvenile justice system. Family-run organizations can also serve as important allies in any attempt to bring attention to critical issues, cultivate political will, and draw new resources to a problem. Families can contribute to systems or policy level work by providing reality-based,



culturally relevant information from a unique perspective (Osher & Hunt, 2002). Families can also influence political and policy-making processes in ways that other policy workers or system administrators cannot (Koyanagi & Feres-Merchant, 2000).

In addition to having family members involved with system-level collaboration, a growing number of juvenile justice and mental health systems are recruiting and training family members as case managers, advocates, and service brokers to work with families whose children become involved with the juvenile justice system (Osher & Hunt, 2002). This changing role is, in large measure, due to the System of Care movement and the work that has been done within the System of Care communities to increase the role of families in planning, delivering, and evaluating children's mental health services.

For example, the Jefferson County, Alabama, Family Court Diagnostic and Assessment unit, which was established with a Federal system of care grant, serves as a diversion program for youth at risk of court involvement and out of home placement. The program provides mental health screening, assessment, and services to youth referred from probation intake or family court, and has clinical staff within the court to work immediately with referred youth and families. In addition to clinical staff, the Unit employs a family advocate who is present for the initial intake and screening process and works with families to explain the process and answer any questions they might have about the program and the system. These paid parent advocates also participate in service planning meetings with families and offer respite care on the weekends, if children and parents "need a break" from each other.

Family-run organizations can also be used to provide training to juvenile justice personnel to help them better understand the family perspective and potential opportunities for families to be educated about the system, its processes, and protocols. These organizations are ideally suited to provide training to the juvenile justice system on how to create a climate that encourages family participation. Families know their child best and can provide information that is critical to keeping the child stable and safe. For example, families who are actively involved can offer information on:

- The child's diagnosis and treatment history, including the use of medication;
- The strengths and needs of their child;

- The family's capacity to participate in treatment;
- Circumstances that affect their child's well-being;
- Their child's patterns of responding to people and events in their surroundings;
- Their child's education history and status, including their IEP if the child is enrolled in special education services; and
- Transition and on-going support services essential for successful and permanent re-entry to the community (Osher & Hunt, 2000).

The adversarial nature of the juvenile justice system often intimidates families, especially if they are unfamiliar with the system and anxious about the future of their child (Osher & Hunt, 2002). By the time many families reach the juvenile justice system, they are quite often in crisis. If families are unfamiliar with what to expect and are not provided basic information about the system, their options, or ways in which they can be involved, the likelihood of cooperation and participation is low. Training juvenile justice staff to better understand the perspective of families and to identify ways to take advantage of parental expertise can result in a calmer and more productive interaction. When families are fully informed about the juvenile justice system and understand its parameters, they can help to make responsible recommendations and decisions for their own child (Smeltzer, 1999).

**1.4 The juvenile justice and mental health systems should identify funding mechanisms to support the implementation of key strategies at critical stages of juvenile processing to better identify and respond to the mental health needs of youth.** Both systems should explore the possibility of using existing funds more creatively, by blending or better integrating funding streams or initiating new jointly funded efforts. In addition, systems should commit to exploring new funding available at the local, state, and national levels that could be used to support joint initiatives.

Sometimes new funding is made available that encourages multi-system collaboration. For example, the 2005 SAMHSA funding announcement for the System of Care initiative, which represents the Federal government's largest investment in children's mental health services, encouraged applicants to consider prioritizing different populations of youth in their grant applications, including

youth in the juvenile justice system. This unprecedented encouragement provides a unique opportunity for more of a juvenile justice focus within systems of care, and provides the opportunity for the mental health system to involve the juvenile justice system in planning for how these resources could be used to provide services to justice-involved youth.

Another example is the Harris County, Texas, Special Needs Diversionary program. This program is funded by the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI) and the Texas Juvenile Probation Commission, and administered jointly by the Harris County Juvenile Probation Department and the Mental Health Mental Retardation Authority of Harris County. This collaborative funding arrangement allows the county to employ teams of probation officers and mental health practitioners who jointly staff and manage cases. WrapAround Milwaukee is a managed care model that blends funds from the county juvenile justice, child welfare, mental health, and education agencies to provide a range of services to youth with emotional and behavioral needs who are at risk of out of home placement. Savings from the reduction in costly residential placements are re-directed into the program to support prevention and early intervention services.

**1.5 The juvenile justice and mental health systems should collaborate at every key stage of juvenile justice processing, from initial contact with law enforcement to re-entry.** The juvenile justice system must be viewed in its entirety, as a continuum, and not as a series of discrete and isolated points. Collaboration between the juvenile justice and mental health systems must occur at each of these key stages.

There are examples of collaboration all along the juvenile justice continuum. For example, The Alabama Juvenile Court Liaison program is a statewide initiative that provides clinical liaisons to work exclusively with youth and families who come to the attention of the juvenile court and have mental health needs. The liaisons are employed by the community mental health center and serve as a link between juvenile justice and mental health by identifying needs, explaining issues to the court, and brokering services. New York State's Mobile Mental Health Teams are a collaborative between the Office of Mental Health and the Office of Children and Family Services designed to enhance the provision of mental health services to youth in the state's juvenile correctional facilities. Clinical staff, employed by the Office of Mental Health, provide on-site clinical services

to youth residing in secure juvenile correctional facilities throughout the state. Rhode Island's Project Hope is a collaborative re-entry initiative between the state's Department of Children, Youth and Families, Division of the Children's Behavioral Health and Education, and the state's Division of Juvenile Probation and Corrections. The program targets youth with mental health needs who are transitioning from the state's juvenile correctional facility back to their homes and communities.

**1.6 The juvenile justice and mental health systems should jointly evaluate any program or service delivery strategy aimed at improving the identification and treatment of mental health needs among youth in the juvenile justice system.** Effective mental health programs and services for youth in the juvenile justice system not only ensure that youth receive the care they need, but can potentially result in cost-savings by reducing delinquency and youth interaction with the juvenile justice system. In order to determine the effectiveness of any new program or service strategy, it is essential that an evaluation component be built into the program from the beginning. Evaluation data, both process and outcome, can help systems determine the degree to which any new initiative is successful in meeting its stated goals and objectives, and whether any changes or modifications are necessary. Systems can use evaluation data to jointly lobby for new or continued resources, and system improvements are often more successful than those working in isolation.

The Juvenile Justice Evaluation Center (JJEC) is an on-line resource designed to assist juvenile justice practitioners, policymakers, and state agency administrators with the assessment and evaluation of programs for youth in the juvenile justice system. A range of program areas are provided, including aftercare programs, alternatives to detention and secure confinement, and community-based programs, among others. Performance measures are defined for each type of program to be evaluated as well as a summary of the state of evaluation research for each type of juvenile justice program. Of particular note is their publication (available on-line), *Evaluation Issues in Mental Health Programming in the Juvenile Justice System*.

**1.7 Cross-training should be available for staff from the juvenile justice and mental health systems to provide opportunities for staff to learn more about each system, to understand phrases and terms common to each system, and to participate in exercises and activities designed to enhance systems collaboration.**

System change cannot exist solely as assurances at the top levels of the participating agencies; it must penetrate to the line-worker level if it is to make a real difference (National GAINS Center, 1999). Cross-training staff from the juvenile justice and mental health systems, for example, allows for the exchange of perspectives relating to the treatment and supervision of youth with mental health needs. The National GAINS Center developed a cross-training curriculum that focuses on increasing collaboration among professionals in the fields of mental health, substance abuse, and juvenile justice when working with youth with co-occurring disorders. This curriculum has been used to train staff in many communities across the country and offers practical information and strategies for reducing barriers across systems and providing a common ground from which to go forward.



## Cornerstone #2: Identification

### **2. The mental health needs of youth should be systematically identified at all critical stages of juvenile justice processing.**

#### Background

Arguably, the most important first step to better respond to mental health treatment needs among youth in the juvenile justice system is to systematically identify these needs as youth become involved with the system. The development of a sound screening and assessment capacity is critical in order to effectively identify and ultimately respond to mental health treatment needs. Despite the fact that we now know that large numbers of youth in the juvenile justice system have mental health disorders, many of the youth who enter the system do not routinely undergo a comprehensive mental health screen and, when necessary, a full evaluation. In fact, while almost 90 percent of facilities for which completed staff surveys were obtained reported screening for mental health problems, less than half of these facilities actually reported screening all youth in their facility (NCMHJJ, 2005). If screening does happen, it is likely to occur after a youth has been adjudicated and placed in a secure juvenile correctional facility. While it certainly is important to screen and assess for mental disorders upon placement in a secure juvenile correctional facility, for many youth, this is too late. Screening and assessment should occur at a youth's earliest point of contact with the system, such as at probation or juvenile court intake, as well as at all key transition points, and should be used to inform decision-making around diversion or other next steps.<sup>1</sup>

---

<sup>1</sup> Grisso (2004) suggests that screening and assessment serves an important role in protecting the legal rights of youth in the juvenile justice system. Some youths' mental health problems may place them at risk of incompetence to stand trial. Virtually all jurisdictions require that in cases being processed for adjudication, all parties (judges, defense attorneys, prosecutors) are obligated to raise the question of incompetence if there is even a slight doubt that a youth is competent to stand trial (Melton, Petrila, Poythress, & Slobogin, 1997). In part, then, the juvenile justice system's obligation to identify the mental health needs of juveniles is embedded in its obligation to assure due process.

Screening and assessment share a common objective to evaluate youth, but they differ in terms of their purposes and the manner in which they are accomplished. Screening describes a relatively brief process to identify youth who are at increased risk of having disorders or conditions that warrant immediate attention or further evaluation. Assessment, on the other hand, is a more comprehensive examination of psychosocial problems identified during the initial screen. Assessments are not typically performed on all youth; rather they are necessary for some subset of youth who undergo an initial mental health screen. They are generally more time-consuming, often involving discussions with a youth's parents or teachers, and can include psychological testing, clinical interviewing, and the review of past records from other agencies or systems. There is also a growing movement to conduct assessments that are "strength based" as opposed to "deficit based." Strength-based assessment offers a strategy for empowering youth by building on the personal strengths and resources that are frequently overlooked or given minimal attention in more problem-oriented approaches to assessment (Rudolph & Epstein, 2000).

Screening and assessing mental health needs is part of a larger process designed to collect information about a youth that will assist in making decisions about next steps and further processing. Often this larger process includes the administration of a risk assessment to determine a youth's risk of reoffending, receiving technical violations, failing to appear before court or other negative outcomes (Austin, Johnson, & Weitzer, 2005). Like mental health screens and assessments, risk assessments are typically performed at key decision making points within the juvenile justice system, such as at the initial detention decision, at disposition, at the point of commitment to a secure juvenile correctional facility, and in preparation for release from placement. The results of a risk assessment, linked with the results of a mental health screen and evaluation, should be used to help guide decisions about a youth's suitability and need for diversion to community-based services and programs. If diversion is not possible, the results can be used to ensure that detained or confined youth are assigned to the most appropriate program that addresses both public safety and the youth's needs, while allowing youth to maintain relationships with their

families and communities whenever possible (Austin et al., 2005).

Recently, significant progress has been made around mental health screening and assessment for youth in contact with the juvenile justice system. New screening and assessment tools and instruments for youth have been developed, many tested and designed specifically for use with youth in juvenile justice settings. In addition, there are now resources describing screening and assessment tools available for use in juvenile justice settings, as well as information on models and approaches that have been developed for this purpose.

The creation and implementation of a screening and assessment capacity within a juvenile justice setting will depend upon a wide range of factors—the specific point of contact within the justice system where screening and assessment will occur; the resources available to support this effort; the amount of time available to conduct the evaluations; the qualifications of the staff responsible for administering the evaluations; and the extent to which need and risk levels can be balanced to develop treatment plans that appropriately reflect the level of risk presented by the youth and their need for treatment. All of these factors must be taken into account when developing a screening and assessment capacity for a particular point in the juvenile justice processing continuum, as well as when selecting the instruments to be used for this purpose.

## Recommended Actions

**2.1 Every youth who comes in contact with the juvenile justice system should be systematically screened for mental health needs to identify conditions in need of immediate response, such as suicide risk, and to identify those youth who require further mental health assessment or evaluation.** While a screen is considered most critical at a youth's earliest point of contact with the juvenile justice system, for example at probation intake, it should also be employed periodically to monitor a youth's mental health status at all stages of justice system involvement, particularly after transitions from one setting to another (e.g., detention to secure corrections).

Some states require that all youth entering the juvenile justice system be administered a mental health screen. For example, in 2001, Texas mandated that all juvenile probation departments in the state administer the

Massachusetts Youth Screening Instrument (MAYSI-2) to all youth entering probation intake (Texas Juvenile Probation Commission, 2003). The MAYSI-2 is a 52-item self report instrument that identifies potential mental health and substance use needs of youth at any entry or transitional placement point within the juvenile justice system. The instrument has been widely tested and demonstrates strong validity and reliability when used with the juvenile justice population.

In 2004, the Minnesota state legislature enacted statewide mental health screening for child welfare and juvenile justice populations (Wyss, 2004). This legislation, however, allows for exemptions under certain conditions, such as if a youth has undergone a mental health screen within the last 180 days, or if a parent objects to their child undergoing a mental health screen and communicates this concern to the court in writing. The state has opted to use both the MAYSI-2 as well as the Problem-Oriented Screening Instrument for Teenagers (POSIT) with youth in the juvenile justice system. The POSIT, which takes approximately 25 minutes to administer, is a 139 item self-report screening instrument that measures a variety of problem areas, including mental health and substance abuse, and also includes questions about mental health and juvenile justice system contacts (Grisso & Underwood, 2004).

**2.2 The mental health screening process should include two steps—the administration of an emergency mental health screen as well as a general mental health screen.** The first step in the process involves an initial “emergency” screen whose purpose is to identify any immediate mental health crisis, the potential risk of suicide or harm to self or others, and to determine whether the youth is currently on any type of psychotropic medication. It is recommended that this initial screen be conducted within the first hour of a youth's contact with the system, regardless of the setting. Often, these questions are included within an overall health intake screen conducted immediately upon intake. However, they can be asked separately as part of a mental health intake process.

The second step of the screening process involves the administration of a mental health screen, whose purpose is to identify any mental health concerns that require further evaluation or assessment. This screen should be brief in nature and easily administered by non-clinical staff within a variety of juvenile justice settings. Mental health screening is conducted to determine short-term needs. Screening results alone should not be used to

make long-term treatment planning decisions, but to make informed decisions about the need for immediate service or follow-up evaluation. A mental health screen should be administered to youth anywhere from 24 to 48 hours after initial contact with the juvenile justice system.

Some jurisdictions are using the MAYSI-2 to screen for emergency mental health needs, as well as to determine the need for further mental health evaluation. Other jurisdictions use a separate emergency mental health screen, and then follow-up with a mental health screen. For example, Washington State uses the Youth Suicide Risk Assessment (SRA) to determine whether a youth has immediate mental health needs that need to be addressed, and then administers the MAYSI-2 as the mental health screen.

**2.3 Access to immediate, emergency mental health services should be available for all youth who, based on the results of the initial screen or the mental health screen and staff observations of youth behavior, indicate a need for emergency services.** Crisis conditions typically involve youth who are believed to be at risk of harm to self or others, youth who are at immediate risk of substance use consequences (e.g., withdrawal), youth in acute mental or emotional distress, and youth who are at risk of discontinued medication (Grisso, 2004). Youth identified as “in crisis” must be provided immediate access to psychiatric and other medical services. This can include immediate referral to a mental health facility or hospital, or placement of the youth in a separate and specialized unit of a detention or correctional facility (if such conditions are available within the facility) for psychiatric care and close staff monitoring. All probation intake units and detention centers should have referral procedures in place for youth in need of immediate psychiatric placement or hospitalization, and should have access to a psychiatrist and a pharmacy to ensure continued medication administration for youth already on psychotropic medication.

**2.4 A mental health assessment should be administered to any youth whose mental health screen indicates the need for further assessment.** This assessment should be based on a review of information from multiple sources (for example, mental status examination, case records, family interviews) and must measure a range of mental health concerns. A mental health assessment will yield more detailed, and sometimes diagnostic, information about a youth’s mental health status and can be used to form the basis of treatment recommendations.

The Voice Diagnostic Interview Schedule for Children (Voice DISC) is one example of a mental health assessment instrument that was designed specifically for use with youth in juvenile justice settings (Grisso & Underwood, 2004). This is a structured youth self-report interview, administered on a computer that provides provisional DSM-IV diagnoses on a range of disorders, including anxiety disorders, mood disorders, disruptive disorders, and substance use disorders. It has been extensively tested on the juvenile justice population and is being used in juvenile justice settings (probation, detention and corrections) in 13 states.

**2.5 Instruments selected for identifying mental health needs among the juvenile justice population should be standardized, scientifically sound, have strong psychometric properties, and demonstrate reliability and validity for use with youth in the juvenile justice system.** In addition, it is important to recognize that the developmental needs of younger adolescents are different from those of older adolescents, and care should be taken to select instruments that are developmentally appropriate for the target group of youth who will be screened and assessed.

A number of excellent resources are available to help guide the selection of screening and assessment instruments. These resources include:

- The National Center for Mental Health and Juvenile Justice Research and Program Brief on Screening and Assessing Mental Disorders Among Youth in the Juvenile Justice System (2003);
- OJJDP’s Screening and Assessment Resource Guide for Practitioners (2004)
- The Handbook of Mental Health Screening and Assessment for Juvenile Justice by Thomas Grisso, Gina Vincent, & Daniel Seagrave (2005).

**2.6 Mental health screening and assessment should be performed in conjunction with risk assessments to inform referral recommendations that balance public safety concerns with a youth’s need for mental health treatment.** Assessing a youth’s risk for future violence or re-offending is a critical function of the juvenile justice system and is necessary in order for the system to satisfy its obligations to ensure public safety. Mental health screening and assessment must be linked to the administration of risk assessments, to fully inform decision-makers about the risks and needs that each youth presents. The combined results of

these screens and assessments should be used to guide decisions that not only ensure the appropriate level of security or supervision, but that also ensure that youth have access to the services and treatment that they need. The Washington State Juvenile Court Assessment (Washington State Institute for Public Policy, 2004), and the Global Risk Assessment Device (GRAD) (Gavazzi, Slade, Buettner, Partridge, Yarcheck, Andrews, 2003) are both examples of risk assessment instruments for youth in the juvenile justice system.

**2.7 All mental health screens and assessments should be administered by appropriately trained staff.** Most instrument developers provide guidelines for the level of training and/or education needed in order to appropriately administer the instrument. Often, screening instruments for use in juvenile justice settings, such as probation, detention or corrections are designed to be administered by non-clinical staff, such as juvenile justice staff who are trained on how to administer and interpret the instrument. Assessments, on the other hand, typically require more extensive and individualized data collection and most often (although not always) require the expertise of a mental health professional.

**2.8 Policies controlling the use of screening information may be necessary to ensure that information collected as part of pre-adjudicatory mental health screen is not used inappropriately or in a way that jeopardizes the legal interests of youth as defendants.** Legally, there are concerns about the appropriateness of having youth disclose information in a pre-adjudication setting, such as detention, that could be used against them in court (Grisso, 2004). There is a concern that a youth's responses to a mental health screen, for example their admission to using drugs, tendencies toward anger or poor attitudes about school, could be used in plea bargaining at trial or to argue for more restrictive dispositions after adjudication. Information disclosed to detention staff during a mental health screen or assessment may not be confidential. Facilities that are responsible for managing youth prior to adjudication must balance the need to provide mental health care with the responsibility to protect youth from self-incrimination (Wasserman et al., 2003).

Two potential solutions to this problem are offered by Grisso. The first is to select screening tools, in part, on the basis of the degree of jeopardy associated with their content and questions, selecting tools that minimize the potential prejudice as much as possible while still meeting primary objectives. The second solution is to

develop a policy that restricts the use of pre-trial mental health screening information to the use for which it was intended—to identify any immediate mental health concerns and the need for further evaluation. In Texas, this issue was resolved by having a clause inserted in state juvenile justice legislation prohibiting the use of mental health screening information in any legal proceeding against youth. Other communities have resolved the issue by developing agreements between the prosecutor and the juvenile defense bar that place limits on the use of this information (Grisso, 2004). Strong judicial leadership on this issue is considered essential. In almost all instances where agreements have been reached to limit the use of screening data and protect youth from this information being used during adjudication, judges have played a pivotal role in establishing the policy (Grisso, 2004).

**2.9 Mental health screening and assessment should be performed routinely as youth move from one point in the juvenile justice system to another, for example from pre-trial detention to a secure correctional facility.** Since screening provides a view of a youth's short-term and immediate needs, it is recommended that it be performed repeatedly, as youth transition within or out of the juvenile justice system (say from detention to corrections or corrections to the community), as well as periodically during long sentences to monitor any changes that may occur in a youth's mental status.

As more jurisdictions implement mental health screening measures for youth involved with the juvenile justice system, new questions have arisen about the need for repeat mental health screens as youth move through the system. How frequent is too frequent? How much time should pass between screenings? Can screening information be passed on between points of contact within the system so that repeat screenings are unnecessary? These questions are playing out in communities across the country that have implemented screening mechanisms. For example, one jurisdiction, following local rules, was re-screening youth who were returning to detention following a court appearance because local rules called for all youth to be screened who were entering detention from the community. One might interpret this as unreasonable—the youth had only been “in the community” for several hours in court and there would be no reason to re-screen. Another interpretation might make a re-screen necessary if the court appearance had gone badly and the youth was despondent or emotionally upset as a result of the appearance. Research is currently underway in the field that hopefully, will begin to provide more guidance around these types of issues and questions. Until then,



we would argue that systems employ a standard that errs on the side of caution but recognizes the need for flexible and refined application as necessary.

**2.10 Given the high rates of co-occurring mental health and substance use disorders among this population, all screening and assessment instruments and procedures should target both mental health and substance use needs, preferably in an integrated manner.**

There have been advances made to develop instruments that identify the presence of mental health and co-occurring substance use disorders among youth. The MAYSI-2 and the POSIT, both mentioned earlier, can be used to screen for mental health and co-occurring substance use needs. Another example is the Global Appraisal of Individual Needs (GAIN), which is an evaluation instrument that includes questions for documenting substance use and mental health disorders (Grisso & Underwood, 2004). Designed for use in diverse settings, including juvenile justice, the instrument is organized into sections that assess current symptoms over the past year and the frequency of symptoms over the last 90 days.

**2.11 Existing screening and assessment instruments may need to be adapted for critical groups of youth, particularly youth of color and girls, pending further research.**

While the field has seen significant advances in the general area of mental health screening and assessment over the last decade, more needs to be done to develop mental health measures that are responsive to the needs of specific populations of youth within the juvenile justice system. There continues to be substantial evidence that youth of color (especially black youth) are overrepresented at virtually every key processing point within the juvenile justice system (Snyder & Sickmund, 1999) in comparison to their proportions in the general population (Snyder, 2003). Studies have found that youth of color in the juvenile justice system experience substantial rates of mental health disorders (NCMHJJ, 2005). Many mental health screening and assessment tools currently being used with youth were originally developed with samples of youth in which the majority of youth were non-Hispanic white (Grisso et al., 2004). If these instruments perform differently when used with youth of color, it could result in the under-identification or misidentification of mental health needs (Grisso, et al., 2004). Given the large numbers of youth of color in the juvenile justice system and the expected growth of minority youth in the general youth population over the next decade (Snyder & Sickmund, 1999), it is imperative that more research be directed

to increasing the availability of culturally valid mental health screening and assessment tools that are tested and analyzed on youth of color. These tools will lead to the better identification of mental health needs, and ultimately the development of more informed treatment plans to ensure that these youth have access to the most appropriate and effective interventions.

Until better tools are available, it is important to select screening and assessment instruments whose validation samples included substantial numbers of youth of color. It is also important to determine if the developer of the instrument provides data on ways in which different minority groups score on average on the instrument's scales, and whether the instrument has been translated into languages that are relevant to the population of youth being evaluated. (Grisso, 2004). Beyond the selection of culturally valid instruments, it is important that screening and assessment be performed in a way that is sensitive to the influences of each youth's culture, heritage and ethnicity (Underwood, 2002).

Girls represent one of the fastest growing segments of the juvenile justice population (Greene, Peters and Associates, 1998). Between 1990 and 1999, the number of delinquency cases involving males increased by 20 percent while the number of delinquency cases involving girls increased by 60 percent (U.S. Department of Justice, 2003). Juvenile court statistics indicate that between 1990 and 1999, the number of cases in which courts ordered delinquent girls to be placed in a residential facility increased by 64 percent, while the number of formal probation cases increased by 53 percent (U.S. Department of Justice, 2003). There is a strong body of evidence indicating that the majority of girls in the juvenile justice system have significant mental health and substance abuse needs. The prevalence study conducted as part of the development of this Model found that over 81 percent of girls in the sample, as compared to 66.8 percent of boys, met criteria for at least one mental health disorder. Girls were at significantly higher risk for anxiety disorders, mood disorders, and substance use disorders (NCMHJJ, 2005). These findings are consistent with prior research documenting high rates of mental disorders among female juvenile detainees (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002).

Despite the steady increases in the number of girls involved with the juvenile justice system, many of the mental health screening and assessment instruments designed for use in juvenile justice settings traditionally were developed for boys. This tradition is changing

but is still in evidence (Grisso & Underwood, 2002). We know from the research that there are other girl-specific issues that should be taken into consideration such as a history of trauma and abuse and the presence of children. Further, the literature suggests that many disorders common among girls, such as depression and anxiety, tend to go unnoticed. Screens and assessments must be designed to ensure that disorders not typically associated with aggressive behaviors are identified (Veysey, 2003).

## Cornerstone #3: Diversion

### **3. Whenever possible, youth with identified mental health needs should be diverted into effective community-based treatment.**

#### Background

On any given day, over 130,000 youth are being held in custody in juvenile justice facilities across the country, either awaiting trial in detention centers or having been placed in residential facilities after being adjudicated delinquent (Sickmund, 2004). The placement of these youth in juvenile justice facilities is part of a growing tendency toward the “criminalization of the mentally ill.” This phrase refers to the increasing trend of placing individuals with mental health disorders in the justice system. Often, the placement is seen as a means of accessing mental health services that are otherwise unavailable or inaccessible in the community.

While this trend has been evident at the adult level for some time, it is now being observed at the juvenile level as well. For example, a 1999 survey by the National Alliance for the Mentally Ill (NAMI) found that 36 percent of their respondents reported having to place their children in the juvenile justice system in order to access mental health services that were otherwise unavailable to them (National Alliance for the Mentally Ill [NAMI], 2001). A more recent study conducted by the U.S. General Accounting Office (GAO) found that in 2001, parents placed over 12,700 children into the child welfare or juvenile justice systems in order to access mental health services (United States General Accounting Office [GAO], 2003). Thus, the juvenile justice system is viewed as becoming the “public mental health system” for large numbers of youth. Simply warehousing them in juvenile facilities with no access to treatment will only exacerbate their conditions and create a more dangerous situation for youth and the staff who are responsible for supervising them. While it is recognized that some youth in the juvenile justice system have committed serious crimes and may not be appropriate for diversion to the community, many youth are in the system for relatively minor offenses but have significant mental health needs, and simply end up there because there is nowhere else to go. Given the needs of these youth and the documented inadequacies of their care within the juvenile justice

system, there is a growing sentiment that whenever possible, and when matters of public safety allow, youth with serious mental health disorders should be diverted into effective community-based treatment.

Over the last several years, there has been increasing focus on the issue of diversion for both youth and adults with mental health disorders. The 2003 final report of the New Freedom Commission on Mental Health called for the wide adoption of diversion programs to reduce unnecessary court involvement on the part of children and adults with mental illness (New Freedom Commission, 2003). Following the release of the New Freedom report, the Campaign for Mental Health Reform, which comprised 16 national mental health advocacy and service organizations, released a report in July 2005 detailing a constructive set of steps necessary to implement the recommendations in the New Freedom report. One recommended step was to stop making criminals out of those whose mental illness results in inappropriate behavior by eliminating “warehousing” of youth with mental disorders in juvenile justice facilities.

The growth in specialized treatment courts, such as drug and mental health courts, is another example of the increasing interest in diversion. These courts can be viewed as “diversion” programs to the extent that they are used to successfully connect individuals to treatment in lieu of further processing or placement within the juvenile or criminal justice systems. While most of the growth of mental health courts has occurred at the adult level, there are an increasing number of juvenile mental health courts developing across the country. There is a great deal of variation in terms of how these courts are organized and who they serve, with some courts seeking to serve lower level offenders and others seeking to serve more high risk youth with complicated treatment and justice histories. The commonality is that they strive to ensure a youth receives and participates in treatment in lieu of a more punitive sanction, such as out of home placement, using the power of the court as leverage.

It is recognized that not all youth in contact with the juvenile justice system will need, or are necessarily appropriate for, diversion to treatment. Many youth do not have significant mental health needs and are diverted from the juvenile justice system, but not to

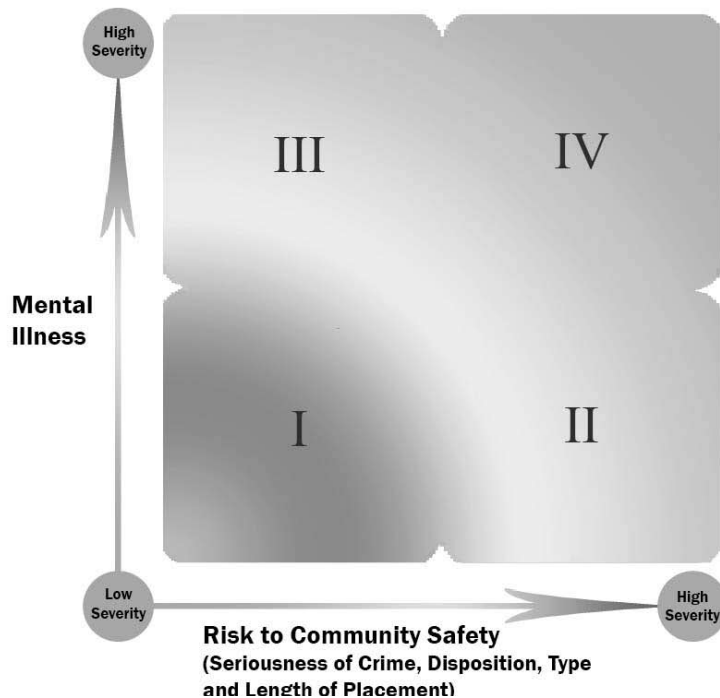
community-based treatment. There are also youth who have mental health needs, but because of their security risks will be maintained in a secure facility and are not seen as appropriate for diversion in general or diversion to treatment. Clearly, both a youth's level of risk and mental illness should be considered when determining whether a youth can be appropriately diverted into community-based treatment. It is also recognized that diversion into community-based treatment sometimes involves on-going monitoring or supervision on the part of the juvenile justice system, in order to ensure compliance with the terms of the referral or the court order. In order to clarify and define the population of youth that we are focusing on for diversion to community-based treatment, it is helpful to view the mental health needs and risk levels of the juvenile justice population on a continuum. On one end of the continuum are youth who present no or very low mental health needs and no or very low risk levels. On the other end of the continuum are youth who present very high levels of mental health need and very high risk levels. This continuum is presented below in **Table II**.

Youth who have low severity on this continuum in terms of mental health needs represent those youth for whom diversion to community-based treatment would not necessarily be needed or appropriate. Youth with both low mental health needs and low delinquency risks are

represented in **Quadrant I** of the diagram. Typically, these are youth who should not be in the juvenile justice system at all and who require no further formal mental health interventions. Many of these youth are simply diverted from the juvenile justice system and never seen again. We know from research that over half of all males (54%) and almost three-quarters of females (73%) who are arrested will have no further involvement with the juvenile justice system (Austin, Johnson, & Weitzer, 2005). Youth in **Quadrant II** have low mental health needs and high delinquency risks. Typically, these would be youth, who by virtue of the seriousness of their current offense or their risk for re-offending, are considered high risk and who require some level of juvenile justice system involvement. However, their mental health needs are low and they may not require mental health interventions. Broadly speaking, while some of these youth may be diverted out of the juvenile justice system, youth represented in Quadrants I and II would not be prioritized for diversion to community-based mental health treatment.

Youth falling on the high end of the continuum of mental health needs are the primary target for the recommendations included in this section. These are youth who present high mental health needs, but varying levels of delinquency risk. Youth who fall into **Quadrant III** include those whose risk levels are low—they may

### Severity of Mental Illness and Risk to Community Safety



**Table II A Continuum of Mental Health Need and Risk Levels Among the Juvenile Justice Population**

have been charged with a relatively minor or nonviolent offense, have no or a very limited prior juvenile justice record and present a very low risk for violence or re-offending. They do, however, present considerable mental health needs and require intervention or treatment. Based on recent reports, these youth are often referred to the juvenile justice system in order to access treatment or services that are unavailable or inaccessible in the community. A report issued by Congress in July 2003 documenting the inappropriate use of detention for youth with mental health needs found that in 33 states, youth were reported held in detention with no charges against them (U.S. House of Representatives, 2004). This is a population of youth for whom diversion to treatment should be considered. The potential benefits of diversion for these youth include:

- reducing recidivism,
- providing more effective and appropriate treatment,
- decreasing overcrowding of detention facilities,
- facilitating the further development of community mental health services,
- increasing the safety of detained youth,
- improving working relationships of cross-system groups,
- expediting court processing of youth into services, and
- encouraging family participation in treatment (Arredondo, Kumli, Soto, Colin, Ornellas, Davilla, Edwards, & Hyman, 2001; Coccozza & Skowyra, 2000).

Family and community-based treatment have been found to be the most effective form of intervention for successfully treating youth with mental health disorders and reducing recidivism, and every attempt should be made to keep youth in their home and community environments while providing a comprehensive array of services that respond to their mental health and related problems. A 2000 review of the research on the characteristics of effective treatments for youth in the juvenile justice system found that community-based treatment and programs are generally more effective than incarceration or residential placement in reducing recidivism, even for serious and violent juvenile offenders (Lipsey, Chapman, & Landenberger, 2001). Further, numerous reviews of new, evidence-based treatment interventions, such as Multi-Systemic Therapy, Functional Family Therapy and Multi-Dimensional Treatment

Foster care, have consistently found positive outcomes associated with their use with youth referred from the juvenile justice system, including decreased psychiatric symptomatology and reduced long-term rates of re-arrest (Elliot, Henggeler, Mihalic, Rone, Thomas, & Timmons-Mitchell, 1998). These evidence-based interventions are all family and community-based models, and are being used throughout the country for youth referred from the juvenile justice system. Diverting youth into effective treatment that addresses their mental health needs and reduces the likelihood of further delinquency offers a more effective alternative than simply locking them up with limited access to effective treatment. This is a group of youth who could safely and appropriately be diverted to community-based services with only minimal juvenile justice system involvement, most typically in the form of probation supervision.

Youth represented in **Quadrant IV** are the most challenging group of juvenile offenders. This includes youth who have committed a serious or violent offense requiring juvenile justice system involvement, and who also have significant mental health needs. Frequently, these youth are placed in secure juvenile justice facilities. While some correctional facilities have the capacity to identify and appropriately treat mental disorders among youth in their care, many facilities do not, raising significant concerns around the appropriateness of incarceration for youth with significant mental health needs. Many juvenile justice scholars agree that juvenile correctional settings should be reserved only for a small number of chronic or serious juvenile offenders, with graduated or community-based options used for all other offenders (Redding, 2000). There is evidence that traditional incarceration, scared straight programs, wilderness programs, and boot camps are typically not effective for youth with mental illness, and that youth have a better chance of success when receiving services and treatment in the least restrictive setting possible, generally within the context of their homes or communities (Coalition for Juvenile Justice, 2000). The general philosophy of interventions with children and adolescents is to provide appropriate services in the least restrictive setting possible (Rogers, 2003). Community-based interventions involve a youth's family and community, and focus on helping a youth function more effectively in their natural environment. Recently, communities have begun to use community-based alternatives to placement for serious offenders with mental health needs. Diversion strategies used for this population of youth link youth with treatment but also employ strict supervision strategies to monitor the youth

in the community to ensure compliance with the terms of the referral or court order.

## Recommended Actions

### **3.1 Whenever possible, youth with mental health needs should be diverted to community treatment.**

There are large numbers of youth involved with the juvenile justice system who have significant mental health problems. Many of these youth end up in the juvenile justice system for behavior brought on by or associated with their mental disorder. Some of these youth are charged with serious offenses; the majority, however, are in the juvenile justice system for relatively minor, nonviolent offenses. Whenever possible and when matters of public safety allow, efforts should be made to divert these youth into community-based services. Mental health experts and administrators across child-serving systems agree that it is preferable to treat children and youth with serious mental disorders outside of institutional settings in general, and outside of the correctional system in particular (Koppleman, 2005). Diversion to treatment offers youth their best hope of receiving effective services to address their mental health issues as well as the behaviors that brought them to the attention of the juvenile justice system. Community treatment affords families the opportunity to be involved with their child's care and provides a cost-effective alternative to juvenile detention or correctional placement.

**3.2 Procedures must be in place to identify those youth who are appropriate for diversion.** A formal screening and assessment mechanism must be instituted to identify youth with mental health needs who may be appropriate for diversion. The results of this needs assessment must be linked to any risk assessment performed on the youth to determine their potential suitability for diversion. Systematic assessment of needs and risks provides the foundation for effective intervention (Borum, 2003). These procedures must be instituted at key decision-making points within the juvenile justice continuum where referral to treatment diversion could be considered, such as at probation intake, at detention, at adjudication, and at disposition. Once youth are identified for diversion to treatment, referral mechanisms must be created to allow for the efficient referral of a youth to services.

In 2002, the NCMHJJ developed a Composite Need/Risk Index for the assignment of services and supervision to assist the Miami-Dade Juvenile Assessment Center

(JAC) in making decisions about the appropriate level of services and sanctions for youth referred to a diversion program. The index consists of need and risk categories and is intended to serve as an objective decision-making system that matches mental health and substance abuse need and delinquency risk, to services, interventions, and intensity of diversion supervision. For example, youth with the highest levels of need and risk, as evidenced from the results of both the needs and risk assessments, would receive the highest level of services, as well as the most intensive levels of supervision.

**3.3 Effective community-based services and programs must be available to serve youth who are diverted into treatment.** In order for diversion programs to be effective, there must be not only procedures and mechanisms in place to identify and refer youth, but as importantly, the availability of effective community-based services to which youth can be referred. Simply having a diversion mechanism in place is not enough. Diversion programs can only be successful when there are effective community-based mental health service providers available to serve these youth. Linkages must be established with community-based treatment providers to ensure that youth referred from the juvenile justice system will have immediate access to treatment.

Often, youth referred from the juvenile justice system will continue to have some level of juvenile justice involvement, typically in the form of probation supervision or requirements for community service. On-going communication and collaboration between the juvenile justice and treatment systems is essential during the diversion period in order to monitor a youth's participation in treatment, provide necessary updates to the court on progress, and provide joint case management or oversight as necessary.

**3.4 Diversion mechanisms should be instituted at virtually every key decision-making point within the juvenile justice processing continuum.** Ideally, diversion opportunities should occur at the earliest stages of juvenile justice processing to allow youth with identified mental health needs to be referred into community-based settings and to prevent further involvement with the juvenile justice system. However, diversion mechanisms can be instituted at later stages of justice processing to prevent further penetration into the system and expensive out of home placements. The programs listed below are examples of diversion programs that have been instituted at both the pre- and post-adjudication stages of juvenile justice processing.

### Pre-Adjudication Diversion

The Special Needs Diversionary Program, in Harris County, Texas, uses a team approach involving probation officers and clinicians who jointly supervise youth on their caseloads. Youth are typically referred to the program at probation intake after undergoing a screen and comprehensive assessment. Based on the results of the assessment, youth are provided individualized treatment using a wraparound approach and the majority of services are provided to youth in their homes and in their schools.

Family Intervention Specialists (FIS) in Douglass County, Georgia, is a diversion program that provides intensive family intervention services to youth referred by probation intake or the juvenile court. The program serves youth with mental health or substance use disorders who are at risk of out home placement or who are currently in out of home placement returning home. Probation officers, who are specially trained to identify youth with mental health or substance abuse needs, administer a standardized screening tool to screen for disorders. Upon referral to the program, youth undergo comprehensive evaluation and are provided Brief Strategic Family Therapy (BSFT), as well as other services and supports.

### Post Adjudication Diversion

The Integrated Community and Home-Based Treatment (ICT) Model, Akron, Ohio, is specifically designed to serve youth with co-occurring mental health and substance use disorders. The ICT program is both a reintegration program (for youth returning from placement) as well as a placement diversion program for youth referred from the court as a condition of probation. Program clinicians are available to youth (and their families) 24 hours a day, 7 days a week and use a treatment stage approach to meet a youth and family's primary presenting needs prior to proceeding to more complex needs.

### Pre and Post Adjudication Diversion

The Indiana Family Project, Bloomington, Indiana, uses Functional Family Therapy as the primary intervention for youth involved with the juvenile justice system. Referrals come from the probation intake if a youth is diverted pre-adjudication, or from the Family Court if the youth is diverted post-adjudication. All services are provided by specially trained therapists under the guidance of an FFT clinical supervisor. Probation officers work with the therapists to monitor the youth while they participate in the program and report back to the court on progress.

Onondaga County, New York, employs a comprehensive and holistic approach to linking justice-involved youth to evidence-based community services. The county probation department contracts with a private MST provider, Liberty Services, to provide MST services to youth at multiple stages of juvenile justice system involvement: probation intake, detention, and family court. In addition, the state's juvenile justice agency contracts with the MST provider to provide re-entry services for youth returning to Onondaga County from juvenile correctional placement, creating a full continuum of care for youth. Referral mechanisms at key processing points allow youth to be diverted from formal juvenile justice system involvement or out of placement to MST services.

### 3.5 Consideration should be given to the use of diversion programs as alternatives to traditional incarceration for serious offenders with mental health needs.

It is critical that judges have a range of alternatives to secure correctional placement to consider when making dispositional decisions for youth with mental health needs so that youth can be diverted into community-based settings whenever possible. For serious offenders with mental health needs, any diversion strategy should include a combination of supervision, sanctions, and treatment. Some communities have instituted community-based programs for this population of youth that serve as an alternative to traditional incarceration for youth with mental health needs. Multi-Dimensional Treatment Foster Care (MTFC) is an evidence-based alternative to incarceration for youth with histories of chronic and severe antisocial or delinquent behavior and emotional disturbance. Community families are recruited, trained, and closely supervised to provide youth placed in their care with treatment and intensive supervision at home, in school, and in the community. Host families undergo intensive training and receive on-going support and supervision from the program coordinator. Youth participate in a structured daily behavior modification program and receive individual therapy. School attendance, behavior, and homework completion are closely monitored, and interventions are provided in the school as needed. The youth's biological or adoptive family receive therapy while the youth is participating in MTFC with the ultimate goal of returning the child to the family.

From a conceptual perspective, intensive probation programs with a strong treatment component may offer a safe and effective alternative to institutional care for some youth. Some communities have begun to blend the

role of a traditional probation officer with that of a case manager. This expanded role of a probation officer continues to carry the leverage of the juvenile court in terms of compliance and sanctions, but also provides a case management function to ensure that youth have access to, and participate in, treatment. Lorraine County, Ohio, as part of their Linkages program, used Probation Officers/Case Managers (PO/CM's) to supervise youths' participation in a placement diversion program. The PO/CM's, who work in conjunction with treatment providers, function as a combined probation officer and case manager; they maintain smaller caseloads in order to provide intensive supervision to youth receiving mental health and substance use treatment. Each PO/CM has a caseload of 15 to 20 youth and work flexible hours to accommodate evening and weekend contact with their clients (Cocozza & Stainbrook 1999).

This role is not unlike those of the probation officers who are part of the Harris County, Texas, Special Needs Diversionary Program. Specialized juvenile probation officers and licensed professional staff from the mental health agency work together to provide intensive community-based case management services to prevent further involvement with the juvenile justice system. While this program targets youth at the front-end of the processing continuum, as well as youth returning from placement, there is reason to believe that this expanded juvenile probation function could be employed as a post-dispositional alternative to correctional placement.

Juvenile mental health courts are emerging as an alternative to traditional juvenile court settings for youth with mental health needs (see page 55 for more detailed discussion about these courts). Some juvenile mental health courts have very strict exclusionary criteria for youth participation, barring youth who have committed serious or violent felonies or sex offenses, while others use broader criteria and discretion when making determinations about youth participation. For example, while the Los Angeles County, California, juvenile mental health court has no formal exclusion criteria with respect to a youth's current charges, the judge, working in conjunction with a team of juvenile justice, mental health and school officials, uses discretion when dealing with very serious felonies.

**3.6 Diversion programs should be regularly evaluated to determine their ability to effectively and safely treat youth in the community.** Decision-makers such as judges and agency administrators need to feel confident about diverting youth into the community. Data

should be routinely collected to track both short-term outcomes, in terms of treatment compliance and impact, as well as longer term outcomes such as the program's effect on juvenile recidivism. Data collected should aim to answer such questions as: "What percentage of youth referred to the program in a given year successfully complete the program? What percentage of youth who successfully complete the program re-offend within 6 months of program completion?" Evaluation data can help build support for the use of diversion programs as a way to effectively treat youth with mental health needs in a community setting, and can build community confidence in the use of such interventions.

Cost benefit analysis, while more complicated to complete, can demonstrate the financial savings that occur when youth are served in the community rather than in institutional settings, and can help decision-makers to allocate limited public resources. The Washington State Institute on Public Policy has conducted numerous cost-benefit reviews of interventions used with the juvenile justice population to reduce crime (Aos, Phillips, Barnoski, & Leib, 2001). Many of the reports that the Institute has released have focused on the comparative economics of certain policies, violence prevention programs, and other efforts to reduce particular at-risk behaviors. Among the programs reviewed are Multi-Systemic Therapy, Treatment Foster Care, and Functional Family Therapy. These reports, and the documented methodologies used to complete the analyses, could be useful to policymakers or administrators interested in establishing similar programs or policies.



## Cornerstone #4: Treatment

### **4. Youth with mental health needs in the juvenile justice system should have access to effective treatment to meet their needs.**

#### Background

Youth who require mental health treatment should be afforded access to treatment regardless of the setting in which they reside. Clearly, as indicated in the prior chapter, every attempt should be made to divert youth with mental disorders into appropriate and effective community-based care. However, it is recognized that diversion will not be an option for all youth. For those youth who cannot be diverted and who remain in juvenile detention or correctional settings, access to quality mental health treatment must be provided to aid in their rehabilitation.

The 2000 Surgeon General's Report on Children's Mental Health indicated that approximately 20 percent of children and youth in the general population experience a diagnosable mental health disorder, with 10 percent of youth experiencing illness severe enough to cause impairment (USDHHS, 2000). It is estimated that as few as 10 percent of youth in the general population with severe mental illness will receive the treatment that they need (USDHHS, 2000). There is simply not enough mental health treatment capacity in this country to respond to the need.

The situation for youth in the juvenile justice system is worse, where an estimated 67 to 70 percent of youth meet criteria for a mental health disorder. Investigations by the U.S. Department of Justice of juvenile detention and correctional facilities across the country have consistently found a lack of appropriate mental health screening, assessment and treatment services available to youth, a lack of qualified mental health personnel available to these youth, the inappropriate use of medications,, and inappropriate responses to suicide threats (US DOJ, 2005). The results of the prevalence study conducted as part of this project validate these findings. Of those youth with a mental health diagnosis, only 64 percent reported receiving mental health services while in their current juvenile justice placement. The adequacy of substance abuse treatment appears to be even more

problematic. Only 35 percent of those youth diagnosed with a substance use disorder reported receiving any substance abuse services (NCMHJJ, 2005).

Up until about 10 years ago, there was a general sense that "nothing works" for youth with mental health needs in the juvenile justice system. Since that time, significant research advances have broadened our understanding of the nature of mental health disorder among youth and have led to an improved understanding of the characteristics of effective treatment and intervention programs (Redding, 2000). Much of this work has centered on the development of demonstrated, effective interventions, commonly referred to as evidence-based practices (EBPs). EBP's involve standardized treatments that have been shown through controlled research to result in improved outcomes across multiple research groups. These advancements have occurred in both the mental health and juvenile justice fields. On the mental health side, there have been a number of studies and meta-analyses reviewing the effectiveness of treatment for mental disorders in children and adolescents (Burns, Hoagwood, & Mrazek, 1999; USDHHS, 2000; Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). Similarly, there have been efforts in juvenile justice to identify effective programs, most notably the Blueprints for Violence Prevention work (Mihalic, Irwin, Fagan, Ballard, & Elliot, 2004).

These efforts confirm that effective interventions do exist. Further, evidence-based practices can be found in different intervention categories, including psychosocial approaches such as Cognitive Behavioral Therapy (Rhode, Clarke, Mace, Jorgensen, & Seeley, 2004), community-based approaches such as Multi-Systemic Therapy (Elliot et al., 1998) and Functional Family Therapy (Alexander & Sexton, 1999), and medication therapy (Jensen & Potter, 2003). Some of these interventions, particularly the community-based approaches, are found in both the mental health and juvenile justice research literature. However, a major obstacle to the wider use of evidence-based practices lies in the lack of dissemination and implementation efforts to replace existing services with services that are empirically based.

In an attempt overcome this obstacle, some states have created centers to promote the implementation of

evidence-based practices for youth with mental health disorders in communities throughout their states. These centers provide information, assistance, and training to communities interested in implementing EBP's and often serve as liaisons to the EBP developers to ensure that implementation efforts are structured and adhere to the recommended protocols associated with each particular intervention. These centers are typically supported by a combination of public and private funds. States that have created such centers include Connecticut, Ohio, Pennsylvania, and Colorado (Blau, Coccozza, Bernstein, Williams, & Canary, 2004).

Other states have gone so far as to pass legislation requiring that public funds allocated to state agencies for services to youth in the juvenile justice, mental health, and child welfare systems be spent on evidence-based practices. For example, the state of Oregon recently passed legislation that requires the state juvenile justice, mental health, and child welfare agencies to document that 25 percent of their budget, including both Federal and state dollars, be spent on evidence-based practices. This requirement, which is being phased in over a four year period, increases to 50 percent in the second phase, and ultimately reaches 75 percent at the end of the four-year period (Oregon Department of Human Services, 2005).

Despite the recent attention being paid to EBP's, Scott Henggeler, the developer of MST, estimates that less than 1 percent of the youth who could benefit from evidence-based services currently receive them (Henggeler, 1997). It is recognized that the vast majority of mental health services and programs currently available to treat youth involved with the juvenile justice system are not evidence based, including many of the programs that are highlighted in this model. More research is necessary to develop new EBP's to treat youth in their homes and communities, especially youth who have co-occurring mental health and substance use disorders, and more work needs to be done to promote the wider use of EBP's with justice-involved youth.

## Recommended Actions

**4.1 Youth in contact with the juvenile justice system who are in need of mental health services should be afforded access to treatment.** This includes youth who are diverted into the community as well as youth who cannot be diverted and are placed in residential programs. The Coalition for Juvenile Justice,

in their 2000 Annual Report, "Handle with Care: Serving the Mental Health Needs of Young Offenders" identifies the following as important characteristics of treatment programs:

- Highly structured, intensive, and focused on changing specific behaviors
- Emphasize the development of basic social skills
- Provide individual counseling that directly addresses behavior, attitudes, and perceptions
- Sensitive to a youth's race, culture, gender, and sexual orientation
- Use community-based treatment rather than institutional-based programs
- Involve family members in the treatment and rehabilitation of their children
- Provide individualized services, support, and supervision to each child and family
- Within institutions, use mental health professionals, rather than corrections staff, as treatment providers
- Offer developmentally driven services that recognize adolescents think and feel differently than adults, especially when under stress
- Include an aftercare component
- Focus on measuring program effectiveness and meeting quality standards.

### **4.2 Regardless of the setting, all mental health services provided to youth should be evidence based.**

Enormous advances have been made in this area over the last decade, and there are now evidence-based interventions, including improved psychosocial approaches, medication therapies, and family and community-based models, that are well documented and proven effective for treating mental disorders among youth (Hoagwood, 2005).

Examples of some of the most effective interventions are identified below.

**A) Home and Community-Based Models.** Family and community-based treatments have been found to be effective forms of intervention for successfully treating youth with mental health disorders and reducing recidivism. A 2000 review of the research on the characteristics of effective treatments for youth in the juvenile justice system found that community-based

treatment and programs are generally more effective than incarceration or residential placement in reducing recidivism, even for serious and violent offenders (Lipsey, Chapman, & Landenberger, 2001). Examples of these models include:

**Multi-Systemic Therapy:** This is an intensive, family-based intervention for juvenile offenders with serious antisocial behavior who are at imminent risk of out of home placement. MST therapists collaborate with the family to determine the factors in the youth's "social ecology" that are contributing to the identified problems and design strategies for addressing these problems. Ultimately, the goal of MST is to empower families to cope with the challenges of raising children with emotional problems and to empower youth to cope with family, peer, school, and neighborhood difficulties (Henggeler, 1997).

**Functional Family Therapy:** This is a family-based prevention and intervention program therapy for youth who have demonstrated the entire range of maladaptive, acting out behaviors and syndromes. It is designed to improve family communication and problem-solving skills and includes phases that build on each other. These phases include engagement and motivation, assessment, behavior change, and generalization (Sexton & Alexander, 2001).

**Multi-Dimensional Treatment Foster Care:** This is a family-based foster care program used as an alternative to institutional care for juvenile offenders with severe antisocial behavior. Community families are recruited, trained, and closely supervised to provide youth placed in their care with treatment and intensive supervision at home, in school, and in the community. Host families undergo intensive training and receive on-going support and supervision from the program coordinator in order to closely supervise youth who are placed in their care. The youth's biological or adoptive family receive therapy while the youth is participating in MTFC with the ultimate goal of returning the child to the family (Chamberlain, 1998).

**B) Psychosocial Therapies.** Psychosocial treatments, sometimes called talk therapy, are used to provide guidance and support to persons with mental illness. They are typically provided by trained professionals, including psychologists, psychiatrists, social workers, or counselors. The type and duration of the treatment will vary depending on the needs of the youth and

the individual treatment plan that is developed. Some examples include:

**Cognitive Behavioral Therapy:** This is a relatively short-term, focused psychotherapy that combines two forms of therapy—cognitive therapy and behavior therapy—to address a wide range of psychological problems. It is action-oriented and helps youth gain independence and effectiveness in dealing with real life problems (Burns, Hoagwood, & Mrazek, 1999)

**Brief Strategic Family Therapy:** This is a time-limited, family-based therapy that attempts to change family interactions and cultural/contextual factors that influence a youth's behavior problems. It targets unsuccessful family interaction patterns that are directly related to the youth's behavior problems and establishes a practical plan to help the family develop more effective patterns of interaction (USDHHS, 2004).

**Aggression Replacement Therapy:** This is an intensive life skills intervention that is designed to alter the behavior of aggressive youth, reduce antisocial behavior and offer alternative pro-social skills. ART has three main components—Structured Learning Training, which teaches social skills; Anger Control Training, which teaches youth a variety of ways to manage their anger; and Moral Education, which helps youth develop a higher level of moral reasoning (Goldstein, Glick, Reiner, Zimmerman, Coultry, & Gold, 1986).

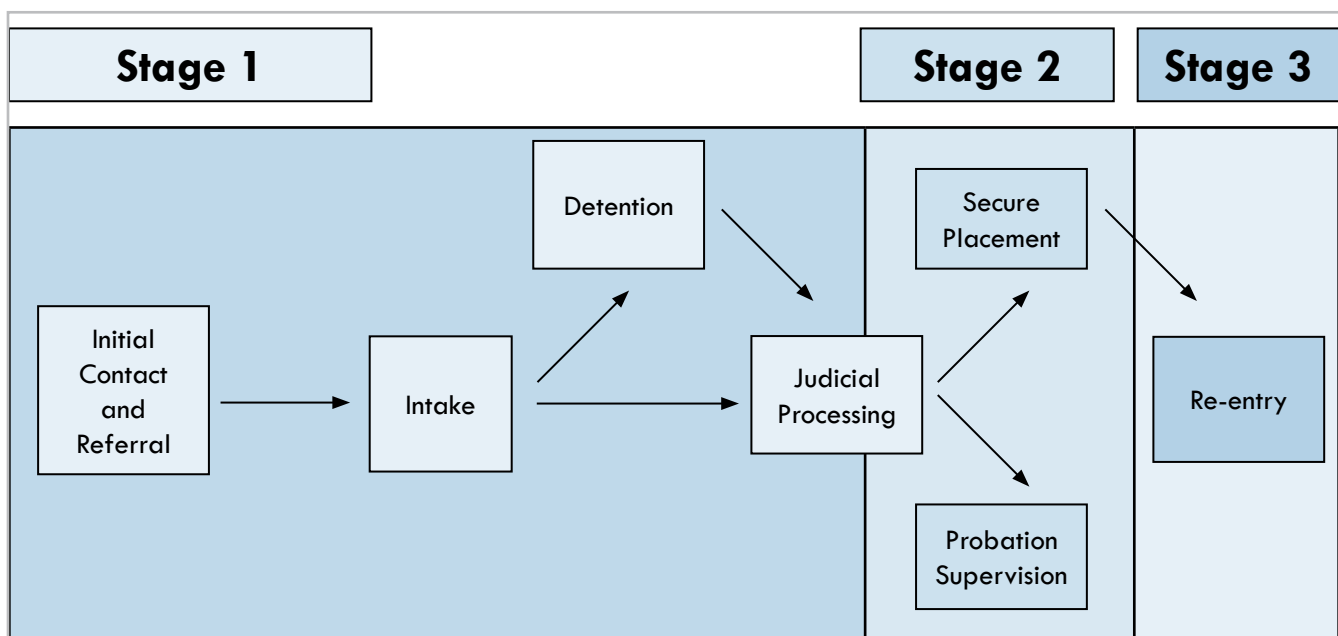
**Dialectical Behavior Therapy:** This is a mode of treatment designed for individuals with borderline personality disorder particularly those with suicidal behavior. Dialectical behavioral therapy aims to help people validate their emotions and behaviors, examine those behaviors and emotions that have a negative impact on their lives, and make a conscious effort to bring about positive changes (Swenson, Torrey, & Koerner, 2002).

**C) Medication Therapies.** Advances have been made to improve medication therapies for treating specific disorders in children and youth, such as attention deficit hyperactivity disorders (ADHD), depression, and certain anxiety disorders (Hoagwood, 2005). These advances have significantly improved the quality of life for many youth and have enabled them to remain in the community in the least restrictive and most natural living arrangement possible (Burns & Hoagwood, 2002).

Many of the psychosocial and medication therapies can and are being used with youth who are committed to secure care, and there are efforts underway to abstract elements of community-based models for use in correctional settings. Washington State’s Juvenile Rehabilitation Administration (JRA), recognizing the sizable portion of youth with mental health needs in their system, created a program that incorporates best practice interventions for youth with mental health needs. The Integrated Treatment Model (ITM) takes the evidence-based components of Cognitive Behavioral Therapy, Dialectical Behavioral Therapy and Functional Family Therapy and uses these therapies to provide individual treatment and skill development to youth from the point that they are admitted to a secure facility through their release back to the community (Juvenile Rehabilitation Administration, 2002). Staff within JRA’s correctional and community-based facilities were extensively trained to use cognitive-behavioral treatment interventions to address the multiple treatment needs of youth and prepare youth for their return to the community. Wanting to maximize the positive changes begun in residential care using this new cognitive-behavioral approach, JRA also redesigned its aftercare program to gear aftercare service to families, as opposed to individual youth. Parole counselors were trained in a new service delivery model, called Functional Family Parole, based on Functional Family Therapy, which focuses on techniques for motivating and engaging families in the rehabilitation process, and teaching families to recognize and support positive changes made by the youth (JRA, 2002).

**4.3 Responsibility for providing mental health treatment to youth involved with the juvenile justice system should be shared between the juvenile justice and mental health systems, with lead responsibility varying depending on the youth’s point of contact with the system.** In light of the growing awareness around the large numbers of youth in the juvenile justice system with mental health needs and the increasing pressure on the juvenile justice system to respond to these youth, it is necessary to clarify the roles and responsibilities that each system has for responding to the treatment needs of these youth. Currently, there is a great deal of confusion in the field about who is responsible for providing mental health treatment to youth involved with the juvenile justice system and how this treatment is best provided. It is recommended that responsibility for treatment be shared between the two systems, with primary responsibility shifting between the two agencies depending on the point of contact within the juvenile justice system. Examining the juvenile justice system as a continuum and identifying the general stages of activity can provide a context in which to begin to determine responsibility. Earlier in the document, we presented the seven key points within the juvenile justice continuum for mental health intervention (see pages 5–6). For the purposes of determining responsibility for mental health treatment, these key points have been grouped into three stages, depicted below in **Figure III**.

Stage 1 includes pre-adjudicatory processing; Stage 2 includes placement in a secure correctional facility or



**Figure III Key Points in the Juvenile System for Mental Health Intervention**

on probation supervision; and Stage 3 represents re-entry to the community following a juvenile correctional placement. Using this framework, the mental health system would have primary responsibility for providing treatment at the front and back ends of the continuum, with the primary locus of care being community or home-based settings. The juvenile justice system, in turn, would have primary responsibility for mental health treatment in the middle of the continuum, for youth who are committed to secure care and placed on probation supervision, according to the diagram.

For example, youth who are diverted to community-based treatment at probation intake, detention or juvenile court would most likely be diverted to a community-based mental health provider. While the juvenile justice system might still have supervision and oversight responsibilities for these youth, the mental health system would assume primary responsibility for treatment.

Youth with mental health needs who cannot be diverted from juvenile detention and remain in custody until the dispositional hearing should be afforded access to mental health treatment during this period. However, given the short-term nature of these placements, it does not make sense for detention centers to create long-term mental health treatment capacity within their facilities. Doing so could inadvertently result in more youth being placed in detention solely to access treatment services, a phenomenon referred to as net-widening. Rather, the recommended approach is that detention centers be able to systematically identify mental health needs among youth entering the detention system and have the capacity to link with community-based providers to provide treatment. Youth could receive treatment in one of two ways: they could be referred out of detention to receive mental health treatment over the course of their detention stay or mental health providers could come in and provide services to youth in the facility. Under this arrangement, the juvenile justice system would have primary responsibility for ensuring that youth have access to short-term treatment, but actual mental health service delivery would primarily fall to the mental health system. (Examples of programs that have been developed to provide mental health services to youth in detention can be found on pages 65–97).

Adjudicated youth with mental health needs who are placed on probation supervision would likely be referred to a community-based mental health treatment provider, per the terms of the dispositional order. While the juvenile justice system would monitor and supervise the

youth in the community as part of probation supervision plan, primary responsibility for mental health treatment would fall to the mental health system. For youth who are committed to a secure juvenile justice facility, a higher level of responsibility for providing mental health services to youth would fall to the juvenile justice system. Youth are typically placed in these settings for longer periods of time, creating an opportunity to capitalize on the period of confinement to provide treatment that aids in a youth's rehabilitation, and prepares them for their eventual return home.

There are different models for providing treatment to youth in juvenile justice facilities. New York State, for example, operates Mobile Mental Health teams to provide mental health services and treatment to youth in the state's juvenile correctional system. Executed through an annual Memorandum of Understanding (MOU) between the NYS Office of Mental Health and the NYS Office of Children and Family, teams of mental health professionals are deployed throughout the state to provide on-site assessment, crisis intervention, and counseling services to youth incarcerated in juvenile correctional facilities. In addition, mental health team members conduct case consultation with OCFS facility staff and provide staff training as necessary. Other states, such as Ohio and Texas, have chosen to create specialized mental health facilities within the state's juvenile justice system. Youth are typically referred to these specialized facilities after undergoing a comprehensive evaluation at a centralized intake or reception center. Youth receive intensive clinical and other services during their incarceration by treatment staff who are employed by the state juvenile justice agency.

At the back end of the continuum, as youth are released from secure care and transition home, primary responsibility for mental health treatment would fall to the mental health system. Youth in need of mental health services would be referred to community-based mental health providers as part of their re-entry plan. While the juvenile justice system would retain responsibility for supervising youth as part of an aftercare plan (in the form of probation or parole), responsibility for providing mental health treatment would fall primarily to the mental health system.

**4.4 Qualified mental health personnel, either employed by the juvenile justice system or under contract through the mental health system, should be available to provide mental health treatment to youth in the juvenile justice system.** Regardless of the setting and which agency has primary responsibility for treatment, all mental health services available to youth involved with the juvenile justice system should be provided by qualified mental health personnel. These include psychiatrists, psychologists, psychiatric nurses, social workers, and others, who by virtue of their credentials, are permitted by law to evaluate and care for the mental health needs of patients (AACAP, 2004).

In community settings, these staff would be employed by the public or private mental health provider. In juvenile facilities, these staff would be employed either by the juvenile justice agency that is responsible for operating the facility, or by a public or private mental health provider that contracts with the facility to provide treatment services. Contractual arrangements are most easily achieved through linkages between the juvenile justice and mental health systems, and these arrangements can vary from consultation and support to the actual delivery of services. Generally, it is not advisable for non-clinical staff, such as line staff within the juvenile justice system, to provide mental health services to youth. Further, many of the new evidence-based interventions call for strict adherence to a standardized set of implementation protocols that often dictate who can provide the intervention and the type of training that is necessary to credentialize a provider.

**4.5 Families should be fully involved with the treatment and rehabilitation of their children.** In order for families to be actively involved with their child's mental health treatment, they need to be informed about the juvenile justice system and the mechanisms for their participation in its proceedings. Families can provide a strong source of support for their children, serve as advocates to make sure youth get the care they need, and work in partnership with the juvenile justice and treatment staff by providing them with information that can aid in a child's treatment.

As part of the development of the Model, a series of focus groups were convened with families to learn more about how the juvenile justice and mental health systems can be improved to better respond to youth with mental health needs. These focus groups revealed the following:

- Support to families was viewed as critical to help them effectively navigate the juvenile justice system and better understand their rights and responsibilities;
- Families view the treatment services within the juvenile justice as largely inadequate. One of the few exceptions was wraparound services that link community services with in-home services; and
- Families want to be more involved with the process and viewed as potential resources and sources of support by juvenile justice staff and treatment providers.

In order for families to be actively involved, they need information. It is reasonable to believe that when families feel supported and have an understanding of what they can expect to happen to their child, they will be more inclined to support and participate in their youth's treatment than families who are not provided essential information about the process. The NCMHJJ Research and Program Brief, *Involving Families of Youth Who Are in Contact with the Juvenile Justice System* (2003), provides specific and concrete examples of ways in which family involvement can be supported at each stage of juvenile justice processing. Examples include asking parents how they want to be involved, ensuring that parents understand the adjudication process, and asking parents about the supports they may need to comply with the conditions of release and assisting them in accessing those supports.

Many families are capable of being strong advocates for their children while they are involved with the juvenile justice system and are actively involved with their child's mental health treatment. It must be noted, however, that some families do not have the capacity to be involved in their child's treatment; in other instances, the involvement of the family could actually be damaging to a youth. In these situations, it is important that a youth's opportunity to participate in treatment not be jeopardized by their family's lack of involvement. Every effort should be made to ensure that there is someone available to support and advocate for the youth, and be actively involved with their rehabilitation. The National Federation of Families for Children's Mental Health, in their definition of family driven mental health care, calls for all children and youth to have a biological, adoptive, foster or surrogate family voice advocating on their behalf. If a biological family member is not available, it is important that steps be taken to identify someone else who could serve as an advocate

for the child while they are involved with the juvenile justice system, and support the youth's involvement in mental health and other types of treatment (Federation of Families for Children's Mental Health, 2005).

#### **4.6 Juvenile justice and mental health systems must create environments that are sensitive and responsive to the trauma-related histories of youth.**

Many youth in the juvenile justice system have been exposed to numerous traumatic events at some point in their life, either as witnesses or as victims (Mahoney, Ford, Ko, & Siegfried, 2004). Many of these youth are the victims of physical or sexual abuse (National Clearinghouse on Child Abuse and Neglect, 2005). As a result, many of these youth develop post-traumatic stress disorder (PTSD) and other mental disorders that impact their ability to achieve normal developmental milestones in a timely manner (Arroyo, 2001). Studies have documented high prevalence rates of post-traumatic stress disorder among youth in the juvenile justice system, and indicate that trauma and PTSD appear to be more prevalent among juvenile detainees than in community samples, and more common among girls than boys (Abram, Teplin, Charles, Longworth, McClelland, & Duncan, 2004; Saigh, Yasik, Sack, & Koplewicz, 1999). For some youth, the juvenile justice experience itself can be a traumatic event, and can trigger memories and reactions to previous traumatic experiences (Mahoney et al., 2004). This is especially true for girls, where traditional methods of juvenile justice management and control (such as seclusion, restraint, and other physically confrontational approaches) can exacerbate feelings of loss of control and result in re-traumatization (Hennessey, Ford, Mahoney, Ko, & Siegfried, 2004).

Youth exposed to traumatic events can exhibit a wide range of symptoms, presenting not just internalizing problems, such as depression or anxiety, but also externalizing problems as well, such as aggression, conduct problems, and oppositional or defiant behavior patterns (Caporino, Murray, & Jensen, 2003). Very often, externalizing problems associated with trauma manifest themselves in behaviors that bring youth to the attention of the juvenile justice system. As such, it is increasingly important for juvenile justice and mental health staff to understand that there are multiple pathways to similar symptom patterns, and staff should be trained to routinely inquire about a history of trauma in their encounters and interactions with youth who present behavior problems (Caporino et al., 2003). The research tells us that trauma exposure puts youth at risk for PTSD as well as other mental health disorders (Albert,

Chapman, Ford, & Hawke, overheads). Therefore, it is recommended that trauma-related questions be included as part of the mental health screening and assessment process used with youth involved with the juvenile justice system. Some instruments, such as the MAYSI-2 and the V-DISC, include questions about traumatic experiences. Other instruments have been designed to specifically address trauma among children and youth. These include the Traumatic Events Screening Inventory for Children (Ford et al., 2000), the UCLA PTSD Index (Pynoos et al., 1998), the Trauma Symptom Checklist for Young Children (Briere, 2005), and the Childhood Trauma Questionnaire (Bernstein, Ahluvalia, Pagge, & Handelsman, 1997).

In terms of trauma-focused treatment, Cognitive Behavioral Therapy has emerged as the best validated therapeutic approach for children and adolescents who experience trauma-related symptoms, particularly symptoms associated with anxiety or mood disorders (Caffo & Belaise, 2003). The National Child Traumatic Stress Network reports that Cognitive Behavioral Therapy for PTSD (Cohen, Mannarino, & Deblinger, 2003) received the highest rating for adolescent trauma treatment in a 2003 U.S. Department of Justice publication on treatment for victims of physical or sexual trauma (Mahoney et al., 2004). Other therapies that do not address PTSD directly but have empirical support that they effectively target symptoms and functional problems associated with PTSD include Behavioral Parent Training, Multi-Systemic Therapy, Functional Family Therapy, Multi-Dimensional Treatment Foster Care, and Brief Strategic Family Therapy (Mahoney et al., 2004).

#### **4.7 Gender-specific services and programming should be available for girls involved with the juvenile justice system.**

There is growing evidence that large numbers of girls in the juvenile justice system have significant mental health needs (NCMHJJ, 2005; Teplin et al., 2002). In order to effectively respond to these girls, it is important to understand the gender-related issues that impact their experiences in the juvenile justice system. First, girls often present very complicated clinical profiles as a result of the pervasive violence they have experienced in their lives (Prescott, 1997). Girls are three times as likely as boys to have experienced sexual abuse, which is often an underlying factor in high-risk behaviors that lead to delinquency (Greene et al., 1998). Girls who have been abused or neglected are nearly twice as likely to be arrested as juveniles as those who have not (Widom, 2000). Research shows that girls and boys respond to different experiences differently and have different pathways to delinquency. Girls tend to get into

trouble more quietly than boys (Greene et al., 1998) by manifesting internalizing disorders, such as depression and anxiety (Veysey, 2003), and may hurt themselves by abusing drugs, prostituting themselves, or mutilating themselves (Belknap, 1996). Because these behaviors may not seem dangerous to society, their mental health needs may be overlooked or untreated (Greene et al., 1998)

Significant research has been done within the last several years to better understand these gender differences. This research has led to a greater understanding of the importance of providing gender-specific services to girls involved with the juvenile justice system. Gender-specific services refer to program models or services that comprehensively address the special needs of a targeted gender group, such as adolescent girls. These services foster positive gender identity development, recognizing the risk factors that are most likely to affect girls, as well as the protective factors that can build resiliency and prevent delinquency (Greene et al., 1998).

The PACE (Practical and Cultural Education) Center, in Florida is a non-residential, gender-specific, school-based prevention and diversion program for adolescent girls ages 12 to 18. Referrals to the program are accepted from many sources, including the Florida Departments of Juvenile Justice and Children and Families, as well as from schools, community providers, and family members. THE PACE Center also provides training and technical assistance to the juvenile justice system and community providers to help them develop gender-responsive programs for at-risk girls (PACE, 2005).

#### **4.8 More research is necessary to ensure that evidence-based interventions are culturally sensitive and designed to meet the needs of youth of color.**

Despite the advances that have been made to develop and implement evidence-based mental health treatments for youth in general and youth in contact with the juvenile justice system, some significant gaps remain. The U.S. Surgeon General's Report on Culture, Race and Ethnicity, prepared as a supplement to the Surgeon General's Report on Mental Health, found the gap between evidence-based research and practice to be particularly problematic for racial and ethnic minorities (USDHHS, 2001). An analysis conducted as part of the preparation of the report revealed that clinical research trials, used to generate professional treatment guidelines, did not conduct specific analyses for any minority group (USDHHS, 2001). It is critical that ethnic-specific analyses be routinely conducted in clinical research to ensure that

treatment is effective for a diverse range of individuals who could benefit from such treatment. This is particularly necessary for youth in the juvenile justice system, given the fact that minority youth are over represented at virtually every key processing stage (Snyder & Sickmund, 1999).

There is also a need for investment in research to develop new evidence-based treatment interventions for specific minority populations. There is evidence indicating that programs that specialize in serving identified minority communities are successful in encouraging minorities to enter and remain in treatment (USDHHS, 1999). These programs appear to succeed by maintaining active, committed relationships with community institutions and leaders and making aggressive outreach efforts; by maintaining a familiar and welcoming atmosphere; and by identifying and encouraging styles of practice best suited to the unique problems of racial and ethnic minority groups (USDHHS, 1999). Investment in clinical research to determine the extent to which these programs improve treatment outcomes for youth and families is necessary.

#### **4.9 All youth in juvenile justice placement should receive discharge planning services to arrange for continuing access to mental health services upon their release from placement.**

Ideally, planning for a youth's re-entry into the community should begin shortly after a youth's arrival in placement. The goal of the placement is to successfully rehabilitate the youth for their eventual reintegration into society. Critical to this is recognizing a youth's need for mental health services, providing effective services while a youth is in care, and ensuring that linkages are in place to allow for continued access to quality mental health care upon release. All re-entry planning should include efforts to ensure a youth's enrollment in Medicaid or some other type of insurance plan to pay for services upon release. A more detailed discussion of re-entry services for youth with mental health needs can be found on page 62.



## Section Four: Critical Intervention Points of the Comprehensive Model

This section of the model is designed to examine each of the critical decision making points within the juvenile justice processing continuum to identify where there are opportunities for improved collaboration, identification, diversion, and treatment for youth with mental health needs. Each of the critical intervention points is reviewed to provide general information on the point of contact, and an examination of the mental health needs and issues associated with that particular point in the continuum. The critical intervention points examined include:

**Initial Contact with Law Enforcement:** This includes the initial contact a youth has with the police at the time they are suspected of committing a crime.

**Intake (Probation or Juvenile Court):** This includes the point at which a youth is referred by law enforcement to juvenile court. Often, the juvenile court intake function is the responsibility of the local probation department.

**Detention:** This includes the point at which a youth is placed in a secure detention setting.

**Judicial Processing:** This includes the point at which a petition is filed in juvenile court, an adjudication hearing is held, and the judge orders a disposition in the case.

**Dispositional Alternatives (Juvenile Correctional Placement or Probation):** This includes a discussion of two dispositional alternatives—placement in a juvenile correctional facility or placement on probation supervision.

**Re-Entry:** This includes the point at which a youth is released from a juvenile correctional placement and returns home.

## Critical Intervention Point: Initial Contact with Law Enforcement

### Overview of Intervention Point

There are essentially two types of young offenders. *Status offenders* are youth who engage in behavior, such as running away from home, skipping school or breaking curfew that if committed by an adult, would not be considered illegal. *Delinquents* are those youth under the age of 18 who engage in behaviors, such as shoplifting, trespassing, and assault, that if committed by an adult would be deemed illegal (Coalition for Juvenile Justice, 2000).

If a youth is suspected of committing a status or delinquency offense, the police are frequently the first to intervene. At this point, law enforcement officials play a pivotal role in determining whether the case proceeds into the juvenile justice system, or whether the case can be diverted, often into alternative programs (Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2004). Generally, the police have a fair amount of discretion in determining how best to respond to the situation. The Coalition for Juvenile Justice (2000) identifies the most common practices used by law enforcement upon an encounter with a delinquent youth or a status offender:

- 1) **Street corner adjustment:** Police officers use verbal persuasion to order a youth to go home in response to mischievous behavior.
- 2) **Station house adjustment:** Police officers take the youth to police headquarters where the youth is sternly warned by the police to improve their conduct and released. No official complaint is filed with the juvenile court.
- 3) **Station house adjustment with parental involvement:** Police officers take a misbehaving youth to police headquarters, and their names and addresses are often entered into a police database. Parents or guardians are asked to come to police headquarters where the youth is sternly warned by the police to improve their conduct. The youth is released to the parents or guardian once the matter is discussed with the youth and the parent or guardian. No official complaint is filed with the juvenile court.

- 4) **Police Diversion:** Police officers bring a youth engaging in disruptive behavior to police headquarters and agree not to file an official complaint with the juvenile court if the youth agrees to certain conditions, such as obtaining specific services or performing community service.
- 5) **Formal Complaint:** Police officers file a formal complaint or charges with the juvenile court. This moves the case formally into the jurisdiction of the juvenile justice system.

In 2000, twenty percent of all youth arrested were handled within the police department and then released. Seventy percent of all youth arrested were referred to juvenile court (OJJDP, 2004). Most cases are referred to juvenile court by law enforcement officials (84% in 2000), while the remainder of cases are referred to court by either parents, victims, schools or probation officers (OJJDP, 2004).

### Mental Health Needs and Issues

Often, a youth's disruptive or delinquent behavior is the result or a symptom of a mental health problem that has gone undetected and untreated. The problem may manifest in behavior that brings the youth to the attention of law enforcement. Police response at this initial contact has significant implications in determining what happens next to the youth. An opportunity exists at this point for law enforcement, upon an encounter with a youth who appears to have a mental health problem, to connect the youth with emergency mental health services, or refer the youth for mental health screening and evaluation. In some ways, this represents the ideal time to prevent youth with mental disorders from further penetrating the juvenile justice system by diverting them at their earliest stage of justice contact into community-based mental health care. This type of a response, however, requires a number of factors to be in place. First, law enforcement officials either need to be properly trained to identify the signs and symptoms of mental disorder among the youth with whom they are interacting, or mental health professionals need to be available to assist the police in responding to incidents involving youth with mental disorder. Second, it is critical that law enforcement have a place where they can take youth who may require immediate mental health attention.

There is also growing concern that zero tolerance policies within schools are resulting in more youth entering the juvenile justice system for relatively minor infractions that previously had been addressed by school administrators. It is believed that the juvenile justice system is becoming a “dumping ground” for many of these youth (Rimer, 2004). Further support comes from a recent study conducted in Pennsylvania, which found that students with disabilities are referred to the police at twice the rate of others (Lynagh & Mancuso, 2004). School district staff, including school police officers, need to be trained to educate and manage the behavior of students with disabilities, including youth with mental health needs, instead of unnecessarily referring these youth to law enforcement (Browne, 2003).

Recently, there has been much attention given to the idea of training law enforcement officers to better identify and respond to individuals with mental health needs and disorders. Much of the work that has been done in this area has focused on the adult criminal justice population with far less attention being paid to training law enforcement officials to identify the signs and symptoms of mental illness among juveniles. On the adult level, the Criminal Justice/Mental Health Consensus project report, released in 2002 by the Council of State Governments, offers a series of recommended policies and practices aimed at improving the criminal justice response to people with mental illness, including contact with law enforcement. The report recommends, among other things, that law enforcement officers recognize signs and symptoms that may indicate that mental illness is a factor in the incident; that de-escalation techniques be used that are appropriate for people with mental illness; and that area hospitals or mental health facilities be designated as disposition centers to facilitate intake for people with mental illness (Council of State Governments, 2002). In 2004, the TAPA Center for Jail Diversion released a report, “A Guide to Implementing Police-Based Diversion Programs for People with Mental Illness,” which builds on the Consensus report and discusses a series of specialized police approaches to people with mental illness. This report suggests that there are essentially two models of specialized police response. The first model involves specially trained police officers that provide crisis response at the scene, typically referred to as Crisis Intervention Teams (CIT’s). The CIT model, which was created by Major Sam Cochran of the Memphis Police Department, is made up of officers who are specially trained to respond to all crisis calls that involve an individual with mental illness. The core components of the CIT model include 1) selective recruitment and intensive

training of police officers who become specialists in crisis intervention and de-escalation; and 2) improved access to mental health care and services. The second model involves a close partnership between police officers and mental health officials who co-respond to the scene (Reuland, 2004). Independent of the specific model, the author suggests that there are three essential elements to establishing a police-based response to people with mental illness: extensive training for law enforcement and mental health staff; justice/mental health partnerships; and an adapted view of the role of the police.

In the absence of any specific work done to date to develop a knowledge base on the issue of police responses for youth with mental health disorders, the work that has been done at the adult level can provide some general guidance. In fact, some communities across the country have initiated specialized programs to assist police when responding to calls or incidents involving youth. In most of these communities, an existing adult program has been expanded to serve juveniles. Colorado operates a CIT program that serves both adults and youth with mental illness. The program has trained hundreds of officers, deputies, and dispatchers on mental illness and de-escalation techniques. Although the program is not specific to youth, crisis calls involving youth accounted for almost 20 percent of the total calls in two pilot sites (Colorado crisis intervention, 2004). Services are provided by partnerships that have been formed by the police, providers, hospitals, and advocates. The Rochester Community Mobile Crisis Team (RCMCT) is part of a larger system of mental health services available to youth. The RCMCT responds to calls from schools, parents, and the police, and performs evaluations and provide access to a range of mental health services. In 2004, the city of Rochester created a team comprising police and probation officers, as well as civilians with mental health backgrounds called the Emotionally Disturbed Persons Response Team (EDPRT) to help law enforcement respond to individuals experiencing a psychiatric emergency. The team recently added two school resource officers to help address situations concerning juveniles, and the RCMCT provided specialized training to the EDPRT on responding to youth. Since its inception, the EDPRT team has responded to approximately 30 calls concerning youth.

## Critical Intervention Point: Intake

### Overview of the Intervention Point

Once a case is referred to juvenile court, an intake assessment process is initiated. In many jurisdictions, juvenile intake is both the initial point of formal juvenile justice system contact, as well as the entity responsible for making decisions about diversion or further referral to juvenile court (Grisso & Underwood, 2004). The intake function is structured differently across jurisdictions. In some states, this function is the responsibility of the juvenile court. In other states, it occurs outside of the juvenile court, for example, within the juvenile probation system, a state juvenile justice agency or the prosecutor's office. Some states have created centralized juvenile intake centers (JACs) to provide comprehensive intake and assessment services to all youth referred to the juvenile justice system. Regardless of who takes responsibility for the function, intake officers are responsible for making a determination about whether a case should be dismissed, handled informally, or referred to juvenile court for formal intervention. Depending on state law, a decision to waive a case to adult criminal court may also be made at intake processing (McCord, Spatz-Widom, & Crowell, 2001).

When making these decisions, intake officers exercise considerable discretion (Butts & Harrell, 1998). First, an intake officer must conduct an initial screen to review the facts of the case and determine if there is sufficient evidence to prove the allegation. If intake determines that there is not sufficient evidence to go forward, the case is dismissed. Cases may be dismissed for a variety of reasons, including insufficient legal evidence, the offense is a relatively minor one, and the juvenile is a first-time offender, the juvenile or his or her family has compensated the victim, the family background is strong, and the youth is amenable to parental supervision, or formal processing is unnecessary (Kelly & Mears, 1999).

If it is determined that there is sufficient evidence to proceed, intake will then decide if formal intervention with the juvenile court is necessary. About half of all cases referred to juvenile intake are handled informally and most informally processed cases are dismissed (OJJDP,

2004). In the other informally processed cases, the youth voluntarily agrees to specific conditions for a period of time. These conditions, which are often documented in a written contract with the youth, may include such items as restitution, community service, school attendance or participation in some sort of treatment program (OJJDP, 2004). A youth's compliance with these conditions is typically monitored by a probation officer. As a result, this process is referred to as informal diversion or probation. If the youth successfully meets the terms of the informal disposition, the case is dismissed. If a youth does not meet the terms of the informal disposition, the intake officer can decide to formally proceed with the case and refer the youth to juvenile court for an adjudicatory hearing.

When making decisions about whether a case should be dismissed, diverted or formally referred to juvenile court, intake officers often engage in a process to collect information on which to base their decision (Torbet, 1996). This includes collecting information from the youth, his or her family, and any social service agencies involved with the youth on such factors as school attendance, behavior at home and in the community, and family and peer relationships. Emphasis is also placed on examining the circumstances of the offense and the youth's previous record, if there is one (Torbet, 1996).

### Mental Health Needs and Issues

Intake is very often viewed as the "gatekeeper" to juvenile court and, as such, represents an ideal opportunity to intervene early and identify the need for mental health or other types of rehabilitative services. Considering the potential influence that intake decisions can have on subsequent juvenile justice processing, it constitutes one of the most critical points within the juvenile justice continuum for applying prevention and early intervention strategies (Kelly & Mears, 1999). Despite this potential, there is concern that this opportunity is not fully seized to routinely collect information on a youth's mental health status and to use this information to make effective referral or diversion recommendations.

There is a lack of mental health prevalence research on youth at intake; most studies have focused on youth in post-intake settings such as detention and corrections (Kelly & Mears, 1999). A recent study that examined gender differences in psychiatric disorders among youth at probation intake in Texas found that nearly half of

the entire sample met diagnostic criteria for at least one mental health disorder (Wasserman, McReynolds, Ko, Katz, & Schwank, 2005).

There is concern that intake units, such as probation departments, are not fully prepared to adequately identify and respond to these needs. A 1999 study of juvenile intake practices in Texas found that while most jurisdictions value appropriate assessment and referral processes, not all are well positioned to provide them (Kelly & Mears, 1999). One of the most frequently cited problems was the lack of communication and collaboration between juvenile justice and other child serving systems, with the authors citing the need for improved relations in order to more effectively identify and respond to youth with mental health needs. A recent study that examined probation officers' responses to a survey on mental health knowledge and practices when working with youth found that there are gaps between existing practice and current knowledge about mental disorders, assessment, and appropriate treatments. This lack of knowledge may, in fact, limit some probation officers from effective execution of their "gatekeeper" role (Vilhauer, Wasserman, McReynolds, & Wahl, 2004).

One of the most important strategies that can be applied at this point in the processing continuum is the standardized use of a mental health screen on all youth entering intake. The most common purpose of screening at intake is to identify those youth who are most likely to have special mental health needs that require more detailed clinical assessment or emergency referral for community mental health services (Grisso et al., 2005). Mental health screening at this point can result in a youth being diverted from the juvenile justice process, with intake officers using their discretion to arrange for appropriate community-based evaluation and services in lieu of referral to juvenile court (Grisso & Underwood, 2004).

Diversion programs and strategies are employed at intake in communities throughout the country. Some programs aim to divert status and other low level offenders to community treatment; other diversion programs specifically target youth with more serious offenses or with more complicated treatment histories and needs. When implementing a diversion strategy, there are a number of questions that need to be considered. How early should a youth be identified and diverted into services? Should the decision to divert be made at intake, prior to the case being referred to court, or

should diversion occur after a petition is filed but before adjudication? If a pre-adjudication diversion strategy is employed, does the Probation department have linkages with community-based mental health service providers to accept these youth? Are there evidence-based services available in the community for these youth? Does the probation department have the capacity to provide supervision to youth who are diverted into treatment?

Communities have responded to the issue of early identification and diversion for youth with mental health needs in a variety of ways. The Family Intervention Resource Services Team (FIRST) in Lexington, Kentucky is a county diversion program for first-time status offenders in grades 6 through 8 who have mental health and substance abuse problems and who appear for adjudication in juvenile court. The goal of the program is to connect youth with effective, community-based interventions as an alternative to further (and more formal) court processing. A Court Designated Worker (CDW) makes referrals to the program based on referrals to the court from probation intake. The CDW administers the Problem Oriented Screening Instrument (POSIT) to determine mental health status and shares the results of this evaluation with the FIRST program. The FIRST case manager then meets with the family (either at their home or at the court office) to do the formal program intake and begin the development of a family service plan. The case manager provides referrals and linkages to a range of community services, including mental health and substance abuse services, as well as case management to the family. The family case manager regularly reports to the CDW on how the case is progressing, and if a youth meets the goals included in the individual service plan, the case is closed successfully.

Jefferson County, Alabama, operates Diagnostic and Assessment Units that serve to identify youth with mental health disorders who are at-risk of out of home placement. Four units are in place—one in family court, two in the schools, and one in the child welfare agency. Referrals to the court unit come from Probation intake or the family court judge. After an evaluation, the youth goes before the judge, and if the youth agrees to the diversion program, they are linked to services, which can include outpatient mental health care, psychiatric care, respite services, case management, medication management, and tutoring. Most services are provided to the youth and family in their home or in locations that are convenient to the family. Probation staff are involved with all cases to monitor and report back to the judge on progress.

Some communities have created diversion programs that link youth in need of mental health services with evidence-based services at both the pre- or post-adjudication stage of case processing. The Indiana Family project of Bloomington, Indiana, uses Functional Family Therapy as a diversion intervention. Referrals come from the probation intake unit if the youth is diverted pre-adjudication, or from the family court judge if the youth is diverted post-adjudication. An FFT family preservation team is assigned to work with the youth and family and provides treatment in standardized phases. Reintegration planning begins on day one so that a plan is in place upon a youth's discharge from the program.

Family Intervention Specialists (FIS) of Georgia provides intensive family intervention services to youth with a known or suspected mental health disorder, who are at risk of out of home placement or are currently in out of home placement with reunification imminent. The majority of referrals come from probation intake or the juvenile court. Specialized probation officers, who are trained to identify mental health and substance use disorders among youth, use the MAYSI-2 to screen all youth at intake. Youth referred to the program undergo further evaluation and receive Brief Strategic Family Therapy (BSFT) as the primary intervention. Services are provided by FIS staff, and there is strong collaboration between FIS and justice staff, including probation officers and the court, throughout the period of involvement.

The New York State PINS Diversion program, created in 1986 as way to reduce unnecessary court intervention on behalf of persons (alleged) to be in need of supervision (PINS), gives juvenile probation departments the authority to deny access to court to potential petitioners by engaging in a comprehensive assessment and diversion effort for these youth. An interagency designated assessment service (DAS) provides comprehensive assessments and services (either directly or under contract with community-based providers) to youth and their families in an effort to address the issues that brought the youth to the attention of juvenile probation. Successful completion of the service plan results in the case being closed with no formal court intervention.

The Texas Special Needs Diversionary program is a probation-intake based diversion program that targets youth with specific mental health needs by diverting youth into wraparound community services, many of which are provided to the youth and families in their homes or in school. Co-located teams of probation and mental health staff provide joint case management, service delivery,

and supervision to youth involved with the program. Each team has a caseload of 12 to 15 youth. These teams are responsible for jointly securing, providing or supervising the provision of services to youth on their caseload. Program compliance and progress is monitored through weekly unscheduled home visits by the youth's probation officer and the team therapist. Participating families also have three to five program contacts per week, at least two of which are in the home.

## Critical Intervention Point: Detention

### Overview of Intervention Point

During the processing of a case, a youth may be held in a secure detention facility. The organization and administration of juvenile detention varies by state, and even within states, and from community to community depending on state and local practice. In general, juvenile detention is a secure setting intended to safely detain youth who are awaiting adjudication, disposition or placement in a correctional or probation program. Most states use pre-trial detention to hold juveniles awaiting adjudication. However, some states also use juvenile detention for post-adjudication placement or as a temporary disposition while awaiting placement elsewhere.

Typically, after a youth is arrested, they are brought to a juvenile detention facility by law enforcement. Juvenile probation officers or detention intake workers review the case and decide if the youth should be held in detention pending a hearing by a juvenile court judge. In all states, a detention hearing must be held within a time period specified by statute, generally within 24 to 72 hours. At the detention hearing, a judge reviews the case and determines if continued detention is warranted or if the youth can be released to the custody of a parent or guardian. Youth are typically placed in secure detention for two main purposes: to ensure that the youth appears for all court hearings and to protect the community from future offending (Austin et al., 2005). In 2000, juveniles were detained in 20 percent of all delinquency cases processed by juvenile courts (OJJDP, 2004).

In 1990, juvenile courts handled 1.3 million delinquency cases; by 1999 this number increased by 27 percent to almost 1.7 million cases (Harms, 2003). The increase in the number of delinquency cases in the juvenile court system resulted in an 11 percent increase in the number of delinquency cases involving juvenile detention (Harms, 2003). In 1999, 33,400 more juvenile delinquency cases were detained than in 1990 (Harms, 2003). While the overall proportion of delinquency cases referred to detention remained relatively stable between 1990 and 1999 (around 20%), the profile of the national juvenile detention population shifted, with more youth

charged with person and drug offenses and a greater proportion of adolescent girls detained (Harms, 2003). It is estimated that anywhere from 300,000 to 600,000 youth cycle through secure juvenile detention centers each year, and that on any given day, approximately 27,000 youth are held in some 500 secure juvenile detention facilities across the country. This represents an increase of over 70 percent since the early 1990s (Coalition for Juvenile Justice, 2003).

A youth is detained in pre-trial detention because they are accused of conduct that is subject to the jurisdiction of the juvenile court. The average length of stay in juvenile detention is approximately 15 days (Parent et al., 1994). While the National Juvenile Detention Association recommends that quality health, mental health, and education services be afforded to youth while in detention, there is tremendous variation in the scope and quality of services provided to youth. Further, many of the nation's juvenile detention facilities are seriously overcrowded—nearly 70 percent of youth in public detention centers are in facilities operating above their official capacity (Smith, 1998). Staffing shortages within detention centers only exacerbate the issues of overcrowding and can result in an extremely chaotic and stressful experience for both detained youth and the staff who are responsible for supervising and managing them.

### Mental Health Needs and Issues

Contributing to the concerns about juvenile detention centers is the increasing number of youth entering the system with mental health disorders. Since the release of the 1992 research monograph, *Responding to the Mental Health Needs of Youth in the Juvenile Justice System* (Cocozza, 1992) the research base on the prevalence of mental health disorder among the juvenile justice population has steadily grown. Interestingly, juvenile detention centers have served as the setting for many of these new studies and therefore provide the clearest picture of the prevalence of disorder within the broader juvenile justice system. For example, Teplin's study of juvenile detainees in the Cook County, Illinois juvenile detention center found that nearly 66 percent of the males and 73 percent of the females met diagnostic criteria for one or more psychiatric disorders (Teplin et al., 2002).

There have been recent attempts to encourage the development of alternatives to secure juvenile detention. One of the most prominent efforts is the Juvenile Detention Alternatives Initiative (JDAI), which is supported by the Annie E. Casey Foundation. Established in 1992, the JDAI seeks to reduce the number of youth unnecessarily or inappropriately detained; to reduce the number of youth who fail to appear in court or re-offend pending adjudication; to re-direct public funds toward successful reform strategies; and to improve the conditions of confinement for youth who are detained (Casey/JDAI website). The goal is to create new and more effective strategies for youth without compromising public safety, and many communities across the country have made significant progress in developing secure detention alternatives. While successful, the initiative has not placed a priority on reforms that specifically address the mental health treatment needs of these youth.

Juvenile detention can be a traumatic experience for all youth, but the situation can be much worse for youth with serious mental health needs. Feelings of depression, anxiety, and hopelessness are heightened for all youth in juvenile detention, some of whom are experiencing their first separation from parents or caregivers, but can be much worse for youth with mental health needs. The potential for crisis is high. Youth with mental health disorders may also be particularly vulnerable to victimization because of their disorders. Detention can also mean an interruption in both medication and therapeutic services for youth who already receive these things in the community. While suicide among youth in juvenile detention centers is a significant concern (Hayes, 2000), there have been no national studies conducted to date that have compared suicide rates among youth in confinement with those of youth in the general population (Hayes, 2004). The only national survey on the incidence of juvenile suicides in custody contained several flaws (Flaherty, 1980); a reanalysis of suicide rates in that survey found that youth suicide in detention centers was estimated to be more than four times greater than in the general population (Memory, 1998).

While the average length of stay in detention is about two weeks, youth who stay longer in detention (often more than 30 days) are usually those with complicated placement needs rather than those charged with more serious offenses (Woolard, Gross, Mulvey, & Reppucci, 1992; Butts & Adams, 2001). As a result, youth with mental health problems are particularly susceptible to extended detention stays. The public health crisis that exists generally around children's mental health is only

exacerbated by placing youth in juvenile justice settings, such as detention, where staff often do not have the knowledge, training, or expertise to appropriately deal with these youth.

A report issued by Congress in July 2004 further documents the inappropriate use of detention for youth with mental health problems. A survey, commissioned by Representative Henry Waxman and Senator Susan Collins, was conducted to look specifically at the issue of youth with mental health needs who are unnecessarily incarcerated in juvenile detention facilities awaiting mental health services in the community (United States House of Representatives, 2004). In a study of 698 detention centers across the country, the authors concluded that the nation's juvenile detention centers have become "warehouses" for mentally ill youth, many of whom have not committed any crimes. Among the study's findings:

- Two-thirds of juvenile detention facilities surveyed reported holding youth who are waiting for community mental health treatment.
- Over a 6-month period, nearly 15,000 incarcerated youth waited for community mental health services.
- One quarter of the facilities reported providing poor or no mental health treatment to juvenile detainees, and over 50 percent reported inadequate levels of staff training.
- Juvenile detention facilities spend an estimated \$100 million each year to house youth who are awaiting community services.

One solution might be to create an extensive mental health system within the juvenile detention system to respond to youth with mental health needs. However, given the short-term nature of most juvenile detention placements and concerns over net-widening, the better approach for ensuring that youth have access to mental health treatment is to establish linkages with community-based mental health providers to provide treatment to youth while they are in detention. Several communities have created programs that illustrate this approach. The Bernalillo County Juvenile Detention Center (BCJDC) developed an intake process that identifies youth with mental health needs and diverts these youth to a community mental health clinic, the Children's Community Mental Health Clinic (CCMHC), which is located 200 yards away from the detention facility and is fully funded by Medicaid. The CCMHC serves all youth in Bernalillo County who would benefit from the services provided



by a mental health treatment team. Referrals to the clinic can be made by the juvenile detention center, care providers, parents or patients, thereby reducing any incentive to refer youth to the detention center simply in order to access mental health services. Youth brought to the detention center undergo a comprehensive intake screening to identify any mental health needs. Youth identified through the screening as needing immediate mental health services are walked from the detention center to the mental health clinic. Clinical services, which are available to youth in detention as well as youth in the community, include evaluation and assessment, individual and group therapy, medication management, substance abuse treatment, case management, and crisis management.

The Illinois Department of Human Services (DHS) created the Mental Health Juvenile Justice (MHJJ) Initiative in 2000 to identify youth in detention centers with severe mental illness. DHS provides funding to support mental health juvenile justice service liaisons who work with detention centers, juvenile courts, and others to coordinate community-based services for youth in detention who have a major affective disorder or a psychotic disorder. Youth with disruptive behavior disorders are excluded unless these disorders co-occur with a psychotic or affective disorder. The program targets youth with the most serious of disorders who are in juvenile detention, and funds are provided to the local community mental health agency to pay for the services of a system liaison who works to link youth in detention with local services and care. Once a youth is referred to MHJJ, eligibility assessments are conducted and a care plan is developed for the youth and family. The liaison informs the court that a youth with severe mental illness has been identified in the detention center with specific needs that can be treated in the community. The judge can then release the youth to the community and the liaison assists the family by linking them to services for a period of 6 months. Once the plan is in place, services are provided based on the wraparound model—individualized services that address the youth's needs and strengths. (Lyons, Griffin, Quintenz, Jenuwine, & Shasha, 2003).

The Prime Time Project is a collaborative between the King County, Washington, Department of Youth Services and a community-based mental health clinic. It is a comprehensive intervention model for youth who are in detention, who are between the age of 12 and 17, who have at least two prior admissions to detention, who are in detention for a relatively serious offense, and who have a diagnosable mental health disorder.

The program aims to decrease delinquent behavior, increase pro-social behavior, and stabilize psychiatric symptoms. Services, provided by the community mental health clinic, begin in detention and follow youth as they return to the community; interventions take place over a year-long period with the intensity of services tapering over the course of treatment. Based largely on Multi-Systemic Therapy, the program attempts to address the ecological factors that contribute to a youth's delinquent behavior through evidence-based psychotherapeutic interventions.

## Critical Intervention Point: Judicial Processing

### Overview of the Intervention Point

Once a case is referred to the juvenile court, there are a number of steps involved with judicial processing. There are two types of petitions that may be filed in juvenile court: a delinquency petition or a waiver petition (OJJDP, 2004). A delinquency petition states the allegations against the youth and requests the court to adjudicate (or judge) the youth a delinquent. In response to the delinquency petition, an adjudicatory hearing is scheduled. A waiver petition is filed when a prosecutor or an intake officer believes that a case currently under the jurisdiction of the juvenile court would be more suitably handled in adult criminal court. The decision to waive a case to adult criminal court generally centers around whether the youth is amenable to treatment in the juvenile justice system. Prosecutors can also argue that a youth's previous experiences with the juvenile justice system have not prevented the youth from committing subsequent delinquent acts, or that the seriousness of the crime prevents the juvenile justice system from intervening with the youth for the time period necessary to rehabilitate the youth (OJJDP, 2004). If the judge agrees, the case is waived to adult criminal court. If the judge does not approve the waiver request, an adjudicatory hearing is scheduled.

At the adjudicatory hearing, witnesses are called and the facts of the case are presented to the judge. At this point, the juvenile may be found delinquent and a dispositional hearing is scheduled; the juvenile may be found not guilty and the case may be dismissed; or the case may be continued in contemplation of dismissal (ACD). In the event of an ACD, the youth may be asked to take some action prior to the final decision being made, such as paying restitution or obtaining treatment (McCord et al., 2001). In 2000, juveniles were adjudicated delinquent in 66 percent of cases petitioned to juvenile court (OJJDP, 2004). Once a youth is adjudicated delinquent, a disposition plan is developed. To prepare this plan, probation or court intake staff prepare a detailed history of the youth and assess available support systems and programs. To assist with the preparation of the disposition plan, the court may order psychological evaluations, diagnostic testing or a period of confinement

in a diagnostic facility to ascertain the youth's current mental health status and the need for any specialized treatment services.

### Mental Health Needs and Issues

The judicial processing stage presents numerous opportunities for a youth's mental status to be considered. It is of critical importance that judges have sufficient information about a youth's mental health treatment history and current needs in order to have some sense of how a youth's mental health disorder may have contributed to the problem behavior and/or offense, and make an informed dispositional determination. The judge's decision will have a significant and long lasting affect on a youth's life. Ideally, information on a youth's mental status should be collected prior to the youth's case being referred to court, and the information used to divert youth earlier in the process, for example at probation intake or at detention, to community-based treatment settings. However, for some youth, these diversion opportunities do not exist, and the first attempt to identify any mental health concerns comes at the time when a youth has been adjudicated and intake staff are developing the dispositional plan. Every effort must be made to ensure that a youth's mental status is thoroughly evaluated at this stage so that this information can be presented to the court and considered as part of the disposition plan.

Further, it is critical that intake staff have a thorough understanding of the community-based services and programs available to which a youth can be referred, so that this information can be included in the dispositional plan and communicated to the court. Often, judges complain that they do not have sufficient information about services that are available within the community to which they can order a youth, leaving them with little alternative but to commit a youth to residential placement.

Many large juvenile courts have the resources to order clinical assessments for youth with special needs that must be taken into account by judges when deciding on the proper disposition of a case (Grisso, Vincent, & Seagrave, 2005). Typically, the focus of these assessments is to determine necessary treatment for a youth's mental disorder and the degree of security required in the youth's dispositional plan. In some

instances, juvenile courts operate clinics specifically for this purpose. Court clinics typically employ a range of professionals, including psychologists, psychiatrists, and social workers, who provide court-ordered evaluations, referral services, and some treatment services for youth and families involved with the juvenile court on status, delinquency and sometimes child protective cases (National Center for Juvenile Justice, 2004). In other instances, juvenile courts contract with mental health providers who perform assessments and evaluations and provide reports to the court documenting their findings and recommendations.

The Boston Juvenile Court Clinic was designed to provide evaluation and treatment services to youth involved with the juvenile court. It is one of the first such clinics in the United States. The clinic provides evaluation and some treatment services to over 900 youth a year, and the majority of cases involve delinquency, status offense, and child abuse matters, and problems related to exposure to various types of trauma. Services are provided by a multi-disciplinary team that provides evaluation, consultation, and treatment services for the court. In addition, the clinic operates intervention programs for parents and children, including parenting programs, anger-management interventions, and substance abuse education programs.

The Cook County, Illinois, Juvenile Court Clinic has responsibility for providing a variety of services to judges and court personnel regarding clinical information in juvenile court proceedings. Originally piloted as the Clinical Evaluation and Services Initiative (CESI), the model was expanded and redesigned as the Cook County Juvenile Court Clinic. It consists of four units (Clinical Coordination, Education and Intervention Resources, Clinic Administration, and Program Evaluation) and is managed by a single director who oversees a multidisciplinary staff consisting of psychologists, psychiatrists, social workers, and lawyers. Services include consultation regarding requests for clinical information, forensic clinical assessments in response to court-ordered requests, information regarding community based mental health resources, and education programs on issues relating to mental health information and court proceedings. With a clinical coordinator present in the courtroom, the Court Clinic is able to provide guidance to judges and probation staff about whether an evaluation is necessary and whether a youth's needs can be met in a community-based program.

Some jurisdictions have created specialized courts, such as mental health courts, within the juvenile court to exclusively serve youth with mental health needs. While mental health courts are being used increasingly in adult criminal justice systems, this movement is just beginning to take hold within the juvenile justice system. While there has been no large scale examination of how these courts are developing, the kinds of services that are offered, and how successful they are in addressing psychiatric needs and reducing recidivism, there is significant interest in these courts as a way to provide effective mental health and other services to youth. Some, however, have expressed caution about the growth of these courts, citing concerns that juvenile mental health courts raise many of the same issues posed by adult mental health courts, including lengthier and more intensive court oversight than traditional courts, and the requirement that youth be arrested in order to receive necessary mental health treatment (Harris & Seltzer, 2004). These courts, it is argued, divert attention and resources from prevention and early intervention efforts (Harris & Seltzer, 2004).

The Court for the Individualized Treatment of Adolescents (CITA) in Santa Clara County, California, established in 2001, was the first juvenile mental health court in the country. To be eligible for participation in CITA, a youth must have been under 14 years of age at the time of the offense and have a serious mental illness, including brain disorders (schizophrenia, severe anxiety, bipolar disorder, and severe ADHD) or severe head injury that has contributed to their criminal activity. The court also accepts youth with certain developmental disabilities such as mental retardation and autism. The court uses a multi-disciplinary team approach to assess, monitor, and make recommendations to the court regarding a youth participant's case. The team consists of representatives from mental health and probation, and a prosecutor and defense attorney. Referral sources for CITA include juvenile hall, probation, district attorney, and the public defender.

Upon acceptance to the program, all youth receive a clinical assessment, which includes psychological, behavioral, educational, social, and family assessments. In some instances, standardized assessment instruments, such as the DISC, are used. A mental health coordinator, who is also responsible for conducting the initial assessment to determine eligibility, oversees these assessments. Once accepted into CITA, the coordinator monitors treatment planning and reports to the multi-disciplinary team. Mental health services available through CITA include therapy, emergency services,

medication, and wraparound services. Community supervision through face-to-face visits with the youth and visits with the family is the responsibility of the probation officer, who then reports this information to the court. As the youth progresses through CITA, transition planning is conducted to help facilitate a successful transition to the community.

monthly judicial reviews and reports from probation officers and treatment providers.

Crossroads, a treatment court in Summit County, Ohio, was established as a drug court in 1999 and began mental health treatment in 2003. Crossroads serves court-involved youth ages 12 to 17 who have a major affective disorder, severe post-traumatic stress disorder, psychotic disorders, or who have a co-occurring substance use disorder. The court excludes youth with serious felony charges, as well as previous convictions or current charges for certain drug and gang related offenses. Youth undergo a comprehensive assessment process and receive services from community-based providers. Among the services available to youth is Integrated Co-Occurring Treatment (ICT), an intensive, home-based treatment intervention for youth with co-occurring mental health and substance abuse disorders. Referrals to the Crossroads are made post-adjudication, but if a youth successfully completes the program, the admitting charge, and any related probation violations, are expunged from the youth's record. Youth remain in Crossroads for a minimum of one year.

The King County, Seattle Treatment Court, created in November 2003, is a treatment court for youth with mental health and co-occurring substance use disorders. The probation department, in conjunction with the departments of mental health and substance abuse and the juvenile court, administers the treatment court. To be eligible, youth must have a psychiatric disorder (based on DSM-IV criteria) and substance abuse or dependence. The youth must also be at moderate or high risk for re-offending. The large majority of the treatment court's participants are involved with the court pre-adjudication, with the understanding that successful completion of the court's requirements can result in the dismissal of charges. These youth are screened at probation intake (using the CRAFT). Results of this screen are given to the youth's attorney, who may then request an assessment and consideration for the program. Court participants receive multi-systemic therapy (MST), which includes substance abuse interventions and family therapy. Each youth is also assigned an advocacy team coordinator responsible for case management, wraparound services, and facilitating linkages with community providers. Progress and treatment compliance are monitored by

# Critical Intervention Point: Dispositional Alternatives

## Overview of the Intervention Point

After a youth is adjudicated, the juvenile court holds a dispositional hearing to determine the appropriate sanction. This is similar to the sentencing phase in criminal court. At the disposition hearing, dispositional recommendations are presented and the court must determine the most appropriate sanction for the youth. The range of options include community-based placements or referrals (including probation supervision), and institutional-based placements. In 2000, more than 60 percent of all adjudicated delinquents were placed on probation (OJJDP, 2004). An order of probation typically involves other requirements, such as court-ordered participation in treatment, restitution, or weekend placement in a detention facility. The term of probation may be specified or open-ended. Probation officers must report back to the court periodically on a youth's progress on probation. If the conditions of probation have been successfully met, a judge may terminate the case.

Nearly 25 percent of all delinquency petitions result in the court ordering the youth committed to a residential placement (OJJDP, 2004). These facilities may be publicly or privately operated and have a secure, prison-like environment or a more open setting. In most states, when a judge commits a youth to the state department of juvenile corrections, the state agency is responsible for determining where the youth will be placed and for how long. In other states, the judge controls the type and length of stay, and in these instances, periodic reviews are held to update the court on the youth's progress in placement. Dispositional options available to the court include community-based placements or referrals (including probation supervision) and institutional-based placements. Specific options include commitment to an institution or a facility, placement in a group or foster home, probation (either regular or intensive supervision), referral to an agency or treatment program, community services, fines or restitution. Very often the court imposes some combination of these sanctions (OJJDP, 2004).

In 2000, formal probation was the most restrictive sanction ordered for 63 percent of all adjudicated

cases, and residential placement was ordered for 24 percent of all adjudicated cases (OJJDP, 2004). For the purposes of this model, two dispositional options are reviewed: secure juvenile correctional placement and community probation.

## Secure Correctional Placement

The most restrictive sanction a court can impose entails committing a youth to a secure juvenile correctional facility. Correctional facilities serve to impose a sanction on the youth, protect the public, and provide a structured treatment environment (Bilchik, 1998). The characteristics of these facilities are highly variable and can include training schools, ranches, and military-style boot camps. The primary criticisms leveled against traditional state juvenile correctional facilities have been that they are often sterile, are inappropriate to run rehabilitative programs, and foster abuse and mistreatment (Greenwood, Model, Rydel, & Chiesa, 1996). Critics of these facilities have sought to replace them with smaller, community-based programs because, in their estimation, such programs provide a more realistic and naturalistic setting in which youth can learn and apply social and other kinds of skills and allow youth to maintain contact with their families, schools, and communities (Greenwood et al., 1996).

Further, large, congregate care facilities, such as training schools or juvenile boot camps, have not proven especially effective at reducing recidivism (Howell, 1998). Virtually every study examining recidivism among youth sentenced to juvenile correctional facilities in the past three decades has found at least 50 to 70 percent of offenders are rearrested within one to two years of release (Mendel, 2000). A recent examination of recidivism rates among youth in the Alabama Department of Youth Services (DYS) found that 70 percent of all youthful offenders released from DHS during 2001 and 2002 experienced one or more instances of recidivism, with recidivism rates higher for youth incarcerated for longer periods of time (Bogie, Sedano, & Jones, 2005). Concerns about high recidivism rates have resulted in some state juvenile justice systems altering their approach to treating youthful offenders. Much attention has recently been focused on the "Missouri model"—replacing large congregate care facilities with smaller corrections centers and a variety of non-residential programs and services. Other states, such as New York and Ohio, have focused on redirecting funds

from traditional juvenile correctional beds to investments in community-based programs and interventions that show significant promise in rehabilitating youth and reducing recidivism. Despite these facts and trends, large numbers of youth continue to be placed in juvenile correctional facilities across the country.

## Mental Health Needs and Issues

There is strong empirical evidence that suggests that large numbers of youth in juvenile correctional placement have significant mental health needs. Existing mental health prevalence data obtained from the current OJJDP prevalence study suggest that 76.4 percent of youth (72.4% of males and 87.2% of females) in secure correctional facilities have at least one mental health diagnosis. Even after excluding conduct disorder, 70.8 percent (65.4% of males and 85.2% of females) met criteria for a mental health diagnosis. Disruptive Disorders are most prevalent in secure facilities, followed by Substance Use Disorders and Anxiety Disorders (NCMHJJ, 2005). Youth in secure correctional facilities are also at risk of suicide. Approximately 13 percent of males and 26 percent of females exhibited suicide ideation within four weeks of the Voice DISC-IV interview. Furthermore, almost 26 percent of males and 54 percent of females attempted suicide at some point during their lifetime (NCMHJJ, 2005).

In addition to better data, there is increasing concern about the mental health care and treatment provided to youth in juvenile correctional settings. A 1992 review of the research literature found that the mental health services typically available to youth in the juvenile justice system—when any services are provided—bear little resemblance to what either common sense or empirical research suggests is likely to be effective (Melton & Pagliocca, 1992). Recent investigations by the U.S. Department of Justice, documenting the failure of many juvenile correctional facilities to meet even the most basic mental health needs of youth in their care, suggests that not much has changed over the last decade to improve the overall quality and availability of mental health treatment for youth in juvenile correctional placement.

The results of the current prevalence study, which included a survey of facilities included in the study regarding the services they provide to youth in their care, supports this conclusion. While all of the secure facilities in this study

reported providing some type of mental health services, the proportion of offenders that actually receive these services was dramatically less (NCMHJJ, 2005). For example, while all secure correctional facilities reported providing youth with medications, only 35 percent of youth in those facilities that met criteria for at least one mental health diagnosis reported receiving medications. The results suggest that many youth in need of mental health services are not receiving these services while in secure correctional settings.

These data also suggest that alcohol and drug abuse treatment is even less likely to be provided by secure correctional facilities. Over 44 percent of youth in secure facilities were diagnosed with a substance use disorder. Of those youth, less than 50 percent received any drug or alcohol treatment while in that facility.

States have taken different approaches for responding to the mental health needs of incarcerated youth. Some states, as evidenced by the U.S. Department of Justice investigations, have simply done nothing, often resulting in lawsuits being filed against the state and corrective action plans imposed to force change (United States Department of Justice, 2003). Other states operate centralized intake or reception centers where youth reside for a designated period of time (sometimes up to 60 days) in order to determine the most appropriate placement for the youth within the system. During this period, youth undergo a series of screens and assessments to determine their individual needs and to identify a placement option that would be most appropriate based on their demonstrated needs. Mental health screening and assessment is an integral part of the general “reception” process to not only identify any immediate needs or crisis, perhaps resulting from a youth’s emotional response to incarceration, (Grisso et al., 2005) but to develop an accurate sense of a youth’s overall mental status and the need for individualized treatment to address these needs.

Building on the concept of centralized reception centers, some states, such as Ohio, Texas, and Florida, have chosen to create corrections-based mental health service delivery systems offering specialized treatment institutions for youth with mental health needs (Underwood, Mullan, & Walte 1997). These institutions, which are part of the state’s overall juvenile correctional system, offer intensive and concentrated mental health services to youth while they complete their sentence. Texas, for example, operates the Corsicana Residential Treatment Center for youth with identified mental health

needs. After undergoing comprehensive assessment at the state's centralized intake center, youth with mental health disorders enter the Emotionally Disturbed Treatment Program (EDTP) at the Corsicana Residential Treatment Center, which is a facility that serves mentally ill youth. Here, youth receive evaluation and intensive treatment services for a 9-month period.

## Probation Supervision

Probation supervision is the sanction most often applied to adjudicated youth in a dispositional hearing. Often a judge will impose a period of probation with other conditions, such as participation in community services or treatment, as well as restitution or community service. If a youth is placed on probation, there are numerous ways to link that youth with mental health and other treatment services while they remain in the community. In fact, some communities are using this as an opportunity to provide evidence-based treatments to youth to address their mental health and other treatment needs. Functional Family Therapy and Multi-Systemic Therapy are frequently used with youth who are placed on probation as an alternative to out-of-home placement. For example, the state of Connecticut has aggressively moved to provide more evidence-based treatments and services to youth in lieu of placement. The Connecticut Court Services Division (CCSD) now funds MST programs in all 13 juvenile court districts. These MST "slots" are available to youth who are adjudicated delinquent, placed on probation supervision, and meet certain risk/need criteria using a standardized assessment tool, the Juvenile Assessment Generic (JAG). This use of MST allows youth access to effective treatment in the community, while affording leverage to the juvenile court to ensure that the youth complies with the terms of the disposition. The Indiana Family Project uses FFT with youth who are adjudicated by the court and referred to the program as a condition of probation. Probation officers work with the youth's therapists to monitor the youth and report back to the court on progress.

The Integrated Co-Occurring Treatment Program in Akron, Ohio, is an intensive home-based model specifically designed to treat mental health and co-occurring substance use disorders among youth referred from the court as a condition of probation, as well as for youth returning to the community from placement. Youth who are referred to the program undergo comprehensive screening and assessment, using standardized instruments to determine mental health and substance abuse needs.

Program clinicians are available to youth and their families 24 hours a day, 7 days a week and use a standardized approach to service delivery, including individual and family therapy interventions that focus on skill and asset building while simultaneously focusing on risk reduction.

Another example of an evidence-based intervention that is used as an alternative to secure correctional placement and that can be used with youth who are placed on probation supervision is Multi-Dimensional Treatment Foster Care (MTFC). Developed by the Oregon Social Learning Center in 1983, MTFC is a cost-effective alternative to incarceration for adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. The Cayuga Home for Children in Auburn, NY, was the first provider in New York State to offer MTFC as an alternative to residential treatment, incarceration, and hospitalization for youth who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. The program is also one of only several nationally accredited MTFC programs in the country. The program objective is to change the negative trajectory of antisocial behavior by improving social adjustments with family members and peer groups through simultaneous and well-coordinated treatments in multiple settings. The program serves youth ages 11–17 who are currently in detention; are at risk for placement in the state's juvenile correctional system; or are returning home from a correctional placement. They are placed with well-trained and closely supervised host families who provide the youth with a structured and therapeutic living arrangement. Youth participate in a structured daily behavior modification program implemented in the host home, and receive individual therapy and skills-based training. Community families are recruited, trained, and closely supervised to provide youth placed in their care with treatment and intensive supervision at home, in school, and in the community. Host families undergo intensive training and receive on-going support and supervision from the program coordinator. Youth participate in a structured daily behavior modification program and receive individual therapy. School attendance, behavior, and homework completion are closely monitored and interventions are provided in the school as needed. The youth's biological or adoptive family receive therapy while the youth is participating in MTFC with the ultimate goal of returning the child to the family.

# Critical Intervention Point: Re-Entry

## Overview of Intervention Point

Juvenile re-entry is defined as programs, services, and supports intended to assist youth transitioning from residential placement back into the community (Geis, 2003). It is best accomplished by the establishment of necessary collaborative arrangements with the community to ensure the delivery of prescribed services and supervision as a youth transitions from placement to the community (Gies, 2003). The organization and administration of aftercare services for juveniles who are released from state custody varies by state. Typically, the executive agency that oversees the state's juvenile correctional system is responsible for providing aftercare services to youth released to the community; in other states, executive agencies share this responsibility with local probation agencies (Griffin & Bozynski, 2004).

The number of youth incarcerated in this country rose sharply in the 1990s, due in large measure to the institution of punitive policies that resulted in more youth being adjudicated and placed in residential settings with longer sentences (Altschuler & Armstrong, 1994). It is estimated that approximately 100,000 youth are returned to the community from residential placement each year (Sickmund, 2004). Existing research suggests that the recidivism rate for juvenile parolees ranges anywhere from 55 to 75 percent (Krisberg, Austin, & Steele, 1991). Communities across the country are now facing the challenge of successfully re-integrating large numbers of youth, many of whom have significant mental health, substance abuse, educational, and other needs that may have gone undetected and untreated while in juvenile justice custody. The development of effective re-entry services for transitioning youth is viewed as critical to stemming the high rates of juvenile recidivism, ensuring community safety, and providing youth with the services and supports they need to facilitate a smooth and successful transition home (Mears & Travis, 2004). Despite the recognized importance of this issue, relatively little is known about effective juvenile re-entry or aftercare standards or models. In general, this issue has not received a tremendous amount of attention from the research community. Howell (1998) suggests that evaluations of aftercare programs have been sparse. In

addition to the lack of research, there is also a relative lack of knowledge about effective juvenile re-entry practices and strategies, certainly when compared to the attention given to the issue of adult re-entry.

To date, there is no single source of information describing the characteristics and backgrounds of the population of youth released from juvenile justice facilities nationwide. Snyder (2004) examined multiple sources of information and data, including the 1999 Census of Juveniles in Residential Placement, to provide a representative overview of the population of youth released from secure confinement in 1999. He determined that:

- 88% were male
- 45% were between the ages of 14 and 17
- 39% were white non-Hispanic, 39% were black non-Hispanic and 17% were Hispanic
- 38% were committed for a violent offense; 33% for property offenses, 14% for public order offenses, 11% for a drug offense, and 5% for a status offense.

In terms of social characteristics, he reports that these youth:

- Are more likely to come from single-parent homes and to have relatives who have also been incarcerated;
- Lag significantly behind other youth in terms of their levels of educational attainment. A recent study by the National Council on Disability found the prevalence of special education disabilities among incarcerated juveniles to be 3 to 5 times higher than the general youth population (National Council on Disability, 2003);
- Have significant alcohol and substance abuse problems;
- Have prior criminal histories, including prior adjudications and placements;
- Have high rates of mental health needs (Snyder, 2004).

According to Gies (2003), ideally, the process of re-entry or aftercare does not begin only after an offender is released, but is a more comprehensive process that begins after sentencing, continues through incarceration and after an offender's release into the community. Geis advocates that comprehensive aftercare requires a seamless set of systems across formal and informal social networks, and that a continuum of community services



and supports should be available to youth to prevent the reoccurrence of antisocial behavior.

Altschuler and Armstrong identified five principles of an Intensive Aftercare Model (IAP) that should guide all intervention efforts developed as part of a structured re-entry program for high risk juveniles (Wiebush, McNulty, & Le, 2000). These include:

- Prepare youth for progressively increased responsibility and freedom in the community.
- Facilitate youth-community interaction and involvement.
- Work with the offender and targeted community support systems, such as schools and family, on qualities needed for constructive interaction and the youth's successful community adjustment.
- Monitor and test the youth and community on their ability to deal with each other productively.

Altschuler and Armstrong advocate that a successful aftercare or re-entry strategy for high risk youth leaving secure confinement must include a combination of elements, including coordinated and comprehensive transition planning, information exchange, continuous and consistent access to services, and monitoring in the community. Service brokerage with community providers and linkages to social networks and supports is considered critical.

## Mental Health Needs and Issues

Recently, the issue of juvenile re-entry has received significant policy attention at the Federal level, resulting in new funding being made available for the development and implementation of re-entry programs for youth, including the Young Offender Initiative (United States Department of Labor [DOL], 2003) and the Serious and Violent Offender Re-Entry Initiative (Office of Justice Programs, 2002). Despite this, there remains relatively little knowledge about the characteristics of the youth population that could be served by effective re-entry programs, and little information about the best way to structure these programs (Snyder, 2004). Further, even less is known about effective aftercare and re-entry strategies specifically designed for youth with significant mental health needs who are transitioning out of juvenile placement.

There remains a paucity of research regarding whether youth with mental health needs are at greater risk for re-offending than the general juvenile offender population. One recent meta-analysis found that conduct problems (e.g., the presence of conduct-disordered symptoms) and non-severe pathology (e.g., stress and anxiety) were significant predictors of juvenile recidivism (Cottle, Lee, & Heilbrun, 2001). An earlier meta-analysis (Simourd & Andrews, 1994) that focused on juvenile delinquency but did not distinguish between first time offenders and recidivists found that conduct problems, such as psychopathy, impulsivity, and substance use were among the risk factors most strongly predictive of juvenile offending. Given the large numbers of youth in the juvenile justice system who have diagnosable mental health disorders and the fact that juvenile recidivism rates remain high, one could reasonably conclude that youth with mental health needs released from secure juvenile placement are at high risk for re-offending.

The difficulties associated with community transition for youth are enormous. Many of these youth have spent significant portions of their young lives in out-of-home placement, without the benefit of developing personal bonds or close relationships with any adult, making it difficult to form positive and stable relationships once they are released. Many have significant educational disabilities, often lagging way behind their peers, and too often face unwelcoming school districts who want no part of accepting them back. Communities to which these youth return can also pose significant challenges. Most youth come from and return to communities of concentrated disadvantage where crime is rampant and education and employment opportunities are few (Mears & Travis, 2004). Further, adolescence itself is a period of time often characterized by experimentation, rebellion, impulsiveness, insecurity, and moodiness, further complicating transition from facility to community (Altschuler & Brash, 2004). Altschuler and Brash note that youthful offenders face two transitional challenges: the developmental transition from adolescence to young adulthood, and the transition from life in a correctional facility to life in the community.

Youth with mental health needs face these challenges as well as others in the transition from placement to the community. Roskes, Feldman, Arrington and Leisher (1999) suggest that youth with mental health needs who are transitioning back to the community may have difficulty accessing mental health services due to a "double stigma" that reflects having both a criminal background as well as a mental health disorder. There

is also the problem of leaving a structured environment, with clear behavioral expectations, for a less structured, less consistent home environment. This component of the transition can be particularly difficult for youth with mental health disorders, who often do better in structured settings. Community mental health providers, already reluctant to serve justice-involved youth, may be even more disinclined to provide services to youth recently released from incarceration. A lack of access to quality mental health treatment, including supervised medication management if necessary, can significantly reduce the likelihood that these youth will successfully make this transition. Further, if a youth is diagnosed and treated for the first time while in the custody of the juvenile justice system, their families will need education about their condition and support in caring for them upon their return home.

A study conducted in Washington state to determine the extent to which transition planning and community service would predict lower levels of juvenile recidivism found that transition planning, including the provision of community services, is an essential component of community reintegration and is associated with lower rates of recidivism during the first year post-discharge (Trupin, Turner, Stewart, & Wood, 2004). Participants in this study were mentally ill adolescent offenders incarcerated for 6 months or more in one of Washington's Juvenile Rehabilitation Administration (JRA) facilities. Researchers determined that youth who received more extensive post-discharge planning (defined as greater JRA staff contacts with community providers) were less likely to re-offend, and youth who received mental health treatment within the first 3 months of release were less likely to re-offend (Trupin et al., 2004). The authors conclude that even a low frequency of post-discharge transition planning and service provision appears to have a positive impact on subsequent criminal behavior.

Participants in the above-mentioned study were part of the Family Integrated Treatment Project (FIT) in Washington State, a re-entry program specifically designed for juvenile offenders with co-occurring mental health and substance use disorders. Eligible offenders are identified at intake in the state's juvenile correctional facilities. The youth must be between the ages of 11 and 17 at the time of intake, have a substance use disorder, an Axis I disorder or currently be prescribed psychotropic medication or have demonstrated suicidal behaviors in the last 6 months. The goals of the program include lowering the risk of a youth re-offending, connecting a youth with appropriate community-

based services, improving a youth's educational and vocational opportunities, and improving mental health and stability. The treatment approach used with the FIT program, which is modeled after Multi-Systemic Therapy, encompasses an ecological, family-centered approach. The focus is on improving the psychosocial functioning of youth and promoting a parent's capacity to supervise the youth. Services begin two months prior to release to ensure engagement and community support. All services are strength based and include dialectical behavioral therapy (DBT) and motivational enhancement (ME).

One state used their Federal System of Care funding to create a re-entry program for juveniles. Project Hope is an aftercare program in Rhode Island that targets youth with serious emotional disturbances who are returning to their homes and communities from the Rhode Island Training School (RITS). The target population includes adjudicated youth who are diagnosed with a mental health disorder and who are between the ages of 12 and 22. The goal of the program is to develop a single, culturally competent, community-based system of care for youth to prevent re-offending and re-incarceration. All youth with a mental health diagnosis are eligible to participate. Project Hope services are accessed by youth transitioning out of the RITS through an established referral process facilitated by the RITS clinical social worker 90 to 120 days prior to the youth's discharge. Family Service Coordinators work closely with the Clinical Social Worker at the RITS while the youth is incarcerated and with the Probation Officer when the youth returns to the community to ensure comprehensive planning that incorporates youth service needs with community safety issues. A youth-specific services plan is developed before the youth is released. A case manager is assigned to ensure implementation of the plan for a period of 9–12 months following discharge.

A major obstacle for many youth leaving the juvenile justice system is the need to re-enroll in school. One example of a collaborative school re-entry model is the Center for Alternative Sentencing and Employment Services (CASES) program, based in New York City, which helps court-involved youth continue their education and re-enter the community. A School Connection Center, funded by a Juvenile Accountability Incentive Block Grant, provides educational assessments, transfer of records, and expedited enrollment in community schools. Youth who are not ready to attend community schools upon release from placement are referred to Community Prep High School, which serves as a transition school that addresses the academic, social, and behavioral needs

of youth. Community Prep provides a range of services, including counseling and case management services to prepare students for the transition to traditional community schools, GED or vocational programs, or employment (Roy Stevens, 2004).



## Section Five: Program Descriptions

Numerous programs have been referenced throughout this document, providing illustrations and examples of how communities across the country have taken steps to develop or enhance services for youth with mental health needs involved with the juvenile justice system. The programs included here can offer guidance and, potentially, inspiration to other jurisdictions facing similar situations and challenges. The programs included in the Model were identified in several ways:

- Through a survey conducted by the National Center for Mental Health and Juvenile Justice (NCMHJJ) in conjunction with the National Association of State Mental Health Program Directors (NASMHPD) and the Council of Juvenile Correctional Administrators (CJCA) to identify existing diversion programs for youth with mental health and substance use disorders involved with the juvenile justice system;
- By the NCMHJJ as part of an effort to learn about juvenile mental health courts in operation across the country;
- By the members of the NCMHJJ MacArthur Advisory Board, who provide guidance to the Center on its MacArthur Foundation funded activities, including the Comprehensive Systems Change Initiative;
- By the members of the Model Development Workgroup and the Expert Panel who reviewed drafts of this document and offered program examples and other suggestions for improvement; and
- By the NCMHJJ as part of its national database of programs that target youth with mental health needs at key points of juvenile justice system contact.

Clearly, it would be preferable to include only those programs for which sound, empirical data exists attesting to the program's effectiveness in meeting specific outcome goals. To the extent that outcome data is available, it is included in the program summary. However, the reality is that the field is simply not there yet, and many programs currently serving youth with mental health needs involved with the juvenile justice system have not been extensively evaluated. In the absence of strong outcome data, the program examples highlighted in the Model were chosen because they employ strategies that are consistent with the Underlying Principles, Cornerstones, and Recommendations included in the Model.

More investment in program evaluation and research is necessary to determine the effectiveness of many of the programs in existence today that aim to improve mental health and juvenile justice outcomes for youth. Until then, the field must look to promising program models that incorporate collaboration, early identification, diversion, and effective treatment strategies for justice-involved youth. The following is a complete list of all programs highlighted in the Comprehensive Model.

## Program Description

### Alabama Juvenile Court Liaison Initiative

#### Overview

The juvenile court liaison program is a statewide initiative that funds the creation of a single position in multiple counties across Alabama. The liaison position is a partnership between the Alabama State Department of Mental Health and Mental Retardation (DMH/MR) and Community Mental Health Centers. The DMH/MR provides money to fund 22 liaison positions throughout the state. Each liaison serves a catchment area, which can consist of anywhere between one and five counties depending on population. The goal of the initiative is the development of a mental health presence in the juvenile courts. The liaisons are employees of the community mental health agencies but their position is primarily funded by the state. The State encourages and supports local determination in what the specific duties of the liaison entail. The state initiative is modeled after a liaison position developed in Jefferson County, Alabama, and funded by local county court funds. The liaisons work with the courts to identify youth with mental health needs that the DMH/MR has responsibility for. These include youth with Serious Emotional Disturbance, co-occurring substance use disorders, and youth with mental retardation.

The target population for the Liaison Initiative is youth with mental health needs who are involved with the juvenile justice system. The 22 liaisons combined served an estimated 1,981 youth last year. The average caseload for each liaison is 31 youth but ranges from 2–120. The majority of youth served are boys (61% vs. 39% in FY 2003), nearly evenly split between African Americans and Caucasians. Youth were also nearly evenly split between testing on their grade level and below their grade level, and the majority were involved with multiple systems within their community.

There are multiple points at which youth can be referred to a liaison, though all are from the justice system. Referrals can be made from probation and intake up to and including post-adjudication. Some liaisons have trained detention center staff to identify youth that are being held either pending or post adjudication who may be appropriate for liaison services. Youth in detention centers have been referred to liaisons for evaluations/assessment or crisis intervention.

All liaisons are, at a minimum, master's level clinicians employed by the community mental health center and

work exclusively with youth and families who come to the attention of the juvenile courts and have mental health needs. The juvenile court liaisons are also trained and certified as case managers. While some provide direct clinical services, the typical liaison serves as a link between juvenile justice and mental health agencies by identifying needs, explaining issues to the court, and brokering the provision of services. Services provided by the liaison include intake and evaluation, individual and group counseling, and case management and care coordination. A survey by the DMH/MR showed that the community mental health center and the court are the typical settings in which services are provided, though the setting is flexible and also includes homes, probation offices, schools, detention centers, and hospitals. Liaisons are on call 24 hours a day, seven days a week.

Alabama has indicators showing that the number of youth served and volume of services provided continues to increase. Tracking numbers also show that consultation services with education and outside agencies are on the rise, suggesting that collaboration is increasing. Finally, more courts are reporting improved relations with mental health agencies. The state does not have impact data statewide but some liaisons make an effort to track functional improvement, though it is primarily through subjective evaluations.

#### Program Contact

Steven P. LaFreniere, Director  
Office of Children's Services  
Department of Mental Health and Mental Retardation  
RSA Union Building  
100 N. Union Street  
PO Box 301410  
Montgomery, Alabama 36130-1410  
Phone: 334-353-7110

## **Bernalillo County Juvenile Detention Center (BCJDC), Albuquerque, New Mexico**

### Overview

The director of the Bernalillo County Juvenile Detention Center (BCJDC) created an innovative response to the increasing number of youth with mental health disorders entering the juvenile detention center. The BCJDC developed an intake process that uniformly identifies youth with mental health needs and diverts these youth to a community mental health clinic, the Children's Community Mental Health Clinic (CCMHC), which is located near the detention facility and fully funded by Medicaid.

The initiative began in 1999 when the BCJDC Director, Tom Swisstack, launched a system reform effort designed to reduce the detention center population, increase diversion to community programs, and provide mental health services to youth in the community or stabilize them until placement in an appropriate facility or program was possible. With the support of local elected officials, judges, the probation department, and community providers, a two-pronged approach was developed to first identify, through intake screening, youth with mental health needs, and second, provide them with an array of services.

Youth brought to the detention center undergo a comprehensive intake screening process. The first part involves a brief screen to determine the youth's immediate placement—either in juvenile detention; in the community custody program, which is a probation monitored diversion program; or release home. The second portion of the process involves a medical intake screen, administered by a nurse who is at the detention center 24 hours a day, seven days a week. Both of these intake screens are conducted immediately when a youth arrives at the detention facility, and the accompanying police officers are required to wait until the detention center staff has determined the youth's placement. The nursing staff at the detention center and the mental health clinic rotate between the two buildings, allowing for consistent, high quality screening and knowledgeable referrals as well as familiarity with the youth. Youth identified through the screening as needing immediate mental health services are walked from the detention center to the mental health clinic located about 200 yards away. Other youth are given an appointment for a follow-up assessment, usually the next day.

The CCMHC serves all youth in Bernalillo County who would benefit from the services provided by a mental health treatment team. Referrals to the clinic can be made by the juvenile detention center, care providers, parents or patients, thereby reducing any incentive to refer youth to the detention center simply to access mental health services. Staff at the clinic include two part-time child psychiatrists, nurses, social workers, a licensed alcohol and drug abuse counselor, and case managers. Services provided to youth include evaluation and assessment, individual and group therapy, medication management, substance abuse treatment, case management, and crisis management. Clinical services are provided to youth in detention as well as youth in the community. Further, the CCMHC receives a daily list of youth released from detention. Clinic staff provide outreach services and continue to provide services to all youth released from detention, even if a youth is placed by a judge in a residential setting. Clinic nurses provide training to BCJDC staff on the basic signs and symptoms of mental illness and the possible side effects of certain medications.

Three of New Mexico's Medicaid providers contributed funding to open the mental health clinic. Each provider contributed an amount based on the number of members in their Medicaid plans. It is estimated that about 75 percent of youth in the detention center are Medicaid eligible. Clinic staff work to enroll eligible youth in Medicaid and also work with third-party insurers as necessary.

Since the initiative has been in place, the BCJDC has seen a 37 percent reduction in its population with a reduced length of stay from 33 days in 1999 to about 12 in 2001. Money saved by reducing the population at the detention center, combined with Medicaid reimbursement, keeps the clinic operating without any additional funding. Staff no longer needed at the detention center were trained and re-assigned as case managers for the clinic.

### Reference

Bernalillo County Juvenile Detention Center. Retrieved from <http://www.bernco.gov/live/departments.asp?dept=2337&submenuid=2751>

## Program Description

### Program Contact

Tom Swisstack, Director  
Bernalillo County Juvenile Detention Center  
5100 Second Street NW  
Albuquerque, NM 87107  
Phone: 505-761-6600  
Email: [jdc@bernco.gov](mailto:jdc@bernco.gov)



## The Boston Juvenile Court Clinic, Massachusetts

### Overview

Massachusetts has a statewide system of Juvenile Court Clinics. The Boston Juvenile Court Clinic was designed to provide evaluation and treatment services to youth involved with the Boston Juvenile Court. It is one of the first such clinics in the United States. In a typical year, the court refers about 900 youth to the clinic. The majority of cases involve delinquency, status offense, and child abuse matters, and problems related to a high prevalence of exposure to various types of trauma. Other cases involve youth with anxiety and mood disorders, substance abuse problems, disruptive behavior disorders, learning disorders, and personality disorders.

At probation intake, a risk/need assessment is performed on all youth. Once in the courtroom, attorneys or social service workers raise the issue of any mental health concerns, including learning disabilities and behavioral problems. The juvenile is then referred by order of the judge to the Juvenile Court Clinic. Any youth coming into the system is eligible, with an age range of 7 to 17 years old. At this point, a comprehensive evaluation is carried out that includes interviews with the child and parents, the school, social services, and any mental health providers with whom the child has had contact, and a report is prepared. During this time, the youth is either in detention, in a residential facility, in foster care or at home.

The evaluator makes referrals for the youth to receive services in whatever setting they are in. Services are provided for the court by a multidisciplinary team, and include evaluation, consultation, and treatment services. In addition, the Clinic runs intervention programs, including: an anger management program for youth who have committed minor offenses, such as truancy, and who are considered at risk for committing more serious offenses; and an alcohol and substance abuse education program for at-risk youth. At one time there was a 2-month period of follow up, but present funding does not allow for it.

An 8-year longitudinal study is underway through the University of Massachusetts Medical School as part of a program that is largely examining post-traumatic stress disorders. The Clinic also has close ties with the Children and the Law Service, a division of the Law and Psychiatry Service of Massachusetts General Hospital.

### References

- Barnum, R. et al. (1989). Clinical evaluation of juvenile delinquents: Who gets court referred? *Bulletin of American Academy of Psychiatry and Law*, 17(4), 335-344.
- Mass General Hospital, Harvard Medical School, and McLean Hospital. (Accessed: 10/24/2004). Available at: [http://www.mghmclean.org/child/training\\_pages/boston.html](http://www.mghmclean.org/child/training_pages/boston.html)
- National Institute of Justice. (Accessed: 10/27/2004). Child abuse intervention strategic planning meeting: Background paper #1: Intervention strategies for high risk victims of CAN: Program profiles. Available at: <http://ojp.usdoj.gov/nij/childabuse/bg1i.html>.

### Program Contact

Suffolk Juvenile Court  
Juvenile Court Clinic  
Edward W. Brooke Courthouse  
24 New Chardon Street  
Boston, MA 02114  
Phone: 617-788-6460  
Fax: 617-788-8975

## Program Description

### **Cayuga Home for Children's Multi-Dimensional Treatment: Foster Care Program, Auburn, New York**

#### Overview

The Cayuga Home for Children in Auburn, New York, was the first provider in New York State to offer Multi-Dimensional Treatment Foster Care (MTFC) to youth and is one of only several certified MTFC programs in the country. The MTFC model, developed by the Oregon Social Learning Center in 1983, serves as an alternative to group or residential placement, incarceration, and hospitalization for adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. The goal of the program is to implement an intervention that provides corrective or therapeutic parenting to adolescents to reduce antisocial behavior, delinquency, and emotional disturbance.

The MTFC program operated by the Cayuga Home for Children serves youth age 11–17 who are in the custody of their local department of social services or the state Office of Children and Family Services (OCFS). The program serves youth who are in detention; at risk of placement within the state's juvenile correctional system; in temporary placements; or returning home from a correctional placement. Youth appropriate for the program include:

- Serious and chronic juvenile offenders;
- Seriously emotionally disturbed youth;
- Youth with an IQ in the borderline range who do not do well in congregate settings;
- Youth who have been unsuccessful in other placements; and
- Youth needing highly structured, individualized treatment.

MTFC host families serve as foster families for youth in the program. Host families undergo intensive training that emphasizes behavior management methods to provide youth with a structured and therapeutic setting. After completing the pre-service training and placement of youth, MTFC families attend weekly group meetings run by the program coordinator where ongoing supervision is provided. Supervision and support is also provided to MTFC parents during daily telephone calls to check on youth progress and potential problems.

While in the placement, youth participate in a structured daily behavior modification program implemented within the MTFC home. Individual therapy is also provided weekly to youth. School attendance, behavior, and homework completion are closely monitored, and interventions are introduced as needed for youth in school. Youth in the program also receive skill-focused individual treatment by a skills trainer on a weekly basis. Family therapy is provided to the youth's biological (or adoptive) family, with the ultimate goal of returning the youth back to the home. Parents are taught to use the same structured system being taught in the MTFC home. Closely supervised home visits are conducted throughout the youth's placement in MTFC. Parents are encouraged to have frequent contact with the MTFC program coordinator to get information about their child's progress in the program. Youth stay in an MTFC home for 6–12 months.

#### Reference

Multidimensional Treatment Foster Care Program. Cayuga Home for Children. Retrieved from <http://www.cayugahome.org/content/mtfc.htm>

#### Program Contact

Lisa Emmons  
Director of MTFC  
Cayuga Home for Children  
101 Hamilton Avenue  
Auburn, NY 13021  
Phone: 315-253-5383

**Center for Alternative Sentencing and  
Employment Services (CASES)  
Committee on Court-Involved Students, New  
York, New York**

### Overview

The Center for Alternative Sentencing and Employment Services (CASES), based in New York City, developed a program to help youth leaving custody overcome barriers to school re-entry. The establishment of this program was prompted by the large numbers of youth returning to the City after having been released from juvenile placement, and recognition of the academic and bureaucratic obstacles that many of these youth face when attempting to re-enroll in school. CASES created the Committee on Court-Involved Students, comprising policymakers from the criminal and juvenile justice systems as well as the City Department of Education, to identify barriers to education for students leaving custody and to remove these barriers. The Committee's work resulted in the establishment of two entities—the School Connection Center and the Community Prep High School.

The School Connection Center, funded by a Juvenile Accountability Incentive Block Grant, is a high school admissions office whose staff of juvenile justice and education professionals collaborate to ensure that education re-entry goals are met for students discharged from correctional placements to residences in Manhattan. Its services include educational assessments, transfer of academic records, and expedited enrollment in community schools.

Community Prep High School is a transitional school that addresses the academic and social needs of students who are not ready to attend community schools upon release from custody. Among the services provided by Community Prep include:

- Dual curriculums to build students' academic and social skills;
- Rolling admissions for students released by the justice system throughout the year;
- Student government and other leadership opportunities;
- Family involvement;
- Girls-only advisory and extracurricular activities;

- Individual counseling and case management services.

Preliminary data suggest that Community Prep students engaged in learning and participated in the school community, and demonstrated increased rates of school attendance.

### References

Roy-Stevens, C. (2004). *Overcoming Barriers to School Reentry*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

CASES Website [www.cases.org](http://www.cases.org)

### Program Contact

Joel Copperman, CEO/President  
CASES, Inc.  
346 Broadway  
3rd Floor  
New York, NY 10013  
Phone: 212-732-0076

## Program Description

### Colorado Crisis Intervention Team (CIT) Program

#### Overview

With the rise in the number of people without access to mental health services, police are often called upon as “first responders” to mental health crisis calls. Without proper police training, crisis situations can put both the police officer and the citizen at risk of harm, quickly escalating to arrest. In response, Memphis, Tennessee, developed the first Crisis Intervention Team (CIT), which soon became a crisis response model for police forces around the nation. CIT is quickly becoming a new law enforcement approach for responding to mental health crisis calls. Teams are made up of police officers specially trained in recognizing the signs of mental illness, as well as crisis intervention and de-escalation techniques.

Colorado has developed a statewide multi-jurisdictional CIT initiative for responding to individuals experiencing a mental health crisis. The Colorado CIT program is unique in that it has expanded its services to juveniles. In fact, in 2003, crisis calls involving youth accounted for 14 percent of responses in Denver and 19 percent in Jefferson County. The Division of Criminal Justice leads the expansion of CIT across the state, providing staff support, class development, program coordination, technical assistance, and funding. Initial startup, as well as the first four years of operation of the CIT program were funded by the Edward Byrne Memorial Fund via the Office of Drug Control and System Improvement, a unit of the Colorado Division of Criminal Justice. Currently, the program is partially funded through Community Oriented Policing Services (COPs) and local police department funds allocated to officer training. Additional funds are currently being sought for the proposed statewide expansion. Not only does the Colorado CIT partner with local police and sheriff’s departments, but numerous agencies are also engaged in the planning and development process, including mental health agencies and hospitals, nonprofit organizations, and local chapters of the National Alliance for the Mentally Ill. Many of the volunteer trainers are professionals known for their work on the local, state, and national level. Their willingness to volunteer their time teaching lecture sessions is a demonstration of their commitment to the CIT program.

Crisis calls in Colorado that may have previously resulted in violent confrontations are now handled by trained CIT officers. Services are provided by partnerships that have

been formed between police, mental health and social services providers, hospitals, and advocates. Typically, mental health crisis calls result in voluntary transports to appropriate services. When necessary, CIT officers follow up with individuals and families, and with mental health service agencies, to determine if further action is needed.

As of June 2004, over 1,250 officers from 46 local law enforcement agencies had been trained by Colorado’s CIT program. Reports from CIT officers indicate that over 74 percent of CIT calls have resulted in transport to treatment, only 4 percent of responses involving a CIT officer have resulted in an arrest, and for over 97 percent of CIT calls, no civilian or officer injuries occurred.

#### References

- Colorado Office of Juvenile Justice. (Accessed October 22, 2004). Colorado’s Three-Year Juvenile Justice Plan 2003–2005. Available at: <http://dcj.state.co.us/ojj/3%20Yr.%20Plan/2003-05%20JJ%20Plan.htm>
- Colorado Regional Community Policing Institute (2004). Crisis Intervention Teams (CIT) Fact Sheet. Golden, CO: Colorado Regional Community Policing Institute.
- (2005). Personal Communication with Heather Cameron, Colorado CIT Manager, Golden Colorado.

#### Program Contact

Heather Cameron  
Colorado CIT Manager  
Colorado Regional Community Policing Institute  
Colorado Division of Criminal Justice  
15055 South Golden Road  
Golden, CO 80401  
Phone: 303-273-1971  
Email: [heather.cameron@cdps.state.co.us](mailto:heather.cameron@cdps.state.co.us)

Diane Pasini-Hill  
Office of Research and Statistics  
Colorado Division of Criminal Justice  
700 Kipling  
Denver, CO 80215  
Phone: 303-239-4455  
Email: [diane.pasini-hill@cdps.state.co.us](mailto:diane.pasini-hill@cdps.state.co.us)

## Community Mobile Crisis Team, Rochester, New York

### Overview

The Rochester Community Mobile Crisis Team (RCMCT) is part of a larger system of mental health services available to youth. The RCMCT responds to calls from schools, parents and the police regarding youth experiencing a mental health crisis in order to provide these youth with immediate access to mental health services and divert these youth from potential out-of-home placement. The RCMCT performs an assessment and facilitates access to a range of intensive and coordinated mental health services that are available through Youth Emergency Services (YES), including outpatient, residential, home-based and mobile mental health services. The team also conducts a follow-up with the youth.

The RCMCT works closely with a second crisis response team in Rochester, the Emotionally Disturbed Persons Response Team (EDPRT), which began in 2004. The EDPRT is a team of police and probation officers and civilians with mental health counseling backgrounds. Based on the Crisis Intervention Team (CIT) model, the purpose of EDPRT is to respond to individuals in the community undergoing a psychiatric emergency. Team members undergo training to prepare them to respond to individuals in the community who are experiencing a mental health crisis. Training is conducted by members of the Rochester Police Department and local mental health providers and focuses on topics such as recognizing the symptoms of mental illness and the services that are available through the local health department. The training also includes presentations from people with mental illness to enhance the team member's understanding of the issues involved. Originally scheduled for 40 hours, the training has been recently expanded to 80 hours. Part of the training now includes a session on responding to the needs of youth, which is provided by the RCMCT. In order to further improve its effectiveness in responding to youth, the program recently added two school resource officers to the team that respond to situations at schools involving juveniles experiencing mental health crises.

The EDPRT team members meet monthly to review recent situations, to learn from each other's experiences, and discuss ways the team can improve its effectiveness. Since its inception the program has handled approximately 300 calls to people experiencing a mental health crisis. Of those, 10 percent involved juveniles.

### References

- (2005) Personal communication with Don Kamin, Supervising Clinical Consultant, Monroe County Office of Mental Health, Rochester, NY.
- (2005) Personal communication with Elizabeth Meeker, Psy. D., Program Manager, Coordinated Care Services, Inc., Rochester, NY.
- Youth Emergency Services. (Accessed July 11, 2005). Mobile Crisis Team. Available at: <http://www.yesprogram.org/>

### Program Contact

Rochester Emotionally Disturbed Persons Response Team  
 Don Kamin, Ph.D.  
 Supervising Clinical Consultant  
 Monroe County Office of Mental Health and Director of Performance Management  
 Coordinated Care Services, Inc.  
 1099 Jay Street, Bldg. J  
 Rochester, NY 14611  
 Phone: 585-613-7623  
 Email: [dkamin@ccsi.org](mailto:dkamin@ccsi.org)

Rochester Community Mobile Crisis Team  
 Elizabeth Meeker, PsyD  
 Program Manager, Youth Emergency Services  
 Coordinated Care Services, Inc.  
 1099 Jay Street, Building J  
 Rochester, NY 14611  
 Phone: 585-613-7632  
 Email: [emeeker@ccsi.org](mailto:emeeker@ccsi.org)

## Program Description

### **Comprehensive Multisystemic Therapy (MST) Initiative, Onondaga County, New York**

#### Overview

Onondaga County, New York, employs a comprehensive and holistic approach to linking youth involved with the juvenile justice system to evidence-based services. The county probation department contracts with a private MST provider, Liberty Resources, Inc., to provide MST services to youth at four stages of juvenile justice system involvement: probation intake, detention, family court, and as a re-entry strategy for youth returning to the county from juvenile correctional placement.

At intake, a probation officer meets with a youth and their family. If the probation officer determines that the youth is at risk for out of home placement, they can divert the youth directly to the MST provider. Both status offenders and delinquents can be diverted. If the family agrees to participate in the program, they sign a release and MST services are provided for an average of 120 days. If the youth successfully completes the MST program, probation can close the case with no formal intervention from the court.

For youth who are placed in non-secure detention, screening is done by detention staff to identify youth who may be appropriate for diversion to MST. Once a youth is identified, they are diverted out of detention and referred to the MST program, with Family Court approval. MST provides a treatment summary to the court. If the youth and their family agree to participate in the program, services are initiated. If a youth successfully completes the terms of the program, the case can be closed with no further juvenile justice system involvement. In some instances, after detention, a child remains on, or is placed on, probation. In others, the case is diverted from probation, the youth is given an ACD, and further juvenile justice system involvement is prevented. The program is always seeking to prevent “the next step” in the justice system, but depending on where the child is in the system, this can mean different things.

Youth who are referred to court for a dispositional hearing or for a probation violation can also be diverted from out of home placement into an MST program. The Onondaga County Probation Review Board, comprising supervising probation officers, private providers, and mental health staff, meets twice a week to review cases

where out of home placement is imminent. This Board makes recommendations to the judge about dispositional alternatives for youth. This Board can recommend that a youth be referred to MST in lieu of placement. Frequently, the judge agrees with the recommendations of the Board and can place the youth on probation and, as a condition, require that the youth participate in MST.

Finally, New York State OCFS contracts with Liberty Resources, Inc., to provide MST as a re-entry strategy for youth who are returning to the community after having been placed in one of the state’s juvenile residential facilities. The MST provider receives the names of youth who are returning to the community two weeks in advance of their release, and immediately engages in outreach with the youth’s family to prepare for the youth’s return home and the beginning of MST treatment. Youth participate in the MST program as part of a comprehensive aftercare strategy to provide the youth and family with services and supports necessary to maintain the youth in the community.

#### Reference

Multisystemic Therapy Onondaga. Liberty Resources Inc.  
Retrieved from <http://www.liberty-resources.org/programs/showProgram.cfm?program=7>

#### Program Contact

Anne Dailey, LCSW-R, ACSW  
MST System Supervisor  
Liberty Resources, Inc.  
1065 James Street  
Syracuse, NY 13203  
Phone: 315-424-0577, ext. 217  
Email: [adailey@liberty-resources.org](mailto:adailey@liberty-resources.org)

Mary C. Winter  
Commissioner  
Onondaga County Probation  
421 Montgomery Street  
Syracuse, NY 13202  
Phone: 315-435-5414  
Email: [pbmwint@ongov.net](mailto:pbmwint@ongov.net)

## Cook County Juvenile Court Clinic Model, Illinois

### Overview

The Cook County Juvenile Court Clinic began as a collaborative project between the John D. and Catherine T. MacArthur Foundation, the Children and Family Justice Center at Northwestern University School of Law, and the Office of the Chief Judge of the Circuit Court of Cook County. Initially created as the Clinical Evaluation and Services Initiative (CESI), a multidisciplinary evaluation and intervention project, it was designed to evaluate and improve the acquisition and use of clinical information in juvenile court. In June 2003, the CESI model was expanded and resulted in the redesign of the Cook County Juvenile Court Clinic and is now funded by Cook County.

It consists of four units (Clinical Coordination, Education and Intervention Resources, Clinic Administration, and Program Evaluation) and is managed by a single director who oversees a multidisciplinary staff consisting of psychologists, psychiatrists, social workers, and lawyers. The Clinical Coordination Unit (CCU) handles requests for clinical information. Forensic clinical assessments can only be initiated by court order. After a family has been ordered to undergo a clinical evaluation, a clinical coordinator facilitates the process, which includes evaluating the information request, documenting the request, and arranging an intake interview. The assessment is written by a clinician, who is usually a psychologist or psychiatrist, and is delivered to court before the family's next court date. The information contained in the assessment is used by judges, lawyers, and probation officers to help make informed decisions that promote better outcomes for minors and their families.

The Juvenile Court Clinic has the responsibility for providing a variety of services to judges and court personnel regarding clinical information in juvenile court proceedings. These services include consultation regarding requests for clinical information, forensic clinical assessments in response to court-ordered requests, information regarding community-based mental health resources, and education programs on issues relating to mental health information and court proceedings. A clinical coordinator present in the courtroom is able to provide guidance to judges and probation staff about

whether an evaluation is necessary or not. Judges can then divert youth with clinical needs into the community-based programs targeted for them.

During the disposition of a case, a clinical evaluation is often performed by court clinic personnel to aid in determining the type of post-adjudication intervention appropriate for the youth. Mental health and substance abuse needs can be identified during these evaluations thereby aiding the court in determining different dispositional alternatives.

### Reference

Biehl, J., Kahn, B. (2002) A practice model for acquiring and using clinical information in juvenile court. *Youth Law News* 12(2).

Site visit to program May 2002.

### Program Contact

Julie L. Biehl  
 Director  
 Cook County Juvenile Court Clinic  
 2245 West Ogden Avenue  
 5th Floor  
 Chicago, IL 60612-4487  
 Phone: 312-433-6649  
 Email: [j-biehl@law.northwestern.edu](mailto:j-biehl@law.northwestern.edu)

## Program Description

### **Court for the Individualized Treatment of Adolescents, Santa Clara, California**

#### Overview

The Court for the Individualized Treatment of Adolescents (CITA) in Santa Clara County, California, was the first juvenile mental health court. CITA began in February of 2001 as a multi-system initiative guided by strong judicial leadership. The court is primarily funded through reallocation of existing resources. To be eligible for participation in CITA, a youth must have been under 14 years of age at the time of the offense and have a serious mental illness, including brain disorders (schizophrenia, severe anxiety, bipolar disorder, and severe ADHD) or severe head injury that has contributed to their criminal activity. The court also accepts youth with certain developmental disabilities such as mental retardation and autism. CITA excludes youth who have committed certain violent felonies. The court uses a multi-disciplinary team approach to assess, monitor, and make recommendations to the court regarding a youth participant's case. The team consists of representatives from mental health and probation, and a prosecutor and defense attorney. Referral sources for CITA include juvenile hall, probation, district attorney, and the public defender.

Upon acceptance to CITA, all youth receive a clinical assessment, which includes psychological, behavioral, educational, social, and family assessments. In some instances, standardized assessment instruments, such as the Diagnostic Interview Schedule for Children (DISC), are used. These assessments are overseen by a mental health coordinator, who is also responsible for conducting the initial assessment to determine program eligibility. Once accepted into CITA, the coordinator monitors and coordinates treatment planning and reports to the multidisciplinary team. Community supervision through face-to-face visits with the youth and visits with the family is the responsibility of the probation officer, who then reports this information to the court. A number of mental health services are available through CITA, including therapy, emergency services, medication, and wraparound services. As the youth progresses through CITA, transition planning is conducted to help facilitate a successful transition to the community.

#### Program Contact

Judge Raymond J. Davilla, Jr.  
Court for the Individualized Treatment of Adolescents  
Department 78  
840 Guadalupe Parkway  
San Jose, CA 95110-1714  
Phone: 408-808-6238  
Email: [rdavilla@scscourt.org](mailto:rdavilla@scscourt.org)



## Crossroads, Summit County, Ohio

### Overview

Crossroads was originally established in 1999 as a drug court, and began mental health treatment integration in February of 2003. Collaboration between involved agencies has been a strong component of the court from its inception. Collaboration efforts included the formation of a 40-member advisory board that was involved in planning and conceptualization of the court. Crossroads is funded through private health insurance, Medicaid, Reclaim Ohio grant funds, State 'Fast' 05 funds for Integrated Co-Occurring Treatment (ICT), and court fees. Some services are also covered by other involved agencies. Crossroads serves all youth ages 12 to 17 years of age residing in Summit County who have a major affective disorder, severe post-traumatic stress disorder, psychotic disorders, or who have co-occurring substance use disorders. Youth whose only mental health diagnosis is conduct disorder, oppositional defiant disorder, or ADHD are excluded along with youth who qualify for developmental disability services. In addition, the court excludes youth with very serious felonies and youth with previous convictions or current charges for drug trafficking and youth with gang involvement. Referrals are made to the court post-adjudication. However, if youth successfully complete the program, their admitting charge and any related probation violations are expunged from the youth's record. Crossroads currently has 75 enrolled youth, and serves approximately 70 youth per year. Youth remain in Crossroads for a minimum of one year.

Youth are assessed with the court psychologist's Structured Pediatric Psychosocial Interview, the Diagnostic Interview Schedule for Children – Voice Version, Ohio Scales, and the Global Risk Assessment Device (GRAD). The court typically relies on the diagnoses provided by community providers. Community substance abuse and mental health providers use numerous assessment instruments to make their diagnoses. Mental health assessment and treatment is available primarily through Child Guidance and Family Solutions (community provider). However, youth and their families have the option of choosing any community treatment provider. Some Crossroads participants receive Integrated Co-Occurring Treatment (ICT), which is a pilot project characterized by very intensive in-home treatment that is administered over the course of 3 to 4 months. Each counselor carries a very small caseload, typically three to four youth at a time. Those deemed by the Court's suitability committee or treatment team to

be most in need of home-based services are referred to the ICT supervisor for consideration and eligibility for ICT services. Crossroads probation officers serve as case managers and are responsible for community supervision of participating youth.

Because the court is post-adjudication, it is able to impose sanctions (electronic monitoring, loss/lessening of curfew, suspension of driver's license, residential mental health treatment, or detention time) on both the youth and parents in the event of noncompliance. However, the court emphasizes the use of incentives to encourage compliance.

### Program Contact

#### Crossroads

Dawn R. Jones, Crossroads Administrator  
650 Dan Street  
Akron, OH 44310  
Phone: 330-643-2910  
Email: [djones@cpcourt.summitoh.net](mailto:djones@cpcourt.summitoh.net)

## Program Description

### **The Family Integrated Transitions Project, Seattle Washington**

#### Overview

The Family Integrated Transitions Project (FIT) in Seattle, Washington, is a re-entry program specifically designed for juvenile offenders with co-occurring mental health and substance use disorders. Eligible offenders are identified at intake in the state's juvenile correctional facilities. The youth must be between the ages of 11 and 17 at the time of intake, have a substance use disorder, an Axis I disorder or currently be prescribed psychotropic medication or have demonstrated suicidal behaviors in the last 6 months, have 4 months remaining on their sentence and reside in the service area (Seattle).

The key goals of the program include:

- Lower the risk of re-offending
- Improve the youth's educational level and vocational opportunities
- Connect youth with appropriate community-based services
- Achieve abstinence from use of controlled substances and alcohol
- Improve mental health and stability of youth
- Increase pro-social behavior
- Reduce criminal recidivism

For youth enrolled in the FIT program, services begin 2 months prior to release to ensure engagement and to strengthen community supports. The program emphasizes both family and community involvement and takes a strengths-based approach to treatment. To promote family and community involvement, services are provided in the youth's home and community. In addition, FIT therapists are on call to respond to crises.

The treatment approach used with the FIT program encompasses an ecological, family-centered approach. The focus is on improving the psychosocial functioning of youth and promotes a parent's capacity to monitor the youth. The emphasis is on working with the youth in the context of the youth's natural environments of home, school, and community, modeled after Multi-Systemic Therapy. Specific interventions provided include dialectical behavioral therapy (DBT) and motivational enhancement (ME).

#### Reference

Aos, S. (2004) Washington State's Family Integrated Transitions program for juvenile offenders: Outcome evaluation and benefit-cost analysis. Olympia, WA: Washington State Institute for Public Policy.

#### Program Contact

Washington State Department of  
Social and Health Services  
Juvenile Rehabilitation Administration  
14th and Jefferson Street, P.O. Box 45045  
Olympia, WA 98504-5045  
Phone: 360-902-7804

## Program Description

### Family Intervention Resource Services Team, Kentucky

#### Overview

The Family Intervention Resource Services Team (FIRST) is a county diversion program for first-time status offenders in grades 6 through 8 who have mental health and substance abuse problems and who appear for adjudication in juvenile court. FIRST originated from the collaborative effort of a committee consisting of a Kentucky district judge, the heads of three local school boards, the court administrator, court designated workers, education personnel, the local cabinet for Human Resources, local court personnel, police, health, county governing board, parents, housing authority, alternative school personnel, and the local community services agency. The committee submitted a proposal to the State Commissioner of Mental Health, which resulted in the development of FIRST. The program is operated by Audubon Area Community Services, Inc., and is overseen by an advisory board consisting of the court and other involved agencies. FIRST was originally funded by four sources (state mental health, substance abuse, and education, and local donations) and is now funded solely by the state mental health agency and private donations.

The goal of the program is to connect youth with effective, community-based interventions as an alternative to further (and more formal) court processing. The Court Designated Worker (CDW), who serves as the gatekeeper between the police and juvenile court, makes referrals to the program based on referrals to the court from probation intake. The CDW administers the Problem Oriented Screening Instrument (POSIT) to determine mental health status and shares the results of this evaluation with the FIRST program. The FIRST case manager then meets with the family (either at their home or at the court office) to do the formal program intake, to interview and meet the family and begin the development of a family service plan.

No direct services are provided by FIRST. The case manager provides referrals and linkages to a range of community services, including mental health and substance abuse services, as well as case management to the family. The family case manager regularly reports to the CDW on how the case is progressing, and if a youth meets the goals included in the individual service plan, the case is closed successfully. Typically, cases stay

open 6 months, although the CDW can ask the court to grant an extension if more time is necessary for a youth to meet the plan's goals.

FIRST has a 75 percent success rate based on evaluation data going back to 1996. The University of Louisville also conducts yearly program studies of FIRST. A recent study concluded that children who were referred but declined services were three times more likely to have additional charges compared to children who participated in FIRST. The likelihood of additional charges has been attributed directly to the level of program compliance.

#### Reference

Telephone Interview on January 23, 2004

#### Program Contact

John Blaney  
 Director  
 415 Ann Street  
 Owensboro, KY 42303  
 Phone: 270-852-6510

## Program Description

### Family Intervention Specialists, Georgia

#### Overview

Family Intervention Specialists (FIS), a not-for-profit organization, operates a diversion program that provides intensive family intervention services in Georgia. Services are funded primarily through Medicaid reimbursement. However, FIS also has funding from the Douglas County court (for those youth referred to the program by that court) and the regional mental health department. Any services not covered by these sources are funded through grants. The program serves youth 8–17 years of age with a known or suspected mental health or substance abuse disorder, for whom treatment at a lower level has been attempted (or seriously considered), and who are at risk of out-of-home placement or are currently in out-of-home placement with imminent reunification. To be eligible for the program, youth must reside with at least one competent adult and have a stable family living arrangement. FIS does not accept youth who are actively suicidal or homicidal.

The majority of referrals come from probation intake or the juvenile court. There is strong collaboration between FIS and the courts, which is fostered in part by frequent contact between program and justice staff. FIS staff accompany clients to court, complete progress reports for the court, and talk often with probation officers. The county employs specialized probation officers who are trained to identify mental health and substance abuse disorders and who screen all youth referred to them using a standardized tool. Upon referral to the program, all youth are administered the MAYSI-2 and the CAFAS. The Mauldin Pattern Assessment, which looks at the healthiness and strengths of a child and family, is administered to the youth and the youth's primary caregiver at the beginning and end of program participation. The majority of services are provided directly by FIS, using Brief Strategic Family Therapy (BSFT). The intervention provides families with the tools to decrease individual and family risk factors through focused interventions that improve problematic family relations and skill building therapies. The program also provides parenting skills training, tutoring, and anger management classes. Families are typically discharged from the program after 3–4 months. Planning for discharge begins seven weeks into the program. Aftercare services are available if needed, and program staff makes 3, 6 and 9 month follow-up phone calls with the family using a standardized outcome protocol to track family functioning.

BSFT is designated as a SAMHSA model program. As such, the program has demonstrated positive outcomes through controlled evaluations using comparison groups. The FIS program in particular collects outcomes through follow-up calls with families to track family functioning. FIS also works with the Department of Juvenile Justice to track recidivism.

#### Reference

Site Visit to Program on July 14, 2004

#### Program Contact

David Anthony, Clinical Director  
Family Intervention Specialists, Inc.  
4300 Peachtree Road, NE  
Suite 1537  
Atlanta, GA 30326  
Phone: 404-663-8877  
Email: [info@fisinc.org](mailto:info@fisinc.org)

## The Illinois Mental Health Juvenile Justice Initiative, Illinois

### Overview

The Mental Health Juvenile Justice Initiative was created by the Illinois Department of Human Services (DHS) in March of 2000 to identify youth in detention centers with severe mental illness. The creation of this initiative was prompted, in large measure, by data being reported from Dr. Linda Teplin's study of juvenile detainees in the Cook County Juvenile Detention Center that indicated that large numbers of youth in the detention center had serious mental illness often co-occurring with substance abuse disorders (Teplin et al, 2002). To address this, the Illinois DHS provided \$2 million in funding for the MHJJ initiative for youth with severe mental illness exiting juvenile detention in seven sites in Illinois (Griffin & Quintenz, 15<sup>th</sup> annual conference proceedings-FMHI). In 2001, MHJJ was expanded to all counties with detention centers in the state. This funding is used to support mental health juvenile justice service liaisons who work with detention centers, juvenile courts, and others to coordinate community-based services for youth in detention who have a major affective disorder or a psychotic disorder. Youth with disruptive behavior disorders are excluded unless these disorders co-occur with a psychotic or affective disorder. As a result of the eligibility criteria, the program targets youth with the most serious disorders who are in juvenile detention.

Funds are provided to the local community mental health agency to pay for the services of a system liaison who works to link youth with local services and care. Once a youth is referred to MHJJ, the liaison uses the Childhood Severity of Psychiatric Illness (CSPI) to determine program eligibility for youth in the detention centers. For youth found to have severe mental illness, the liaison uses the Child and Adolescent Needs and Strengths-Mental Health Scale (CANS-MH) to develop a care plan with the youth and their family. The CANS-MH is a service planning tool that also allows for assessing outcomes. The plan specifies which services the youth needs across a broad range of domains and identifies where these services are available in the community. The service plan is based on the wraparound model—individualized services that address the youth's needs and strengths (Psychiatric Services, 2003). Once the plan is in place, the liaison uses "flexible funds" to pay for needed services that are required but otherwise not accessible.

The plan is then presented to the court. The liaison informs the court that a youth with severe mental illness has been identified in the detention center with specific needs that can be treated in the community. The judge can then release the youth to the community, and the liaison assists the family by linking them to services for a period of 6 months, although services to which a youth is linked would be expected to continue beyond the liaison's involvement (Psychiatric Services, 2003).

An evaluation of youth participating in the MHJJ initiative in the initial seven sites found:

- Youth in detention with severe mental illness can be successfully identified and referred for community-based services;
- Youth participating in the MHJJ experienced decreased re-arrest rates; increased school attendance and high rates of parental participation;
- The emotional problems of youth enrolled in the MHJJ initiative decreased considerably within 3 months of their referral;
- Improvement occurred across all symptom areas, including psychosis, attachment and family functioning.

### Reference

- Lyons, J., Griffin, G., Quintenz, S., Jenuwine, M., & Shasha, M. (2003). Clinical and forensic outcomes from the Illinois Mental Health Juvenile Justice Initiative. *Psychiatric Services, 54*, 1629-1634.
- Teplin, et al. (2002). Psychiatric disorders in youth in juvenile detention. *Arch Gen Psychiatry, 59*, 1133-1143.

### Program Contact

Illinois Juvenile Justice Commission  
 Department of Human Services  
 100 South Grand Avenue, E  
 Springfield, IL 62762  
 Phone: 800-843-6154  
 Email: [mailto:dhswebbts@dhs.state.il.us](mailto:mailto:dhswebbts@dhs.state.il.us)

## Program Description

### Indiana Family Project

#### Overview

The Indiana Family Project (IFP) is a county-wide program for youth involved with the juvenile justice system in Monroe County, Indiana. The project was created as a result of more than a year of relationship building and hard work on the part of the community “champions” to build support and obtain funding. IFP is a nonprofit provider of intensive family intervention services. IFP uses Functional Family Therapy (FFT), which is a family model intervention created by Dr. Thomas Sexton and Dr. James Alexander. The program is run under the auspices of the Center for Adolescent and Family Services (CAFS) at Indiana University, of which Dr. Sexton is the clinical director. The staff consists of a team of five therapists (all doctoral students), a project leader, and an office administrator.

The program is funded by a grant from the Indiana Department of Corrections. This funding is directed from the DOC to the Family Court. The Family Court contracts with the Indiana Family Project to be the service provider.

Most youth in the program:

- are between 14 and 15 years old, but must be under age 18
- have been in trouble more than once
- have a diagnosis of oppositional defiant or conduct disorder or another mental health issue
- have used substances, bordering on or including substance abuse
- have trouble in school and have an antisocial peer group
- have high levels of family conflict
- are very well known to the juvenile court system

An intake Probation Officer performs a risk assessment, and an intake assessment team assigns a risk level. The youth is referred to the Indiana Family Project and the project leader assigns the case to a trained FFT therapist. Services are delivered under the guidance of the FFT clinical supervisor and are monitored by the probation officer. Referrals come from the Probation Department if the youth is diverted pre-adjudication, and from the Family Court Judge if the youth is diverted post-adjudication.

FFT is an integrated system for clinical assessment and successful family-based treatment of at-risk adolescents. The target group is youth age 18 and under, and their families, whose problems range from acting out to conduct disorder to alcohol/substance abuse. A family preservation team is assigned to work with the family as they progress through three stages: Phase One—engage and motivate; Phase Two—change behavior; Phase Three—generalize change. Mental health services are included in FFT, and youth and families are not referred to an outside mental health service provider. Transition planning begins with the start of treatment so a plan is in place upon a youth’s discharge from the program.

All FFT programs are connected by a computer database that provides quality assurance. The model has been successfully replicated in six separate sites in Indiana and 140 more sites around the world. FFT has demonstrated positive outcomes across a wide range of youth and communities, including:

- Significant and long-term reductions in youths re-offending and violent behavior
- Significant effectiveness in reducing sibling entry into high-risk behavior
- Very low dropout and high completion rates
- Positive impacts on family conflict, family communication, parenting, and youth problem behavior
- Long-term savings to taxpayers per youth in reduced victim and criminal justice costs.

#### References

Personal communication with Tom Sexton, Director, Indiana University Department of Counseling and Educational Psychology.

Site visit to program on January 21, 2005.

#### Program Contact

Thomas L. Sexton, Ph.D.  
Director  
Center for Adolescent and Family Studies  
201 North Rose Avenue  
Bloomington, IN 47405  
Phone: 812-856-8350  
Fax: 812-856-8317  
Email: thsexton@indiana.edu

## **Integrated Co-Occurring Treatment Program, Akron, Ohio**

### Overview

The Integrated Co-Occurring Treatment Program (ICT) is a treatment model specifically designed to serve justice-involved youth with co-occurring mental health and substance use disorders. ICT was collaboratively developed with support from the Ohio Department of Mental Health. A task force of mental health and substance abuse professionals, consumers, parent advocates, and juvenile justice representatives convened monthly to guide the development of the ICT model. Information collected through focus groups with youth and their families, as well as mental health and substance abuse providers, and education and juvenile court professionals was also incorporated in program design. The model was piloted in 2001, utilizing funds from a Juvenile Accountability Incentive Block Grant (JAIBG) administered by the Ohio Department of Youth Services. In 2003, piloting of the ICT model continued, utilizing Byrne grant funds made available through Ohio's Office of Criminal Justice Services.

Since its inception in 2001, ICT has served 84 youth 13–18 years of age and their families. The program focuses on youth who have a long history of being involved with unsuccessfully with multiple child-serving systems. To be eligible for ICT, youth must have specific substance use (DSM-IV criteria for abuse or dependency) and mental health diagnoses (mood, psychotic, or anxiety-related disorders). Many of the youth who participate in ICT also experience significant difficulty with school success and functioning.

The model is an integrated treatment approach, grounded in System of Care service principles, that uses an intensive home-based model of service. The ICT program is both a reintegration program (for youth returning home from placement) as well as a diversion program for youth referred from the court as a condition of probation. Youth who are referred to the program undergo comprehensive screening and assessment, using standardized instruments, to determine mental health and substance abuse status and needs. Program clinicians are available to youth (and their families) 24 hours a day, 7 days a week and use a treatment stage approach, geared toward meeting the youth and family's primary presenting needs prior to proceeding to more complex needs. Assessment and intervention services are

delivered in the home, school, and community. Program clinicians use individual and family therapy interventions, and individual treatment focuses on skill and asset building, while simultaneously focusing on risk reduction. Family interventions include building parenting skills and rebuilding family relationships.

The program developers have conducted an initial evaluation of ICT, with some promising results. The outcomes tracked include mental health, substance abuse, and juvenile justice outcomes, and functioning in relevant life domains. The recidivism and commitment rates at discharge from ICT average 25 percent, which is significantly lower than the recidivism rate for usual services in the same community. In addition, youth showed improvement in functioning and behaviors, but the small sample size and lack of randomization limits the conclusions that can be drawn at this time. The program systematically collects data and has an evaluation component built in so more in-depth analysis is underway.

### Reference

Personal communication with Helen Cleminshaw, Director, University of Akron Center for Family Studies.

Site visit to program on June 30, 2004.

### Program Contact

Helen Cleminshaw, Ph.D.  
Director, Center for Family Studies  
University of Akron  
Schrank Hall South, Suite 210  
Akron, OH 44325-6103  
Phone: 330-972-8885  
Email: hcleminshaw@uakron.edu

## Program Description

### **Juvenile Mental Health Court, Los Angeles County, California**

#### Overview

In response to the overwhelming mental health needs of youth involved in the juvenile justice system, Congressman Adam Schiff and Legislator Tony Cardenas worked to secure a state grant to start the Los Angeles County Juvenile Mental Health Court (JMHCt) in the fall of 2001. This grant is used to cover staff salaries (except for the alternate public defender). Services are provided through a variety of sources, including the Regional Center and other community-based organizations. This JMHCt is a full-time court that serves youth in Los Angeles County with an Axis I mental health disorder or an Axis II developmental disability. While there are no formal exclusionary criteria with respect to current charges, the team and judge use discretion when dealing with very serious felonies. The court uses a team approach to make decisions about new cases and to monitor the progress of youth. This team consists of the judge, district attorney, public defender, an alternate public defender, Department of Mental Health (DMH) psychologist, school liaison, probation officers, and a psychiatric social worker. The primary source of referrals for the court is post-adjudication from the Los Angeles delinquency/juvenile courts. Youth are screened by a consulting psychiatrist from UCLA for mental health issues. Typically a previous evaluation is available to the JMHCt for these youth. The consulting psychiatrist discusses the results of the screening with the JMHCt team. The court maintains an active caseload of approximately 70 youth. However, at its peak, the court has had as many as 90 youth on its caseload. Youth are involved with the court a minimum of two years.

The psychologist functions largely as a case manager, forming linkages with providers, and overseeing treatment and progress. Participating youth receive case management services and linkages to community-based mental health services, including medication and therapy. Many of these youth are at least temporarily detained in juvenile hall, which has a care unit for youth with mental illness. Most youth reside in group homes or with their family during their participation in the court. Participants are monitored through formal delinquency court review every 6 months as well as through judicial review in the JMHCt. The frequency of these reviews is tailored to meet the specific needs of each youth and may be as frequent as every week if appropriate. If

reduced frequency of appearances is deemed to be an incentive to a youth, such action will be used by the court to encourage positive change. Upon successful completion of the program, petitions are routinely dismissed.

#### Program Contact

Juvenile Mental Health Court  
Commissioner Christina Hill  
201 Centre Plaza Drive  
Monterey Park, CA 91754  
Phone: 323-226-8916  
Email: [chill@lasuperiorcourt.org](mailto:chill@lasuperiorcourt.org)



## Program Description

### King County Treatment Court, Washington State

#### Overview

The King County Juvenile Treatment Court, begun in November 2003, serves approximately 30 youth per year with co-occurring Axis I psychiatric disorders (excluding Conduct Disorder, Oppositional Defiant Disorder, paraphilia or pedophilia) and Substance Abuse or Dependency Disorder who are also identified as moderate to high risk for re-offending. The court excludes most violent felons and sex offenders. The Treatment Court primarily serves targeted high risk areas of King County, but occasionally also serves youth on the periphery of these areas. The court is part of the *Reclaiming Futures Initiative*, funded by the Robert Wood Johnson Foundation, which funds certain administrative positions within the probation department. Services are funded through court fees, Medicaid, and Foundation support. The large majority of the court's participants are involved with the court pre-adjudication, with the understanding that successful completion of the court's requirements can result in the dismissal of charges. These youth are screened at probation intake. Results of this screen are given to the youth's attorney, who may then request an assessment and consideration for the program. No youth has declined participation to date. The average length of court involvement is 12 months.

Court participants receive multi-systemic therapy (MST), which includes substance abuse interventions and family therapy. Each youth is also assigned an advocacy team coordinator responsible for case management, wraparound services, and facilitating linkages with community providers. This coordinator plays a minor role while the youth is involved in MST, but becomes more active as the youth's involvement with the court approaches its end. Finally, the court offers enrolled youth a mentoring program. Progress and treatment compliance are monitored by monthly judicial reviews and reports from probation officers and treatment providers. In the event of non-compliance, the court has several sanctions it may impose, including work crew, electronic monitoring, and detox. Furthermore, the court may opt not to remove the charges from the youth's record.

The court actively works to initiate systems change by operating the Treatment Court within the three current juvenile courts (instead of through a separate court) and through dedicated treatment teams (including the

judge, prosecutor, defense attorney, juvenile probation counselor, mental health/substance abuse clinician, police officer, and an advocacy team liaison). Such an approach has resulted in some challenges associated with the fact that both attorneys and probation officers rotate with respect to their involvement with the court. However, this has also promoted the court's goal of encouraging systems change by involving all players and educating a larger number of individuals who are involved with these youth.

#### Reference

Interview with Margaret Tumulty, Project Director, Reclaiming Futures, Seattle, WA, March 24, 2005.

#### Program Contact

Margaret Tumulty, Reclaiming Futures Project Director  
 Juvenile Treatment Court  
 1211 East Alder  
 Seattle, WA 98122  
 Phone: 206-205-9425  
 Email: Margaret.Tumulty@metrokc.gov

## Program Description

### Mental Health Diagnostic and Evaluation Units, Jefferson County, Alabama

#### Overview

Under the guidance of the Jefferson-Blount-St. Clair Mental Health Authority (JBSMHA), the Jefferson County Community Partnership (JCCP) was awarded a \$5.9 million dollar grant to more formally establish Jefferson County's system of care. As part of this initiative, the JCCP established four Diagnostic and Evaluation (D&E) Units in Jefferson County, including two units in schools, one in the child welfare agency, and one in the Family Court (which is the focus of this summary). The program was initially funded through a SAMHSA/CMHS grant that required matching funds. Local sustainability began in FY 2005, with the Family Court of Jefferson County pledging enough funds to sustain the court at 75 percent of its level under the Federal grant. Several characteristics of JCCP encourage collaboration, including their oversight of the SAMHSA grant and matching funds, and a multi-needs facilitation team. Furthermore, there is a strong history of collaboration within Jefferson County agencies. Daily contacts between program staff and probation and the co-location of these staff in the courthouse help foster collaboration.

The Court D&E unit serves approximately 170 youth per year between 5 and 21 years of age who reside in Jefferson County and who meet the Alabama State Department of Mental Health's definition for Serious Emotional Disturbance. To be eligible, youth must have a DSM-IV diagnosis and **either** previous separation from family due to emotional or behavioral disturbance and/or significant functional impairments at home, school, and/or in the community **and** must be at risk for placement if services are not received.

The goal of the court unit is to complete a timely assessment of the youth and their family and develop an individualized service plan. Referrals to the court unit come from probation intake or from the family court judge. Referrals from probation intake include cases in which charges will be filed and cases that are diverted at probation intake without charges being filed. A master's level professional, known as a D&E specialist, performs an initial mental health and substance abuse screen and determines which youth need to be referred for further evaluation. The D&E specialist also provides mental health consultation to school personnel, probation officers, and social workers. A family advocate is often

present for the initial screen. Evaluations are provided by either the D&E specialist or a licensed psychologist under contract to the unit. A range of mental health services are provided directly by the court unit, including medication monitoring, crisis intervention, and coordinated case management services. Out-patient therapy is provided on-site by a full-time therapist who receives referrals from the D&E specialist. Court unit staff also includes a part-time psychiatrist, two full-time case managers, and a family advocate. In addition to these on-site staff, the JCCP contracts with 17 additional providers to whom youth can be referred.

Youth are discharged from the program once individualized service plan goals have been met and the terms of their probation have been completed. Many youth actually choose to remain in the program after probation has ended because of the program's accessibility and flexibility. The average length of involvement is 18 months.

#### References

Personal communication with Tim Dollard, Project Director, Jefferson County Community Partnership.

Site Visit to program on July 13, 2004.

#### Program Contact

Tim Dollard, M.S., L.P.C.  
Project Director, Jefferson County Community Partnership  
Director of Children's Services  
JBS Mental Health Authority  
Phone: 205-443-2224  
Email: lswann@jbsmha.com

## The Miami-Dade Juvenile Assessment Center, Florida

### Overview

In the mid-1990s, the Florida Legislature enacted state statutes creating Juvenile Assessment Centers (JAC). JACs are characterized by a processing center that serves as a single point-of-entry that utilizes an integrated case management process to link youth with appropriate services based on an initial comprehensive assessment. These processing centers are also characterized by co-located agencies that are typically involved with youth with mental health needs involved in the juvenile justice system.

The Miami-Dade JAC was established within the Miami-Dade Police Department (MDPD) as one of eighteen JACs that resulted from a Florida state statute in the mid-1990s. The Miami-Dade JAC is funded by the MDPD and the Florida Department of Juvenile Justice (DJJ). While the JAC is funded by the MDPD and the Florida DJJ, all stakeholders were invited to participate in the planning and implementation of the JAC. This partnership of agencies agreed that a primary goal of the JAC was to assess and effectively respond to the target population's risk factors and needs. As a result, the JAC received Federal funding to establish a national demonstration project to develop a system that was responsive to the needs of the youth it served.

The program also seeks to divert youth from further penetration into the juvenile justice system whenever possible. As part of the demonstration project, the JAC began the Post Arrest Diversion (PAD) program in December of 2000. The target population for the PAD is first-time, nonviolent, misdemeanor juvenile offenders under 17 years of age being processed at the JAC. The goal of PAD was to divert youth to community programs that offer a range of mental health services, including counseling, educational assistance, drug testing, and youth and family treatment. For youth who qualify for the program, diversion alternatives are described to the youth and his or her family member. Both the arresting officer and the victim must agree to the terms of the diversion. Once the required parties accept diversion, PAD staff evaluates the youth and develops a treatment and supervision plan. Services are provided through a variety of community providers, while PAD staff provides case management and follow-up. Youth participating in the PAD program receive a justice sanction. Youth are

typically involved in the program for approximately 60 days.

### Reference

Cocozza, et al (2005). Diversion from the juvenile justice system: The Miami-Dade Juvenile Assessment Center Post-Arrest Diversion Program. *Journal of Substance Use and Misuse*, In press.

### Program Contact

Juvenile Justice Center  
330 N.W. 27th Avenue  
Suite 1000  
Miami, FL 33142  
Phone: 305-638-6227

## Program Description

### Mobile Mental Health Teams, New York State

#### Overview

The New York State Mobile Mental Health Teams program is the result of a uniquely collaborative effort, executed through an annual Memorandum of Understanding, between the New York State Office of Mental Health (OMH) and the New York State Office of Children and Family Services (OCFS). Funding for the Mental Health Teams is primarily supported by OMH and administered jointly. Historically, OMH would deploy staff into juvenile justice facilities using a consultative model to provide assessments of mental health needs. Those with severe diagnoses would be transferred to psychiatric hospitals and provided with direct services. In time, OCFS began placing psychologists, social workers, and nursing staff within the facilities. In the 1980s a new approach was developed.

OMH and OCFS established a post-adjudication juvenile reception center in the Bronx called Pyramid, staffed by psychologists and social workers. Here all incoming juvenile offenders are assessed for mental health disorders, among other things. In the mid 1990s, a pilot program was begun aimed at youth who were found to have severe mental health disorders, or who could not successfully be housed with other youth. These juveniles were placed into a small mental health unit of 12 people, as opposed to the regular units of 25. In 1999, funds were allocated for the creation of seven mental health units around the state. A team of clinicians from nearby behavioral health hospitals is assigned to each unit as a “mobile mental health team” to go to the juvenile correctional facility and provide mental health treatment services on a daily basis. The mobile mental health teams also provide case consultation and training to juvenile correctional facility staff. A recent trauma initiative provided training for clinical staff, who are now in the process of training the correctional staff in how to properly respond to both males and females with disorders resulting from traumatization.

While there is no individual follow-up upon release, discharge planning begins immediately upon arrival at the facility. Residents are considered to be ready for discharge when the treatment team staff have determined that the treatment objectives have been achieved. The length of stay is typically 6–12 months. Linkages to mental health services are created within the community so after re-entry a treatment plan is in place. An outcome study has been performed on Highland

Residential Center, the site for the pilot program, by Rockland Children’s Psychiatric Center.

#### Reference

Personal communication with Lois Shapiro, New York State Office of Mental Health.

Mental Health Unit Program Description. Albany, NY: New York State Office of Children and Family Services.

#### Program Contact

Lois Shapiro  
Program Specialist  
New York State Office of Mental Health  
Bureau of Children and Families  
44 Holland Avenue  
Albany, NY 12229

**PACE Center for Girls, Florida****Overview**

The PACE Center (Practical, Academic, Cultural Education) for Girls is a state-wide nonresidential, gender-specific program for at-risk females ages 12–18 in Florida who are experiencing difficulty or conflict in school or at home. The program was created in 1985 as an alternative to incarceration or institutionalization for adolescent girls in the Jacksonville area. Over the next two decades, PACE proved so successful that the model was replicated in 18 additional cities throughout Florida under the Department of Juvenile Justice.

The mission of PACE is to provide girls an opportunity for a better future through education, counseling, training, and advocacy. Reasons for referral include academic underachievement, delinquency, substance abuse, truancy, physical abuse, and sexual abuse. Referrals are accepted from any source, including the Department of Juvenile Justice, the Department of Children and Families, area community agencies, public school professionals, concerned family members, and PACE students. Girls may self refer as well. Length of stay is determined by the needs of the individual girl; typically girls are enrolled from 12–15 months. Individual, group, and family counseling sessions are conducted to meet the individual needs of the student and her family with staff available 24 hours a day, 7 days a week.

Intake interviews and assessments are conducted with each prospective girl to assess the risk factors in her life and what support she needs to possess the necessary motivation to attend the voluntary program. Each PACE Center has a cooperative agreement with the local school board to provide academic programs. These include remedial services, individual instruction, and specialized education plans. Middle and high school self-paced curricula are offered during a minimum of 300 minutes of academic instruction daily, which is designed to meet the academic level of each student. While enrolled in PACE, each girl must work toward attaining her educational goal. After leaving, PACE encourages the girls to continue their education by offering assistance in financial planning for vocational or college enrollment through transitional services case management. Girls are required to participate in monthly volunteer service projects to promote self-worth and involvement within their community. The students determine the type of volunteer service project, learn project management

skills along the way and begin to see themselves as a part of something larger.

PACE conducts three years of comprehensive follow-up for all girls attending the program for more than 30 days to ensure the girls continue with their education, employment or appropriate referral services. For girls served less than 30 days, 3 months of transitional services are provided.

The expansion of PACE has been based on the overall effectiveness of gender-responsive prevention programming and advocacy efforts to help communities understand the critical importance of designing programs, approaches, and systems that incorporate the needs of adolescent girls and their families. This was accomplished by training direct care staff in the delivery of gender-specific programs for girls and maintaining a gender-responsive culture centered on continuous improvement and fiscal responsibility. Since opening in 1985, PACE has served over 15,000 at-risk girls and has helped 93 percent of the girls completing the PACE program stay out of or not re-enter the juvenile justice system.

**Reference**

PACE Center for Girls Website [www.pacecenter.org](http://www.pacecenter.org)

**Program Contact**

Denise Bray  
Executive Director  
Pace Center for Girls  
One West Adams Street Suite 301  
Jacksonville, FL 32202  
Phone: 904 421-8585

## Program Description

### **PINS Diversion Program, New York State**

#### Overview

The Persons in Need of Supervision (PINS) diversion program was established in 1986 as a way to reduce unnecessary court involvement on behalf of status offenders in the state of New York. It is a result of collaboration between nine state agencies, including social services, mental health, probation, substance abuse, and education. State incentive funding was initially available to counties interested in participating in the program. However, state funding is no longer available, and programs rely on a combination of funding from social services, youth services, and probation. The PINS diversion program targets youth who are at risk for a PINS petition. The program was originally targeted to youth under the age of 16 years. However, recent legislation effective in April of 2005 expanded the program to youth up to the age of 18 years.

The goal of the program is to divert status offenders from further penetrating the juvenile justice system by diverting these youth to a variety of community-based services and supports. Since its establishment, the program has been implemented in 38 of 58 localities based on an interagency plan. With the passage of the recent legislation, all counties in New York State are required to provide diversion services to youth at risk for a PINS petition and must designate either the local social services agency or probation department as the lead agency for the program. As part of the program, counties must develop a multi-year interagency planning process and cooperative procedures for diversion. The PINS Diversion program also involves the creation and support of a “designated assessment strategy” (DAS) to provide interagency and interdisciplinary assessments.

Upon referral to the program, the designated lead agency is responsible for conducting a conference with the individual who is seeking a PINS petition, the youth and the youth’s family. In this conference, the lead agency is required to discourage the filing of a PINS petition and assess the youth for appropriateness for diversion. Diversion options and services that are available vary by county, and can include preventive and medical services, and mental health and substance abuse services. The new legislation also prevents family court from filing a PINS petition unless there is appropriate documentation that termination of diversion services was the result of a determination by the lead agency that further diversion services would not be beneficial.

The program has achieved significant success. An independent evaluation found that:

- placements were reduced by 53 percent;
- the \$4.5 million investment in the program saved \$21 million in placements;
- there were 74 percent successful adjustments compared with 43 percent in non-participating counties;
- overall system costs were reduced by 10 percent.

#### Reference

Children’s Aid Society. (Accessed July 7, 2005). Youth and court diversion. Available at: [http://www.childrensaimsociety.org/locations\\_services/youthmediation](http://www.childrensaimsociety.org/locations_services/youthmediation)

Frequently Asked Questions: New Pins Law. Accessed 3/20/2005. [http://www.ocfs.state.ny.us/main/legal/legislation/pins/faqs\\_pins\\_law.pdf](http://www.ocfs.state.ny.us/main/legal/legislation/pins/faqs_pins_law.pdf)

New York State Office of Children and Families. (Accessed July 7, 2005). Chapter 57 of the Laws of 2005 PINS Reform Legislation Summary. Available at: <http://www.ocfs.state.ny.us/main/legal/legislation/pins/>

#### Program Contact

Michael Bigley  
Mental Health Research Specialist  
New York State Office of Mental Health  
Bureau of Children and Families  
44 Holland Avenue  
Albany, NY 12229  
Phone: 518-474-8394  
Email: [cocfmbf@omh.state.ny.us](mailto:cocfmbf@omh.state.ny.us)

## Program Description

### The Prime Time Project, King County, Washington State

#### Overview

The Prime Time Project, which is based out of the King County Department of Youth Services and a community mental health clinic, serves high-risk youth with mental illness who are repeatedly involved with the juvenile justice system. It is a comprehensive intervention model for youth between the ages of 12 and 17 who are in detention, who have at least two prior admissions to detention, who are in detention for a relatively serious offense, and who have a diagnosable mental health disorder.

The program aims to decrease delinquent behavior (recidivism and severity of offense), increase pro-social behavior (attendance, performance, and behavior at school; work; peer and community involvement), and stabilize psychiatric symptoms. Youth are identified and referred to the program while in detention. Referrals come from judges, detention staff, probation counselors, family members, and health clinic staff. Services begin in detention and follow youth as they return to the community, with interventions taking place over a year-long period with the intensity of services tapering over the course of treatment. Based largely on Multi-Systemic Therapy (MST), the Prime Time Intervention emphasizes skill building and behavior changes in the youth's natural environment. In addition to MST the program has integrated components of Dialectic Behavior Therapy (DBT) and Motivational Enhancement Therapy (MET) to enhance family and youth skills in self regulation and reduce dependence on drugs and alcohol. The intervention seeks to facilitate the transition from a delinquent life style with limited support to a pro-social lifestyle with a solid base of family and community empowerment.

Key features of the Prime Time Intervention include:

- Close collaboration with the juvenile justice system;
- All services delivered in the community;
- Services are comprehensive, evidence based mental health treatment, substance abuse treatment, competency enhancement, and community support;
- Services are based on an assessment of the strengths and needs of each youth and family;

- Assertive case management is provided by experienced, cross-trained (mental health, substance abuse, and juvenile justice) therapists and case managers; a staff psychiatrist and psychologist are integral members of the treatment team and provide services to the family and youth in the community.
- Diverse staff, sensitive to the needs of ethnic minority youth, provide culturally relevant services;
- Services are coordinated across multiple systems, including juvenile justice, education, mental health, child welfare, and public health.

#### Program Contact

Eric W. Trupin, Ph. D  
 Professor & Vice Chair  
 University of Washington School of Medicine  
 Department of Psychiatry & Behavioral Sciences  
 Director, Division of Public Behavioral Health & Justice Policy  
 146 N. Canal Street, Suite 100  
 Seattle, WA 98103  
 Phone: 206-685-2085  
 Fax: 206-685-3430  
 Email: trupin@u.washington.edu

## Program Description

### Project Hope, Rhode Island

#### Overview

Project Hope is an aftercare program that targets youth with serious emotional disturbances who are returning to their homes and communities from the Rhode Island Training School (RITS). The target population includes adjudicated youth who are diagnosed with a mental health disorder (Axis I Mental Health Disorder), and who are between the ages of 12 and 22. Youth diagnosed with conduct disorder are eligible for the program. As a result, eligibility rates among the juvenile adjudicated and incarcerated youth population are in excess of 80 percent .

Project Hope began with a Federal Systems of Care grant and is now entirely state funded. It is administered by the state Department of Children Youth and Families, Division of Children's Behavioral Health and Education. Services and supports are funded through traditional resources such as Medicaid or other insurance programs, as well as non-traditional resources such as wraparound funding. The program is administered in conjunction with the state's Division of Juvenile Probation and Corrections. The goal of the program is to develop a single, culturally competent, community-based system of care for youth to prevent re-offending and re-incarceration.

Project Hope services are accessed by youth transitioning out of the RITS through an established referral process facilitated by the RITS clinical social worker 90 to 120 days prior to the youth's discharge. This provides Project Hope staff—Family Service Coordinators and Case Managers—adequate time to get to know the youth and family prior to developing a service plan with them. Family Service Coordinators, each of whom is an individual who was or is the principle care giver of a youth who has had contact with the juvenile justice system, work closely with the Clinical Social Worker at the RITS while the youth is incarcerated and with the Probation Officer when the youth returns to the community to ensure comprehensive planning that incorporates youth service needs with community safety issues.

Once referred to Project Hope, youth and their families will meet with the FSC to participate in a strengths-based assessment and discuss what services they feel will be essential to assisting the youth in remaining in the community and avoiding re-incarceration. This plan is developed in conjunction with a community team that consists of the youth, their parent(s), the clinical social

worker, probation officer, and community officers, before the youth is released. A case manager is assigned to ensure implementation of the plan for a period of 9–12 months following discharge. Throughout the period of involvement, the planning team will be brought together to change or modify the youth's plan as needed.

#### Program Contact

Susan Bowler, Ph.D.  
Administrator  
Rhode Island Department of Children, Youth and Families  
300 New London Avenue  
Cranston, RI 02920  
Phone: 401-528-3758  
Email: [susan.bowler@dcyf.ri.gov](mailto:susan.bowler@dcyf.ri.gov)



## Special Needs Diversionary Program, Texas

### Overview

The Special Needs Diversionary Program (SNDP) is a jointly funded statewide initiative involving both the juvenile justice and mental health agencies, designed to provide youth with mental health services. A total of nineteen programs are operating throughout Texas, including one in Harris County, Texas. SNDP is jointly funded by the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI) and the Texas Juvenile Probation Commission (TJPC). Services are also partly funded by Medicaid reimbursement, CHIP, and third party payers. SNDP serves as both a diversion program for justice-involved youth and a reintegration program for youth released from secure facilities. To be eligible for the program, youth must be between 10 and 18 years of age with a primary mental health diagnosis (DSM-IV, Axis I-MH) **and** have a GAF score of 50 or below, be classified as seriously emotionally disturbed in special education, or be at risk for removal from the home due to psychiatric reasons. There are multiple points of entry to the diversion program, and referrals can be made from virtually all key juvenile justice processing points (from intake through post-adjudication).

Four co-located Probation/ Licensed Practitioners of the Healing Arts (LPHA) Teams provide case management, service coordination, and supervision to approximately 60 youth per year. Each team has a caseload of 12 to 15 youth who are on probation. These teams are responsible for jointly securing, providing or supervising the provision of services to youth on their caseload. The state of Texas requires Probation to use the MAYSI-2 (a mental health and substance use screening tool for use in juvenile justice settings) to screen all youth at Probation Intake. The results of the screen are passed to the Probation/LPHA teams, where youth then undergo a clinical assessment and family interview. Following these assessments, an individualized treatment plan is developed for the youth and family.

All program services are based on a wraparound philosophy of team treatment planning. The Probation/LPHA teams strive to provide the majority of services in the home or school. Services include benefit coordination to assist with Medicaid or CHIP enrollment, psychiatric services, including medication management and group and individual counseling, health care, parent and child support groups, job training services, and transition planning to prepare for discharge from the

program. Mental health services not directly provided by the teams are available through the Mental Health and Mental Retardation Authority of Harris County. Program compliance and progress is monitored through unscheduled home visits by the youth's probation officer three times per week and a scheduled visit by the LPHA therapist once per week. Participating families also have three to five program contacts per week, at least two of which are in the home.

The state of Texas requires locally funded programs to collect specific data elements to measure outcomes. These elements include:

- Number of arrests;
- Number of absconders;
- Number of revocations;
- Number of detention admissions;
- Number of psychiatric inpatient stays; and
- Number of institutional admissions

The Texas Legislature has directed TCOOMMI, the Texas Juvenile Probation Commission, and the other state agencies involved with the initiative to submit a report on a three-year recidivism study of the SNDP initiative.

### Reference

Texas Youth Commission. Specialized Correctional Treatment. Retrieved from the worldwide web on March 15, 2005. [http://www.tyc.state.tx.us/programs.special\\_treat.html](http://www.tyc.state.tx.us/programs.special_treat.html)

Site visit to program June 2004

### State Level Contact

Dee Kifowit, Director  
Texas Correctional Office on Offenders  
With Medical or Mental Impairments  
8610 Shoal Creek Boulevard  
Austin, TX 78757  
Phone: 512-406-5406

### Harris County Contact:

Miguel Anglada  
7011 South West Freeway, 2<sup>nd</sup> Floor  
Houston, TX 77074  
Phone: 713-970-9827

## Program Description

### Texas Youth Commission

#### Overview

The Texas Youth Commission (TYC) is the state's juvenile corrections agency. Within a system of fifteen secure institutions and nine residential halfway houses, the agency cares for the most chronically delinquent and serious violent juvenile offenders. These youth are committed by judges for mostly felony-level crimes that occur between the ages of 10 and 17 years. Offenders can remain in the TYC until their 21<sup>st</sup> birthday. The TYC receives its funding through state funds with a small percentage coming from Federal funds and interagency contracts. The average length of stay in 2002 was nearly 23 months. TYC is funded to meet approximately 40 percent of the specialized treatment needs of their population.

All offenders sent to the TYC begin processing at the Orientation and Assessment Unit. Here they receive mental and physical health screenings and are introduced to the Re-socialization program (required for all inmates). Re-socialization consists of five phases in which the teens learn responsibility, empathy, and prevention techniques. The average length of stay is 45 to 60 days. Youth are then transferred to an appropriate facility after completing the assessment and orientation process. For a small number (approximately three percent) of serious and violent offenders, additional intensive treatment is required. Only juveniles classified as high risk or in high need of specialized treatment participate in these programs. Treatment is delivered through a continuum of services provided in state-operated or private institutions and in community settings. It is designed specifically for violent offenders, sex offenders, chemically dependent offenders, offenders with mental health impairments, and offenders with mental retardation.

Youth with mental health disorders enter the Emotionally Disturbed Treatment Program (EDTP) at Corsicana Residential Treatment Center, which takes 9 months to complete. Participants undergo a 30-day evaluation period to confirm their need for emotional/mental health treatment. The program focuses on behavior management as well as symptoms of emotional disturbance. In addition to EDTP, Corsicana includes a specialized stabilization unit for youth who are dangerous to themselves or others. Other youth may be sent to state hospitals from TYC in order to receive intensive medical and mental health care before the completion of their stay, and may be returned to the EDTP to continue treatment.

Recidivism rates for youth in intensive specialized treatment programs were compared to rates for youth who demonstrated a high need for treatment, but were unable to receive the services. The notable difference in recidivism rates between youth who received specialized treatment and those with high need who did not receive it, indicates that intensive specialized treatment programs reduce recidivism more than the basic TYC Re-socialization program for youths with specialized needs.

#### Reference

Overview of the Juvenile Corrections System in Texas. Retrieved from [www.tyc.state.tx.us/about/overview.html](http://www.tyc.state.tx.us/about/overview.html)

#### Program Contact

Corsicana Residential Treatment Center  
Lynda Smith  
Assistant Superintendent  
4000 W. 2nd Avenue  
Corsicana, Texas 75110  
Phone: 903-872-4821  
Fax: 903-872-6667

## Washington State Integrated Treatment Model in Juvenile Rehabilitation Administration Facilities

### Overview

The Integrated Treatment Model (ITM) is the umbrella term for the combination of approaches utilized by Washington State's Juvenile Rehabilitation Administration (JRA) within their residential programs and parole aftercare services. The design of the program incorporates best practice interventions for juvenile justice-involved youth, such as Cognitive Behavioral Therapy (CBT) and Functional Family Therapy, into a core two-part approach that addresses the needs of youth and their families from the point of admission through the completion of parole aftercare. Both treatment approaches have been demonstrated to be effective with mentally ill and substance abusing/dependent youth.

JRA's residential programming includes three institutions (two with a mental health focus), a work camp, a boot camp, and six state community facilities. Youth also participate in parole aftercare services following release to the community. ITM is the overarching service model structuring services to all youth in these settings — it incorporates CBT in residential settings, and Functional Family Parole (FFP), a family-focused parole case management model based on Functional Family Therapy (FFT), in parole aftercare settings.

Youth are screened by staff upon intake to the institution or facility and referred for mental health services if needed. Treatment for youth in residential settings includes engaging and motivating clients, strength identification and skill building as part of CBT. The treatment is modeled after Dialectical Behavioral Therapy (DBT), developed by Marsha Linehan, Ph.D., primarily for complex, difficult-to-treat cases with severe behavior problems. DBT focuses on enhancing a youth's behavioral skills to deal with difficult situations; motivating the youth to change dysfunctional behaviors; and ensuring that the new skills are used in daily institutional life and generalize back to the community.

Families are invited to learn about their child's care and treatment, but due to travel and other constraints they may have limited involvement while youth are residing in institutions. However, as the youth moves back to the community, the family becomes the central focus. As part of ITM, youth transition into a Functional Family Parole

(FFP) program immediately after release from the institution. FFP has been in place since 2002 and modeled after Functional Family Therapy (FFT) created by James Alexander, Ph.D. and Thomas Sexton, Ph.D., Functional Family Parole addresses the need for families to examine and improve their natural ability to solve problems and access resources in their communities. Counselors also help the youth apply the newly acquired skills and strengths developed in the residential placement. While ITM incorporates two systems of treatment, JRA works to blend them when possible, with families participating in skills groups and family sessions when visiting the institutions, and some parole settings offering DBT skills groups and skills coaching in the community.

Ongoing goals of the ITM include an attempt to link the interventions by providing cross-training to staff; working together with youth and families at all stages of the process; and developing treatment adherence measures and quality improvement processes. Residential treatment based on DBT is being developed for youth with sex offending and substance abuse behavior. One key finding of the ITM is the need for ongoing in-house training to ensure continuous treatment delivery during times of staff turnover. Resources have been allocated to focus on this priority. A core of program administrators has been trained by consultants who have in turn, become trainers for incoming staff. Outside consultants are brought in as necessary.

Future evaluations will focus on identifying where in the process positive effects are being found and on the long-term results of the treatment model. There are no outcome studies underway at this time; however, it is anticipated that outcomes will indicate reductions in assaultive behavior, self-injurious behavior use of isolation within the institutions, and increased use of resources and services in the community.

### Reference

Juvenile Rehabilitation Administration. (2002) Integrated treatment model design report. Olympia, WA: Juvenile Rehabilitation Administration.

Personal communication with Henry Schmidt III, Ph.D., Clinical Director, Juvenile Rehabilitation Administration.

## Program Description

### Program Contact

Henry Schmidt, III, Ph.D.  
Clinical Director  
Echo Glen Children's Center  
33030 S.E. 99th Street  
Snoqualmie, WA 98065  
Phone: 425-831-2500

## Program Description

### Wraparound Milwaukee, Milwaukee County, Wisconsin

#### Overview

In 1994, Milwaukee County was awarded a Comprehensive Community Mental Health Services for Children and Their Families Program grant by the Center for Mental Health Services, a division of the Substance Abuse and Mental Health Services Administration. Through this grant, Wraparound Milwaukee was developed as a system of care for the county's children with serious emotional disturbance and their families. The program's goals include minimizing out-of-home placements, supporting families, and building on their strengths, helping them to access an array of services, coordinating care, and delivering services in a cost effective manner.

Wraparound Milwaukee is administered by the Milwaukee County Mental Health Department, part of Milwaukee County Human Services, which also includes Probation and Developmental Disabilities, among others. The Director of the Child and Adolescent Services Branch is also the Project Director for Wraparound Milwaukee. The program is funded through a blending of child welfare and juvenile justice funds, a monthly capitation from Medicaid, and the Center for Mental Health Services.

Youth can enter the program through the child welfare system if their parents opt to enroll them in lieu of using the HMO for mental health services. From the justice system, intake is determined by court order. The family meets with an enrollment worker who conducts an initial screening and assigns a care coordinator. The care coordinator then works with the child and family to identify a community support team that also includes the probation officer or child welfare worker and family advocate. A Service Authorization Request is then processed to authorize payment to network health providers. Monthly meetings are held to monitor the treatment plan and service delivery.

Wraparound Milwaukee has reduced the use of restrictive placements and reduced costs. There has also been improved collaboration between child welfare, juvenile justice, and mental health. Based on evaluations, youth enrolled for one year or more functioned better in school, at home, and in the community upon disenrollment. The program has also had an impact on improved

community safety as re-offense rates for youth continue to drop even three years after leaving the program.

#### Reference

Kamradt, B. (2000) Wraparound Milwaukee: Aiding youth with mental health needs. *Juvenile Justice Bulletin* 7(1).

#### Program Contact

Bruce Kamradt  
 Director, Wraparound Milwaukee Program  
 9501 Watertown Plank Road  
 Milwaukee, WI 53226  
 Phone: 414-257-7611  
 Email: [bkamradt@wrapmil.org](mailto:bkamradt@wrapmil.org)



## Section Six: Summary

The Comprehensive Model provides a theoretical and practical framework for responding to the large numbers of youth in the juvenile justice system with mental health needs. This challenging project has culminated in the first ever systematic review of the juvenile justice system in its entirety—from intake to re-entry—to identify ways in which mental health service delivery strategies can be strengthened. The premise, however, is not complicated: stronger partnerships between the juvenile justice and mental health systems can result in better screening and assessment mechanisms at key points of juvenile justice contact, enhanced diversion opportunities for youth with mental health needs to be treated in the community, and increased access to effective mental health treatment. This Model provides a detailed blueprint for how to achieve these goals. What it cannot do, however, is actually effect the change. This can only be accomplished by the state and county leaders in the juvenile justice and mental health fields who have been struggling to develop solutions to meet the needs of these youth. This document provides them the tool to move forward. The energy, hard work, and political will to actually make this happen must come from them.





# Appendix A: Key Resources

This Appendix includes a comprehensive listing of key national organizations, web-links, and other sources of information pertaining to juvenile justice and mental health.

## Screening, Assessment, and Treatment

National Youth Screening Assistance Project – MAYSI-2

<http://www.umassmed.edu/nysap/>

Center for Promotion of Mental Health and Juvenile Justice (V-DISC)

<http://www.promotementalhealth.org/index.htm>

Columbia University's Guide to Mental Health Referral

<http://www.promotementalhealth.org/downloads/Guidelines.pdf>

National Registry of Effective Prevention Programs

<http://modelprograms.samhsa.gov/>

Quality and Fidelity in Wraparound

<http://www.rtc.pdx.edu/pgFPF03TOC.php>

Center for the Study and Prevention of Violence – Blueprints for Violence Prevention

<http://www.colorado.edu/cspv/blueprints/>

Connecticut Center for Effective Practices

[http://www.chdi.org/divisions\\_ccep.htm](http://www.chdi.org/divisions_ccep.htm)

Colorado MST Support Services

<http://www.mscd.edu/~mst/>

Ohio Center for Innovative Practice

<http://www.cipohio.org>

Adelphi Village, Pennsylvania

<http://www.adelphovillage.org>

Youth Violence: A Report of the Surgeon General

<http://www.surgeongeneral.gov/library/reports.htm>

Washington State Institute for Public Policy, 2001

<http://www.wsipp.wa.gov/>

“Turning Knowledge into Practice”: A Manual for Behavioral Health Administrators and Practitioners

<http://www.openminds.com/indres/ebpmanual.pdf>

## Key Resources

## Related Topics

“Cultural Competency Guidebook” published by the Hogg Foundation for Mental Health

<http://www.hogg.utexas.edu>

Building Blocks for Youth

<http://www.buildingblocksforyouth.org>

Office of Juvenile Justice and Delinquency Prevention (OJJDP) publications related to disproportionate minority confinement (DMC)

<http://ojjdp.ncjrs.org/dmc/pubs/index.html>

Training Curriculum for Working with Girls Involved with the Juvenile Justice System

<http://www.ncmhjj.com/pdfs/SAcurriculum.pdf>

National Center for Cultural Competency

<http://gucchd.georgetown.edu/nccc/index.html>

OJJDP Publication Related to Detention Diversion Advocacy

<http://www.ncjrs.org/ojjdp/9909-3/contents.html>

Intensive Aftercare Program Juvenile Reintegration and Aftercare

<http://www.nal.usda.gov/pavnet/ff/ffafter.html>

GAINS Cross-Training Curriculum

<http://www.gainsctr.samhsa.gov/curriculum/juvenile/index.htm>

<http://www.ncmhjj.com/training/>

Juvenile Law Center Curriculum

<http://www.jlc.org/home/juvenilejustice/curriculum.htm>

The Juvenile Justice Evaluation Center

<http://www.jrsa.org/ijec/>

Grant opportunities from Federal grant-making agencies

<http://www.grants.gov>

The Criminal Justice/Mental Health Consensus Project — Coordinated by the Council of State Government

<http://www.consensusproject.org>

## National Organizations

### Federal Agencies

#### **Center for Mental Health Services**

<http://www.samhsa.gov/centers/cmhs/cmhs.html>

Office of External Liaison

1 Choke Cherry Road

Rockville, MD 20857

P: 301-443-6239

F: 301-443-9847

The Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMSHA), leads Federal efforts to treat mental illnesses by promoting mental health. CMHS has established the Children's Mental Health Education Campaign to increase awareness about the emotional problems of America's children and adolescents and gain support for needed services.

#### **Center for Substance Abuse Prevention**

<http://www.samhsa.gov/centers/csap/csap.html>

Office of Director

1 Choke Cherry Road

Rockville, MD 20857

P: 301-443-0365

F: 301-443-5447

The Center for Substance Abuse Prevention (CSAP) of the Substance Abuse and Mental Health Services Administration (SAMSHA), provides development of policies, programs, and services that focus on prevention of illegal drug use, underage alcohol and tobacco use, and reducing the negative consequences of using substances.

#### **Center for Substance Abuse Treatment**

<http://www.samhsa.gov/centers/csat/csat.html>

Office of Communication and External Liaison

1 Choke Cherry Road

Rockville, MD 20857

P: 301-443-5052

F: 301-443-7801

The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMSHA) was created in order to expand the availability of effective treatment and recovery services for individuals with alcohol and drug problems. CSAT aims to improve the lives of individuals and families affected by alcohol and drug abuse by ensuring access to clinically sound, cost effective addiction treatment while reducing the health and social cost to our communities.

## Key Resources

### **National Institute of Corrections**

<http://www.nicic.org/>

320 First Street, N.W.  
Washington, DC 20534  
P: 800-995-6423

Morris L. Thigpen, Sr.  
Director

The National Institute of Corrections (NIC) is an agency within the Department of Justice. NIC provides training, technical assistance, information services, and policy/program development assistance to Federal, State, and local correctional agencies.

### **The National Institute on Drug Abuse**

<http://www.nida.nih.gov>

National Institutes of Health  
6001 Executive Boulevard  
Room 5213  
Bethesda, MD 20892-9561  
P: 301-443-1124

Dr. Nora D. Volkow  
Director

The National Institute on Drug Abuse (NIDA) is a division of the National Institutes of Health. The goal of NIDA is to use science to understand drug abuse and addiction. There are two objectives that work support this goal. The first involves strategic support and conduct of research across a broad range of disciplines. The second is to significantly improve drug abuse and addiction prevention, treatment, and policy.

### **National Institute of Mental Health**

<http://www.nimh.nih.gov/>

NIMH Public Inquiries  
6001 Executive Boulevard  
RM 8184, MSC. 9663  
Bethesda, MD 20892-9663  
P: 301-443-4513  
F: 301-443 4279

Dr. Thomas Insel  
Director

Through research, the National Institute of Mental Health (NIMH) hopes to better understand, treat, and prevent mental illness. Basic neuroscience, behavioral science, and genetics are studied in order to gain an understanding of the fundamental mechanisms underlying thought, emotion, and behavior. With these findings the National Institute of Mental Health studies what goes wrong in the brain in mental illness.

**Office of Justice Programs**

<http://www.ojp.usdoj.gov/>

U.S. Department of Justice  
Office of Justice Programs  
810 7<sup>th</sup> Street, NW  
Washington, DC 20531  
P: 202-307-0790

Regina B. Schofield  
Assistant Attorney General

The Office of Justice Programs (OJP) was created in 1984 in order to provide Federal leadership in developing the nation's capacity to prevent and control crime, improve the criminal and juvenile justice systems, increase knowledge about crime and related issues, and assist crime victims.

**Office of Juvenile Justice and Delinquency Prevention**

<http://www.ojjdp.ncjrs.org/>

810 Seventh Street, NW  
Washington, DC 20531  
P: 202-307-5911

J. Robert Flores  
Administrator

The goal of the Office of Juvenile Justice and Delinquency Prevention (OJJDP) is to provide national leadership, coordination, and resources to prevent and respond to juvenile delinquency and victimization. In order to accomplish this goal OJJDP supports state and local communities in their efforts to develop and implement effective prevention and intervention programs. OJJDP also strives to improve the juvenile justice system so that it protects the safety of the public and holds offenders accountable.

**Substance Abuse and Mental Health Services Administration**

<http://www.samhsa.gov>

810 Seventh Street, NW  
Washington, DC 20531  
P: 240-276-1250

Javaid Kaiser  
Acting Director  
Office of Applied Studies

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the Federal agency responsible for improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from both substance abuse and mental health problems.

## Key Resources

### General

#### **American Correctional Association**

<http://www.aca.org>

4380 Forbes Blvd  
Lanham, MD 20706-4322  
P: 800-222-5646

James A. Gondles, Jr.  
Executive Director  
[execoffice@aca.org](mailto:execoffice@aca.org)

The American Correctional Association (ACA) serves as the umbrella organization for all areas of corrections. The ACA is made up of 78 chapters, including Federal, state, and military correctional facilities and prisons, county jails, and detention centers. Along with providing expertise, the American Correctional Association has created its own standards for correctional institutions.

#### **American Jail Association**

<http://www.corrections.com/aja/>

1135 Professional Court  
Hagerstown, MD 21740-5853  
P: 315-435-1710  
F: 315-435-1718

Steven J. Ingley  
Executive Director  
[stevei@aja.org](mailto:stevei@aja.org)

The American Jail Association (AJA) creates the bimonthly magazine American Jails. This magazine provides information on jail issues in the United States and foreign countries. The AJA has also published a national jail directory, Who's Who in Jail Management, and a product and service resource directory.

#### **American Probation & Parole Association**

<http://www.appa-net.org>

2760 Research Park Drive  
P.O. Box 11910  
Lexington, KY 40578-1910  
P: 859-244-8216  
F: 859-244-8001

Carl Wicklund  
President  
[appa@csg.org](mailto:appa@csg.org)

The American Probation and Parole Association (APPA) is an international association composed of individuals from the United States and Canada. The APPA is involved with probation, parole, and community-based corrections, in both adult and juvenile sectors. APPA's mission includes developing standards and models for improved service delivery.

### **American Psychiatric Association**

<http://www.psych.org>

1000 Wilson Blvd  
Suite 1825  
Arlington, VA 22209-3901  
P: 703-907-7300

Dr. Stephan Sharfstein, MD  
President

The American Psychiatric Association is a medical society that specializes in the diagnosis and treatment of mental and emotional illness and substance use disorders.

### **American Psychological Association**

<http://www.apa.org>

750 First Street NE  
Washington, DC 20002-4242  
P: 202-336-5500

Norma N. Anderson  
CEO/Executive Vice President

The American Psychological Association (APA) encourages the generation and application of psychological knowledge on issues important to human well-being. The APA works towards utilization and dissemination of psychological knowledge to advance equal opportunity while attempting to increase scientific understanding and training in regard to those aspects that pertain to culture, class, race, gender, sexual orientation,, and age.

### **American Public Health Association**

<http://www.apha.org>

800 I Street NW  
Washington, DC 20001-3710  
P: 202-777-2742  
F: 202-777-2534

Georges C. Benjamin, M.D.  
Executive Director

The American Public Health Association (APHA) is the nation's oldest organization of public health professionals. APHA is concerned with issues affecting personal and environmental health, including Federal and state funding for health programs and professional education in public health.

## Key Resources

### **American Public Human Services Association**

<http://www.aphsa.org>

810 First Street, N.E.  
Suite 500  
Washington, DC 20002  
P: 202-682-0100  
F: 202-289-6555

Jerry W. Friedman  
Executive Director

The American Public Human Services Association (APHSA) is a nonprofit bipartisan organization of individuals and agencies concerned with human services. APHSA educates members of Congress, the media, and the broader public on what is happening in the states around welfare, child welfare, health care reform, and other issues involving families and the elderly. The association's mission is to develop, promote, and implement public human service policies that improve the health and well-being of families, children, and adults.

### **Council of State Governments**

<http://www.csg.org>

2760 Research Park Drive  
P.O. Box 11910  
P: 859-244-8000

Daniel M. Sprague  
Executive Director

The Council of State Governments (CSG) serves the executive, judicial, and legislative branches of state governments by providing a network for identifying and sharing ideas with state leaders. CSG works to advocate multi-state problem solving and promotes the sovereignty of the states and their role in the American Federal system.

### **Judge David L. Bazelon Center for Mental Health Law**

<http://www.bazelon.org>

1101 15<sup>th</sup> Street N.W.  
Suite 1212  
Washington, DC 20005-5002  
P: 202-467-5730  
F: 202-223-0409

Robert Bernstein, Ph.D.  
Executive Director

The Bazelon Center is a nonprofit legal advocacy organization. The Bazelon Center attorneys provide technical support for and co-counsel selected lawsuits with private lawyers, legal services programs, ACLU chapters, and state protection and advocacy systems. The Bazelon Center collaborates with local, regional, and national advocacy and consumer organizations to reform public systems and promote consumer participation in the design and operation of service programs.



**Learning Disabilities Association of America**

<http://www.lidaamerica.us>

4156 Library Road  
Pittsburgh, PA 15234-1349  
P: 412-341-1515  
F: 412-344-0224

Mary Clare Reynolds  
Board Coordinator

The Learning Disabilities Association of America is a nonprofit organization with the purpose of advancing the education and general welfare of children and adults of normal or potentially normal intelligence who have disabilities of a perceptual, conceptual or coordinative nature.

**National Alliance for the Mentally Ill**

<http://www.nami.org/i.org>

Colonial Place Three  
2107 Wilson Boulevard  
Suite 300  
Arlington, VA 22201  
P: 703-524-7600

Michael Fitzpatrick  
Executive Director

The National Alliance for Mentally Ill (NAMI) is a nonprofit support and advocacy organization for people with severe mental illnesses, such as schizophrenia, major depression, bipolar disorder, obsessive-compulsive disorder, and anxiety disorders. NAMI provides education about severe brain disorders, supports funding for research and advocates for adequate health insurance, housing, rehabilitation, and jobs for people with serious psychiatric illnesses on the national, state, and local levels.

**National Association of Counties**

<http://www.naco.org/>

440 First Street, NW  
8<sup>th</sup> Floor, Suite 800  
Washington, DC 20001  
P: 202-393-6226

Larry Naake  
Executive Director

The National Association of Counties (NACO) is the only national organization that represents county governments in the United States. NACO provides services, including legislative, research, and technical and public affairs assistance to its members. NACO works to improve public understanding of counties, serves as a national advocate for counties and provides them with resources to help find innovative methods to meet challenges.

## Key Resources

### **National Association of Drug Court Professionals**

<http://www.nadcp.org>

4900 Seminary Road  
Suite 320  
Alexandria, VA 22311  
P: 703-575-9400  
F: 703-575-9402

Karen Freeman-Wilson  
Chief Executive Officer

The National Association of Drug Court Professionals (NADCP) seeks to reduce substance abuse, crime, and recidivism by promoting and advocating for the establishment and funding of Drug Courts and providing for collection and dissemination of information, technical assistance, and mutual support to association members.

### **National Association of Social Workers**

<http://www.naswdc.org>

750 First Street, NE  
Suite 700  
Washington, DC 20002-4241  
P: 202-408-8600  
F: 202-336-8311

Elizabeth J. Clark, Ph.D., ACSW  
Executive Director

The National Association of Social Workers (NASW) works to promote the social work profession by advancing social work practice and shaping public policy through advocacy and consumer protection. NASW lobbies for legislation to improve health, welfare, and other human services programs. NASW has established practice standards in order to enforce ethics and promote a high quality of social work services.

### **National Association of State Alcohol and Drug Abuse Directors**

<http://www.nasadad.org>

808 17<sup>th</sup> Street NW  
Suite 410  
Washington, DC 20006  
P: 202-293-0090  
F: 202-293-1250

Lewis Gallant  
Executive Director

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) fosters and supports the development of effective alcohol and drug abuse prevention and treatment programs throughout every state. NASADAD provides training within the field of substance abuse prevention and treatment, establishes national standards for quality assurance and performance, and shapes public policy positions.

**National Association of State Mental Health Program Directors**

<http://www.nasmhpd.org>

66 Canal Center Plaza  
Suite 302  
Alexandria, VA 22314  
P: 703-739-9333  
F: 703-548-9517

Robert Glover  
Executive Director

The National Association of State Mental Health Program Directors (NASMHPD) advocates for the collective interest of state mental health authorities and their directors. NASMHPD analyzes trends in the delivery and financing of mental health services and builds knowledge and experience reflecting the integration of public mental health programming in evolving healthcare environments. The Association identifies best practices in the delivery of mental health services, provides consultation, and technical assistance and promotes effective management practices.

**National Black Child Development Institute**

<http://www.nbcdi.org>

1101 15<sup>th</sup> Street, NW  
Suite 900  
Washington, DC 20005  
P: 202-833-2220  
F: 202-833-8222

Evelyn K. Moore  
President

The National Black Child Development Institute works to improve child care, child welfare, education, and health services delivered to black children and youth. The organization provides direct services as well as public education aimed at local and national polices.

**National Center for State Courts**

<http://www.ncsconline.org>

300 Newport Avenue  
Williamsburg, VA 23185-4147  
P: 888-450-0391  
F: 757-220-0449

Mary Campbell McQueen  
President and Chief Executive Officer

The National Center for State Courts (NCSC) is an independent, nonprofit organization dedicated to the improvement of justice. Its mission is to provide leadership and assistance to the state courts.

## Key Resources

### **National Commission on Correctional Health Care**

<http://www.ncchc.org>

1145 W. Diversey Parkway  
Chicago, IL 60614  
P: 773-880-1460  
F: 773-880-2424

Edward Harrison, Ph.D.  
President

The National Commission on Correctional Health Care (NCCHC) works to improve the quality of health care provided in jails, prisons, and juvenile confinement facilities. NCCHC develops and maintains the nationally recognized standards for correctional health care.

### **National Conference of State Legislatures**

<http://www.ncsl.org>

444 North Capital Street, N.W.  
Suite 515  
Washington, DC 20001  
P: 202-624-5400  
F: 202-624-1069

William T. Pound  
Executive Director

The National Conference of State Legislatures (NCSL) provides state lawmakers and legislative staff with comprehensive information and research tools.

### **National Council on Crime and Delinquency**

<http://www.nccd-crc.org>

1970 Broadway  
Suite 500  
Oakland, CA 94612  
P: 510-208-0500  
F: 510-208-0511

Barry Krisberg, Ph.D.  
President

The National Council on Crime and Delinquency (NCCD) emphasizes juvenile corrections, alternatives to detention for youth and prison for adults, risk-focused prevention, and a risk-focused continuum of graduated sanctions for juvenile offenders.

**National Governors Association**<http://www.nga.org>

Hall of States  
444 N. Capital St.  
Washington, DC 20001-1512  
P: 202-624-5300  
F: 202-624-5313

Raymond C. Scheppach  
Executive Director

The National Governors Association (NGA) is the collective voice of the nation's governors. NGA provides governors and their senior staff members with services that range from representing states on Capitol Hill and before the Administration on key Federal issues to developing policy reports on innovative state programs and hosting networking seminars for state government executive branch officials. The NGA Center for Best Practices focuses on state innovations and best practices for issues that range from education and health to technology, welfare reform, and the environment.

**National Mental Health Association**<http://www.nmha.org>

2001 N. Beauregard Street  
12<sup>th</sup> Floor  
Alexandria, VA 22311  
P: 703-684-7722  
F: 703-684-5968

Cynthia Wainscott  
Interim President and CEO

Through advocacy, education, research, and service the National Mental Health Association (NMHA) attempts to address all aspects of mental health and mental illness in America. The goal of NMHA is to provide a fulfilling, productive life for those who suffer from mental illness.

**National Sheriff's Association**<http://www.sheriffs.org>

1450 Duke Street  
Alexandria, VA 22314-3490  
P: 703-836-7827  
F: 703-836-6541

Thomas N. Faust  
Executive Director

The National Sheriff's Association (NSA) works to raise the level of professionalism among those in the criminal justice field through training and information. A key goal of NSA is to create interagency relationships between local, state, and Federal criminal justice agencies.

## Key Resources

### **National Urban League**

<http://www.nul.org>

120 Wall Street  
New York, NY 10005  
P: 212-558-5300  
F: 212-344-5332

Morc Morial  
President and CEO

The National Urban League is a nonprofit community based movement based in New York City with over 100 affiliates nationwide. Its mission is to enable African Americans to secure self-reliance, parity, and power.

## Youth Specific

### **American Academy of Child and Adolescent Psychiatry**

<http://www.aacap.org>

3615 Wisconsin Avenue  
Washington, DC 20016-3007  
P: 202-966-7300  
F: 202-966-2891

Virginia Anthony  
Executive Director

The American Academy of Child and Adolescent Psychiatry (AACAP) is a membership-based organization that is composed of over 6,500 child and adolescent psychiatrists and other interested physicians. The members of AACAP research, evaluate, diagnose, and treat psychiatric disorders while giving direction and addressing new developments in the health care needs of children and families. The information that AACAP publishes has the goal of promoting an understanding of mental illnesses and removing the stigma associated with mental illness. Publications are geared towards assuring proper treatment and access to services for children and adolescents.

### **Center for the Advancement of Children's Mental Health**

<http://kidsmentalhealth.org/about.html>

New York State Psychiatric Institute  
Columbia University  
1051 Riverside Drive, Unit 78  
New York, NY 10032  
P: 212-543-5334  
F: 212-543-5260

Peter Jensen, MD  
Center Director

In addition to knowledge identification, consensus, and dissemination, the Center for the Advancement of Children's Mental Health provides assistance, in terms of technical and logistical support, to organizations and institutions committed to implementing scientifically based mental health practices. This support may include consultation or on-site training. The Center utilizes scientific reviews, workshops, conferences, researchers, parents, family members, policymakers, and practitioners to identify what is known about pediatric mental disorders.

**Center for Mental Health in Schools at UCLA**<http://smhp.psych.ucla.edu/>

School Mental Health Project at UCLA  
 Department of Psychology  
 P.O. Box 951563  
 Los Angeles, CA 90095-1563  
 P: 310-825-3634  
 F: 310-206-8716

Howard Adelman  
 Linda Taylor  
 Co-Directors  
[smhp@ucla.edu](mailto:smhp@ucla.edu)

In addition to knowledge identification, consensus and dissemination, the Center for the Advancement of Children's Mental Health provides assistance, in the form of technical and logistical support, to organizations and institutions committed to implementing scientifically based mental health practices. This support may include consultation or on-site training. The Center utilizes scientific reviews, workshops, and conferences. Researchers, parents, family members, policymakers, and practitioners work together to identify what is known about pediatric mental disorders.

**Center on Juvenile and Criminal Justice**<http://www.cjcj.org/>

1234 Massachusetts Ave, NW  
 Suite C1009  
 Washington, DC 20005  
 P: 202-737-7270  
 F: 202-737-7271

Daniel Macallair  
 Executive Director

The Center on Juvenile and Criminal Justice (CJCJ) aims to reduce society's reliance on the use of incarceration as a solution to social problems. CJCJ accomplishes this goal by utilizing a variety of programs for persons facing imprisonment, as well as education dealing with imprisonment and technical assistance. CJCJ has formed the Justice Policy Institute (JPI) in order to promote effective and sensible approaches to the American justice system.

**Center for the Promotion of Mental Health in Juvenile Justice**<http://www.promotementalhealth.org/>

Columbia University/NYSPI  
 1051 Riverside Drive  
 Unit 78  
 New York, NY 10032  
 P: 212-543-5298  
 F: 212-543-1000

Gail Wasserman, Ph.D.  
 Director  
[wassermang@childpsych.columbia.edu](mailto:wassermang@childpsych.columbia.edu)

The mission of the Center for the Promotion of Mental Health in Juvenile Justice at Columbia University is to provide expert guidance to the field regarding best practices for psychiatric assessment of youth in juvenile justice settings. The Center is working to aid juvenile justice settings in determining how to incorporate scientifically sound mental health assessments into practice and how to map mental health services onto the results of those assessments.

## Key Resources

### **Child Welfare League of America**

<http://www.cwla.org/>

440 First Street, NW  
Suite 310  
Washington, DC 20001-2085  
P: 202-638-2952  
F: 202-638-4004

Shay Bilchik  
Executive Director

The Child Welfare League of America (CWLA) is an association of more than 1,100 public and nonprofit agencies. These member agencies are involved with prevention and treatment of child abuse and neglect, and they provide various services in addition to child protection, such as: family foster care, adoption, positive youth development programs, residential group care, child care, family-centered practice, and programs for pregnant and parenting teenagers. The Child Welfare League of America establishes its own standards of excellence as goals for child welfare practice.

### **Children and Adults with Attention Deficit/Hyperactivity Disorder**

[www.chadd.org](http://www.chadd.org)

8181 Professional Place,  
Suite 150  
Landover, Maryland 20785  
P: 301-306-7070, ext. 111

E. Clarke Ross, DPA  
Chief Executive Officer

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) is a national nonprofit organization providing education, advocacy, and support for individuals with ADHD. In addition to their website, CHADD publishes a variety of printed materials to keep members and professionals current on research advances, medications, and treatments affecting individuals with ADHD. These materials include *Attention!* magazine, the CHADD Information and Resource Guide to ADHD, News From CHADD, a free electronically mailed current events newsletter, as well as other publications of specific interest to educators, professionals, and parents.

### **Coalition for Juvenile Justice**

<http://www.juvjustice.org>

1710 Rhode Island Avenue, NW  
10<sup>th</sup> Floor  
Washington, DC 20036  
P: 202-467-0864  
F: 202-887-0738

David J. Doi  
Executive Director  
[info@juvjustice.org](mailto:info@juvjustice.org)

The top priority of the Coalition for Juvenile Justice (CJJ) is the prevention of youth violence and delinquency. The CJJ supports community efforts to provide preschool education, mentors, job skills, after school recreation and counseling programs that offer adult guidance and a constructive social outlet to children. CJJ represents 56 governor-appointed advisory groups that support the juvenile court system in the United States.



**Council of Juvenile Correctional Administrators**[www.cjca.net](http://www.cjca.net)

170 Forbes Road  
Suite 106  
Braintree, MA 02184  
P: 781-843-2663  
F: 781-843-1688

Edward Loughran  
Executive Director  
[info@cjca.net](mailto:info@cjca.net)

The Council of Juvenile Correctional Administrators (CJCA) brings together ideas and philosophies at the administrative level of juvenile corrections planning and policy making. Using these ideas, CJCA is involved in the advancement of juvenile corrections and juvenile justice techniques dealing with program development, design of physical facilities, staff training, and management of juvenile facilities.

**Federation of Families for Children's Mental Health**[www.ffcmh.org](http://www.ffcmh.org)

1101 King Street  
Suite 420  
Alexandria, VA 22314-2971  
P: 703-684-7710  
F: 703-836-1040

Sandra Spencer  
Executive Director  
[ffcmh@ffcmh.org](mailto:ffcmh@ffcmh.org)

The Federation of Families for Children's Mental Health provides leadership for a nationwide network of family run organizations that target emotional, behavioral, and mental disorders. The federation strives to react to the needs of all families, believing that mental illness affects all income, education, racial, ethnic, and religious groups.

**Juvenile Law Center**<http://www.jlc.org/>

The Philadelphia Building  
1315 Walnut Street  
4<sup>th</sup> Floor  
Philadelphia, PA 19107  
P: 800-875-8887  
F: 215-625-2808

Robert Schwartz  
President  
[info@jlc.org](mailto:info@jlc.org)

The Juvenile Law Center advocates for children who have come in contact with public agencies. The goal of the Juvenile Law Center is to ensure that children are treated fairly by the systems that were created to help them. Also the Juvenile Law Center focuses on ensuring that these children receive the proper services and treatments. The Juvenile Law Center has staff attorneys that represent a small number of children in dependency and delinquency cases in family court. This direct representation allows the Juvenile Law Center to be involved in the day-to-day activities of the child welfare system.

## Key Resources

### **National Center on Education, Disability and Juvenile Justice**

<http://www.edjj.org>

University of Maryland  
1224 Benjamin Building  
College Park, MD 20742  
P: 301-405-6462  
F: 301-314-5757

Peter E. Leone, Ph.D.  
Project Director  
[leonep@umd.edu](mailto:leonep@umd.edu)

The National Center on Education, Disability and Juvenile Justice (EDJJ) is a collaborative research, training, technical assistance, and dissemination program designed to develop more effective responses to the needs of youth with disabilities in the juvenile justice system or those at risk for involvement with the juvenile justice system. The activities of the center involve school and community-based prevention, education programs in detention and correctional settings, and transition activities as youth leave corrections and reenter their communities.

### **National Center for Juvenile Justice**

<http://www.ncjj.org>

3700 South Water Street  
Suite 200  
Pittsburgh, PA 15203  
P: 412-227-6950  
F: 412-227-6955

Hunter Hurst, III  
Director

As the research division of the National Council of Juvenile and Family Court Judges (see below), the National Center for Juvenile Justice, a private, nonprofit organization, acts as a resource for original, independent research on topics related to juvenile justice. Its three departments—systems research, applied research and legal research—strive to leverage improvements to the juvenile and family court system.

### **National Council of Juvenile & Family Court Judges**

<http://www.ncjfcj.org>

University of Nevada  
PO Box 8970  
Reno, NV 89507  
P: 775-784-6012  
F: 775-784-6628

Mary Mentaberry  
Executive Director  
[staff@ncjfcj.org](mailto:staff@ncjfcj.org)

The National Council of Juvenile and Family Court Judges (NCJFCJ) works to increase awareness and sensitivity to children's issues. The focus of the Council is on providing meaningful assistance to judges, court administrators, and professionals who are in charge of the care of children within the justice system. Along with providing support, the Council provides continuing educational opportunities in the field of juvenile justice.

**National Indian Child Welfare Association**

<http://www.nicwa.org>

5100 SW Macadam Avenue, Suite 300  
Portland, OR 97239  
P: 503-222-4044  
F: 503-222-4007

Terry Cross  
Executive Director  
[info@nicwa.org](mailto:info@nicwa.org)

NICWA provides public policy, research, and advocacy; information and training on Indian child welfare; and community development services to a broad national audience, including tribal governments and programs, state child welfare agencies, and other organizations, agencies, and professionals interested in the field of Indian child welfare.

**National Juvenile Defender Center**

[http://www.njdc.info/about\\_us.php](http://www.njdc.info/about_us.php)

1350 Connecticut Avenue NW  
Suite 304  
Washington, DC 20036  
P: 202-452-0010  
F: 202-452-1205

Patricia Puritz  
Director

The National Juvenile Defender Center (NJDC) was created in 1999 to respond to the critical need to build the capacity of the juvenile defense bar and to improve access to counsel and quality of representation for children in the justice system. In 2005, the National Juvenile Defender Center separated from the American Bar Association to become an independent organization. NJDC gives juvenile defense attorneys a more permanent capacity to address practice issues, improve advocacy skills, build partnerships, exchange information, and participate in the national debate over juvenile crime.

**National Juvenile Detention Association**

<http://www.njda.com>

Eastern Kentucky University  
301 Perkins Bldg  
521 Lancaster Avenue  
Richmond, KY 40475-3102  
P: 859-622-6259  
F: 859-622-2333

Earl Dunlap  
Executive Director  
[njdaeku@aol.com](mailto:njdaeku@aol.com)

The National Juvenile Detention Association (NJDA) exists to advance the science, process, and art of juvenile detention services through the overall improvement of the juvenile justice profession. The Association promotes adequate detention services for juveniles by interpreting and promoting the concepts of juvenile detention services at the national, state, and local levels.

## Key Resources

### **PACER Center**

[www.pacer.org](http://www.pacer.org)

8161 Normandale Blvd.  
Minneapolis, Minnesota 55437  
P: 952-838-9000  
F: 952-838-0199

Lili Garfinkel  
Coordinator, Juvenile Justice Project  
[pacer@pacer.org](mailto:pacer@pacer.org)

The mission of PACER (Parent Advocacy Coalition for Educational Rights) Center is to expand opportunities and enhance the quality of life of children and young adults with disabilities and their families, based on the concept of parents helping parents. With assistance to individual families, workshops, materials for parents and professionals, and leadership in securing a free and appropriate public education for all children, PACER's work affects and encourages families in Minnesota and across the nation.

### **W. Haywood Burns Institute for Juvenile Justice**

**Fairness and Equity** <http://burnsinstitute.org/index.html>

180 Howard Street  
Suite 320  
San Francisco, CA 94105  
P: 415-321-4100  
F: 415-321-4140

James R. Bell  
Director  
[info@burnsinstitute.org](mailto:info@burnsinstitute.org)

The W. Haywood Burns Institute was created to act as a voice for poor youth and youth of color, their families, and communities in juvenile justice. The Institute targets the over-representation of youth of color in the juvenile justice and child welfare systems around the United States.

### **Youth Law Center**

<http://www.ylc.org>

1701 K Street, NW  
Suite 600  
Washington, DC 20006  
P: 202-637-0377  
F: 202-379-1600

Mark Soler  
President  
[info@ylc.org](mailto:info@ylc.org)

The Youth Law Center is a nonprofit, public interest law office that works to protect abused and at-risk children. The focus of the Center is the problems of children living apart from their families in child welfare and juvenile justice systems. Staff attorneys investigate reports of abuse of children in adult jails, juvenile detention facilities, state institutions, and child welfare systems. Center attorneys who investigate use technical assistance and negotiation to bring about change.

## National Technical Assistance, Research and Resource Centers

### Center for Violence Research & Prevention

<http://cpmcnet.columbia.edu/dept/sph/cvrp/>

The Joseph L. Mailman School of Public Health  
at Columbia University  
60 Haven Avenue  
Suite B4-432  
New York, NY 10032  
P: 212-305-7748  
F: 212-305-8280

Jeffrey A. Fagan, Ph.D.  
Investigator

The staff at the Center For Violence Research and Prevention works with researchers, clinicians, public and private agencies, and community organizations to conduct research on the causes and control of interpersonal violence.

### Co-Occurring Center for Excellence

<http://coce.samhsa.gov/>

Center for Substance Abuse Treatment  
Substance Abuse and Mental Health  
Services Administration, DHHS  
1 Choke Cherry Road  
Room 5-1041  
Rockville, MD 20857  
P: 240-276-2791  
F: 240-276-2800

George Kanuck  
COCE Federal Project Officer  
[george.kanuck@samhsa.hhs.gov](mailto:george.kanuck@samhsa.hhs.gov)

SAMHSA has identified as one of its highest priorities the improvement of treatment and services for individuals with co-occurring mental and substance abuse disorders. As part of a mandate from the *Report to Congress*, SAMHSA created the Co-Occurring Center for Excellence (COCE) as a vital link between the agency and States, communities, and providers. COCE provides the technical, informational, and training resources needed for the dissemination of knowledge and the adoption of evidence-based practices in systems and programs that serve persons with co-occurring disorders.

## Key Resources

### **Louis de la Parte Florida Mental Health Institute**

<http://www.fmhi.usf.edu>

University of South Florida  
13301 Bruce B. Downs Blvd.  
Tampa, FL 33612-3807  
P: 813-974-4602

David Shern  
Dean  
[shern@fmhi.usf.edu](mailto:shern@fmhi.usf.edu)

The Louis de la Parte Florida Mental Health Institute was created by the Florida legislature to expand knowledge about how to best serve the mental health needs of Florida's citizens. The institute serves as the state's primary research and training center for mental health services.

### **MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice**

<http://www.mac-adoldev-juvjustice.org/index.html>

Department of Psychology  
Temple University  
Philadelphia, PA 19122  
P: 215-204-0149  
F: 215-204-1286

Laurence Steinburg, Ph.D  
Network Director  
[mdavis@temple.edu](mailto:mdavis@temple.edu)

The goal of the MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice is to reexamine the juvenile justice system by using sound science and legal scholarship. The Network works to achieve this goal through the critical analysis of juvenile justice policies and practices, the design and implementation of new research on adolescent development and juvenile justice, and the communication of the results of these activities to policymakers, practitioners, journalists, and other social scientists and legal scholars.

### **National Mental Health Services Knowledge Exchange Network**

<http://www.mentalhealth.org>

P.O. Box 2490  
Washington, DC 20015  
P: 800-789-2647

Michelle Hicks  
Project Director

The Knowledge Exchange Network (KEN) was established to respond to questions generated by the general public, policymakers, providers, and the media concerning mental health issues. Along with searching KEN publications, the staff at KEN will direct callers to the proper Federal, state, and local organizations that are dedicated to treating and preventing mental illness.

**National Technical Assistance Center for Children's Mental Health**

[http://guchd.georgetown.edu/programs/ta\\_center/index.html](http://guchd.georgetown.edu/programs/ta_center/index.html)

Georgetown University  
Child Development Center  
3307 M Street, NW  
Suite 401  
Washington, DC 20007  
P: 202-687-5000  
F: 202-687-8899

Phyllis Magrab  
Director  
[childrenmh@georgetown.edu](mailto:childrenmh@georgetown.edu)

The National Technical Assistance Center for Children's Mental Health develops knowledge about effective policies and practices that promote children's mental health with an emphasis that includes strategic planning, leadership development, evaluation, interagency collaboration, cultural competence, policy development, prevention, and early intervention.

**National Youth Screening Assistance Project**

<http://www.umassmed.edu/nysap/>

University of Massachusetts  
Medical School  
55 Lake Avenue North  
Worcester, MA 01605  
P: 508-856-8564  
F: 508-856-6426

Thomas Grisso, Ph.D.  
Director  
[nysap@umassmed.edu](mailto:nysap@umassmed.edu)

The National Youth Screening Assistance Project (NYSAP) was formed to promote the use of the MAYSI-2 (Massachusetts Youth Screening Instrument – Second Version) nationwide. The project provides MAYSI-2 users with technical assistance and research services. The MAYSI-2 is a screening instrument used to identify potential mental health needs of youth as they make initial contact with the juvenile justice system.

**Office of Juvenile Justice and Delinquency Prevention****National Training and Technical Assistance Center**

<http://www.nttac.org/index.cfm>

10530 Rosehaven Street  
Suite 400  
Fairfax, VA 22030  
P: 800-830-4031  
F: 703-385-3206

Raymond E. Chase  
Juvenile Grant Administrator  
[info@nttac.org](mailto:info@nttac.org)

By working with the juvenile justice field, the National Training and Technical Assistance Center (NTTAC) works to promote the use of best practices and supports the delivery of high quality training and technical assistance that reflects the diversity of juvenile justice populations within the United States.

## Key Resources

### **Research and Training Center on Family Support and Children's Mental Health**

<http://www.rtc.pdx.edu>

Portland State University  
PO Box 751  
Portland, OR 97207-0751  
P: 503-725-4040  
F: 503-725-4180

Barbara J. Friesen, Ph.D.  
Director  
[gordonl@pdx.edu](mailto:gordonl@pdx.edu)

Utilizing collaborative research partnerships with family members, service providers and policymakers the Research and Training Center on Family Support and Children's Mental Health promotes effective community-based and family-centered services for families and their children who are affected by mental, emotional, and behavioral health disorders.

### **SOLOMON Project Office of Child Development, Neuropsychiatry and Mental Health**

<http://www.childrensprogram.org/solomon>

Commonweal Children's Program  
451 Mesa Road  
Bollinas, CA 94924  
P: 408-369-1917  
F: 408-369-1901

David E. Arredondo, M.D.  
Director  
[david@childrensprogram.org](mailto:david@childrensprogram.org)

SOLOMON provides pro bono psychiatric consultation on mental health issues to Juvenile and Family Courts. The project offers technical assistance and trainings to the juvenile justice and child welfare systems. SOLOMON seeks to disseminate information regarding child development, children's mental health and developmental traumatology to practitioners in the field.

## Foundations

### **Annie E. Casey Foundation**

<http://www.aecf.org>

701 St. Paul Street  
Baltimore, MD 21202  
P: 410-547-6600  
F: 410-547-6624

Douglas W. Nelson  
President

The Annie E. Casey Foundation is a private institution that was founded in 1948. To this day the Foundation works to help build better futures for disadvantaged children who are at risk of poor educational, economic, and health outcomes.



**Davis and Lucile Packard Foundation**<http://www.packard.org>

300 Second Street  
Suite 200  
Los Altos, CA 94022  
P: 650-948-7658

Carol S. Larson  
President

The Packard Foundation provides grants to nonprofit organizations who concentrate on conservation, population, science, children, families and communities, arts, and organizational effectiveness and philanthropy.

**The Hogg Foundation for Mental Health**<http://www.hogg.utexas.edu>

The University of Texas at Austin  
P.O. Box 7998  
Austin, TX 78713-7998  
P: 512-471-5041  
F: 512-471-9608

King Davis, Ph.D.  
Executive Director  
[grants@hogg.utexas.edu](mailto:grants@hogg.utexas.edu)

An administrative unit of the University of Texas at Austin, the Hogg Foundation defines mental health broadly and is interested in programs that implement and evaluate innovative projects that are designed to meet the broad mental health needs of Texans. While the Foundation invites proposals dealing with any aspect of mental health service delivery, program development, research, and education, priority is given to projects targeting its primary program areas of mental health policy and law, mental health services research, public education and outreach, and academic and professional training.

**The JEHT Foundation**[www.jehtfoundation.org](http://www.jehtfoundation.org)

120 Wooster Street  
Second Floor  
New York, NY 10012  
P: 212-965-0400  
F: 212-966-9606

Robert Crane  
President  
[info@jeht.foundation.org](mailto:info@jeht.foundation.org)

The JEHT Foundation was established in April 2000 to support its donors' interests in human rights, social justice, and community building. The name JEHT stands for the core values that underlie the Foundation's mission: Justice, Equality, Human Dignity, and Tolerance. The Foundation's Community Justice and International Justice programs reflect these interests and values.

## Key Resources

### **The John D. and Catherine T. MacArthur Foundation**

<http://www.macfound.org>

Office of Grants Management  
140 S. Dearborn Street  
Chicago, IL 60603-5285  
P: 312-726-8000  
F: 312-920-6285

Jonathan F. Fanton  
President  
[4answers@macfound.org](mailto:4answers@macfound.org)

The John D. and Catherine T. MacArthur Foundation is a private independent grant-making institution dedicated to helping groups and individuals foster lasting improvement in the human condition. The Foundation seeks the development of healthy individuals and effective communities; peace within and among nations; responsible choices about human reproduction; and a global ecosystem capable of supporting healthy human societies. This mission is pursued by supporting research, policy development, information dissemination, education and training, and practice.

### **The Tow Foundation**

[http://www.towfoundation.org/about\\_mission.htm](http://www.towfoundation.org/about_mission.htm)

43 Danbury Road  
Wilton, CT 06897  
P: 203-761-6604  
F: 203-761-6605

Diane Sierpina  
Senior Program Officer

Motivated by the philosophy that no child is beyond help, the work of The Tow Foundation is focused on system reforms that would provide vulnerable youth with an opportunity to succeed and become productive members of their communities.

# Appendix B: Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State, Multi-System Prevalence Study

## Background

Over the last decade, concern has escalated over the number of youth with significant mental health needs involved with the juvenile justice system. The presence of these youth in the juvenile justice system poses significant challenges to the juvenile justice and mental health systems both at the policy and program level. Despite the recent recognition of this issue as a major crisis facing the juvenile justice system (Coalition for Juvenile Justice, 2000), little is known about the exact prevalence and types of mental health disorders among this population. According to a 1992 comprehensive review of the research literature, studies examining the prevalence of mental health disorders among justice-involved youth produced estimates that varied widely. This variation resulted from a variety of factors, including inconsistent definitions of mental disorders, non-standardized measures, and problematic study designs (Cocozza, 1992). The lack of information about the mental health needs of justice-involved youth has hindered the juvenile justice system's ability to understand the needs of the youth in its care and develop appropriate responses.

Significant steps forward have been made in recent years, particularly with respect to the development of standardized screening and assessment instruments tested for use with this population. These instruments represent an important advancement for research because they allow for comparisons among studies that utilize them, as well as among subpopulations within the juvenile justice system. Researchers have begun utilizing these tools, thereby capitalizing on the opportunities they present. Their use in research has expanded the knowledge base with respect to the prevalence of mental health disorders among justice-involved youth, and have yielded more consistent estimates, ranging from 65 percent to 70 percent among youth in residential juvenile justice facilities (Wasserman et al., 2002; Wasserman et al.,

2004; Wasserman, McReynolds, Ko, Katz, & Carpenter, 2005). Research utilizing these instruments with non-residential juvenile justice populations (i.e. probation intake) has found mental health prevalence estimates of approximately 50 percent (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002).

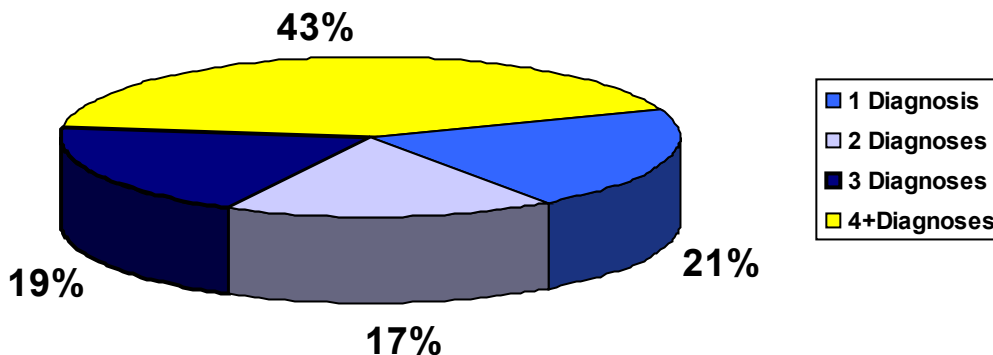
While this new research has overcome many of the limitations cited in the 1992 review, several issues remain. Many of these studies have drawn their sample from one region of the country or from one level of care within the juvenile justice system. As a result, several regions of the country have remained unstudied. Therefore, it has been suggested that the high prevalence rates found in these studies may not be representative of the juvenile justice population nationwide and may instead be attributable to the particular geographic region or facility in which the study was conducted. Furthermore, these studies have been limited by the fact that they often contained very small samples of girls and certain ethnic minorities. Therefore, the prevalence of mental health disorders among these subgroups is even less known.

## Overview of Study

In response to the need for new research to overcome these remaining limitations, the National Center for Mental Health and Juvenile Justice (NCMHJJ), in collaboration with the Council of Juvenile Correctional Administrators (CJCA) and through support from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), conducted the largest mental health prevalence study to date on youth involved with the juvenile justice system. This paper summarizes the results of the NCMHJJ study.

The primary goal of this research endeavor was to comprehensively examine the prevalence of mental health and substance use disorders among youth involved with the juvenile justice system by collecting information

Figure 1. Number of diagnoses among youth with at least one disorder.



on youth from three previously understudied regions of the country and, within each region, from three different juvenile justice settings. Data were collected on over 1,400 youth from 29 different community-based programs, detention centers, and residential facilities in Louisiana, Texas and Washington. In addition, girls and certain minority youth (Hispanics and Native Americans) were oversampled in an effort to improve the knowledge base regarding these understudied populations. Additional information on the study methodology and sample characteristics is available upon request from the NCMHJJ.

## Prevalence of Mental Health and Substance Use Disorders

The data collected during this study clearly indicate that the majority (70.4%) of youth in the juvenile justice system meet criteria for at least one mental health disorder<sup>2</sup>. Disruptive disorders are most common, followed by substance use disorders, anxiety disorders and mood disorders.

Given that many youth in the juvenile justice system meet a number of the criteria for conduct disorder simply as a result of their juvenile justice involvement, and, given that disruptive disorders are the most frequently occurring 2 Mental health disorders were identified using the Diagnostic Interview Schedule for Children – Voice Version IV (Voice DISC-IV; Shaffer et.al, 2000). The Voice DISC-IV is a structured contingency-based interview designed to measure the presence of over 30 different psychiatric diagnoses common among adolescents. All analyses exclude Separation Anxiety Disorder.

disorders in this study, it was possible that this high rate of disorder was largely attributable to a diagnosis of conduct disorder. However, upon further analysis, it was evident that this was not the case. Even after removing conduct disorder from the analysis (i.e., calculating the prevalence of any mental health disorder **except** conduct disorder), 66.3 percent of youth still met criteria for a mental health disorder other than conduct disorder.

Similarly, it was possible that many of these youth were adjudicated for drug-related offenses and that, as a result, substance use diagnoses accounted for the high prevalence of disorder. However, after removing substance use disorders from the analysis, 61.8 percent of youth still met criteria for a mental health disorder other than a substance use disorder. In fact, even if both conduct disorder **and** substance use disorders are removed from the analysis, almost half (45.5%) of the youth were identified as having a mental health disorder. Clearly, neither conduct disorder nor substance use disorders adequately account for the high prevalence rate of mental illness found in this study.

## Comorbidity and Co-Occurring Disorders

The vast majority of youth who meet criteria for a DSM-IV diagnosis actually meet criteria for multiple disorders. This explains why the removal of conduct disorder and substance use disorders did not drastically reduce the overall prevalence rate. **Figure 1** depicts the number of diagnosed disorders among youth with at least one

disorder. What is particularly striking is that over 60 percent of these youth actually met diagnostic criteria for three or more diagnoses.

For many youth in the juvenile justice system, their mental health needs are significantly complicated by the presence of a co-occurring substance use disorder. In fact, among those youth with a mental health diagnosis, 60.8 percent also met criteria for a substance use disorder. Co-occurring substance use disorders were most frequent among youth with a disruptive disorder, followed by youth with a mood disorder.

Youth with comorbid and co-occurring disorders pose a unique challenge to the juvenile justice system. Not only is the intensity of their needs likely to be greater, but proper response to their multiple needs requires increased collaboration, continuity of care, and the ability to recruit and retain providers with the ability to treat multiple needs. This is particularly true for those youth with both mental health and substance use needs, as they require integrated mental health and substance use treatment.

## Gender Differences in the Prevalence of Mental Health Disorders

Over the past decade, the proportion of female offenders in the juvenile justice system has steadily risen (American Bar Association and National Bar Association, 2001). The growth of this population has brought with it new and unfamiliar challenges to the juvenile justice system. Justice-involved girls are at significantly higher risk for mental health disorders than boys<sup>3</sup>. In fact, more than 80 percent of the girls in this sample met criteria for at least one disorder, in comparison to 67 percent of boys. Much of this difference is attributable to higher rates of internalizing disorders among girls. In contrast, girls and boys experience more comparable rates of disruptive disorders and substance use disorders. For many of these girls, histories of trauma further complicate the effective response on the part of the juvenile justice system (Hennessey et al., 2004). **Figure 2** depicts the prevalence of anxiety, mood, disruptive and substance use disorders for males and females in this sample.

<sup>3</sup> Controlling for age, race/ethnicity, type of facility, and state.

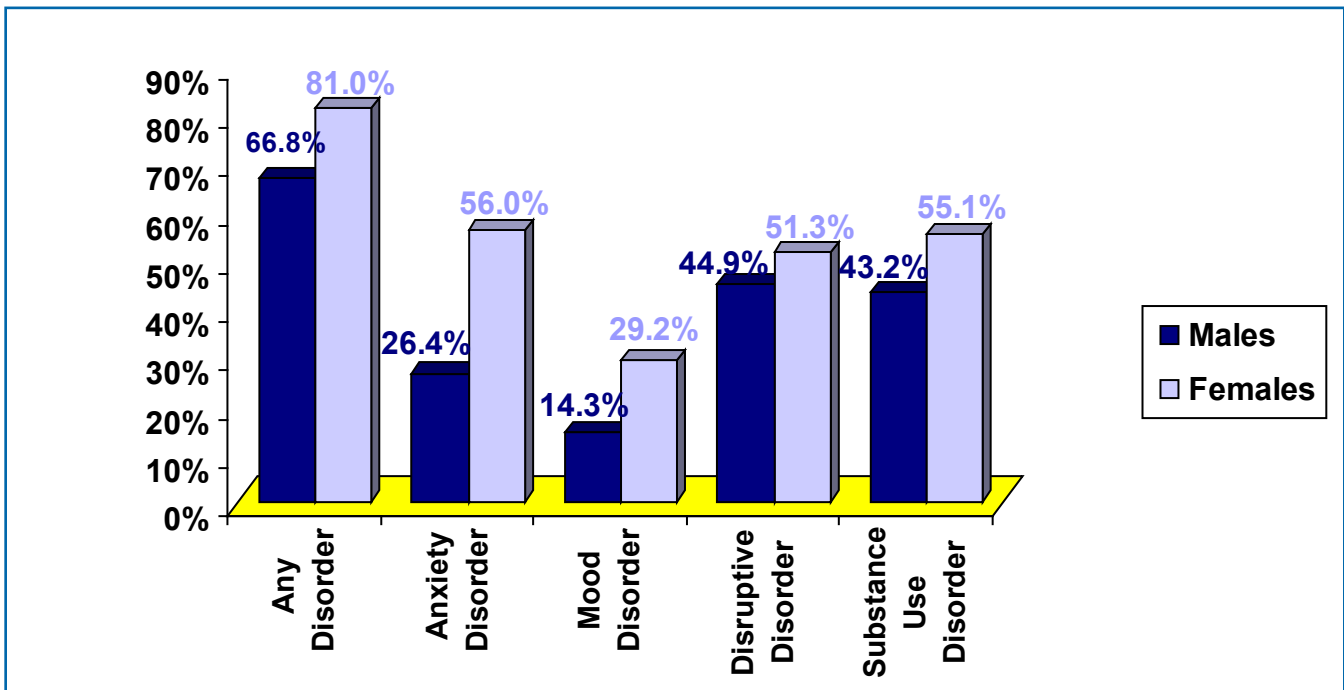


Figure 2. Prevalence of mental health disorders among males and females in the juvenile justice system.

## Conclusion

Based on this research, it is now clear that the vast majority of youth involved with the juvenile justice system, anywhere from 65 percent to 70 percent, have at least one diagnosable mental health disorder. Even when conduct disorder is eliminated, over 65 percent of youth still met criteria for some other mental health disorder. Strikingly, of those youth with at least one disorder, more than 60 percent met criteria for three or more diagnoses. Girls are at significantly higher risk (80%) than boys (67%) for a mental health disorder, with girls demonstrating higher rates of internalizing disorders than boys. Substance use continues to be a major problem for many youth in the juvenile justice system, with 60.8 percent of youth with a mental health diagnosis also meeting criteria for a substance use disorder. This new information broadens the collective understanding of the prevalence of these disorders among the juvenile justice population, and can serve to help juvenile justice and mental health administrators and policymakers make more informed decisions about effective interventions for these youth. This multi-state, multi-system study confirms the high rate of disorder found in earlier studies that often were limited to a particular site or level of care, and provides further support for the critical need for improved mental health services for justice-involved youth.

## References

- Coalition for Juvenile Justice. (2000). *Handle with Care: Serving the Mental Health Needs of Young Offenders*. Annual Report. Washington, DC: Coalition for Juvenile Justice.
- Cocozza, J. (1992). *Responding to the mental health needs of youth in the juvenile justice system*. Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice System.
- Shaffer, D., Fisher, P., Lucas, C., Dulcan, M., & Schwab-Stone, M. (2000). NIMH 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., Abran, K., McClelland, G., Dulcan, M., & Mericle A. (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry*, 59, 1133-1143.
- Wasserman, G., McReynolds, L., Ko, S., Katz, L., Cauffman, E., Haxton, W., & Lucas, C. (2004). Screening for emergent risk and service needs among incarcerated youth: Comparing MAYSI-2 and Voice DISC-IV. *Journal of the American Academy of Adolescent Psychiatry*, 43, 629-639.
- Wasserman, G., McReynolds, L., Ko, S., Katz, L., Carpenter, J. (2005). Gender differences in psychiatric disorders at juvenile probation intake. *American Journal of Public Health*, 95, 131-137.
- 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.

# References

- Abram, K., Teplin, L., McClelland, G., & Dulcan, M. (2003). Comorbid psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry* 60(11): 1097-1108.
- Abram, K., Teplin, L., Charles, D., Longworth, S. McClelland, G., & Dulcan, M. (2004). Posttraumatic stress disorder and trauma in youth in juvenile detention. *Archives of General Psychiatry* 61(4): 403-410.
- Albert, D., Chapman, J., Ford, J., & Hawke, J. (2005, September). *Traumatic Stress in Juvenile Justice*. Presentation to the National Commission on Correctional Health Care.
- Alexander, J. & Sexton, T. (1999). *Functional Family Therapy: Principles of Clinical Intervention, Assessment, and Implementation*. Henderson, NV: Functional Family Therapy, Inc.
- Altschuler, D. & Armstrong, T. (1994). *Intensive Aftercare for High-Risk Juveniles: A Community Care Model*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Altschuler, D. & Brash, R. (2004). Adolescent and teenage offenders confronting the challenges and opportunities of reentry. *Youth Violence and Juvenile Justice* 2 (1): 72-87.
- Annie E. Casey Foundation. *Juvenile Detention Alternatives Initiative*. Retrieved November 7, 2005 from <http://www.aecf.org/initiatives/jdai/>
- Annie E. Casey Foundation. (2003). *Reducing Juvenile Incarceration in Louisiana*. New Orleans, LA: Joint Legislative Juvenile Justice Commission.
- Aos, S., Phillips, P., Barnoski, E., & Leib, R. (2001). *The Comparative Costs and Benefits Of Programs To Reduce Crime*. Olympia, WA: Washington State Institute for Public Policy.
- Arredondo, D., Kumli, K., Soto, L., Colin, E., Ornellas, J., Davilla, R., Edwards, L., & Hyman, E. (2001). Juvenile mental health courts: Rationale and protocols. *Juvenile and Family Court Journal* Fall: 1-19.
- Arroyo, W. (2001). PTSD in children and adolescents in the juvenile justice system. In S. Eth (Ed). *Review of psychiatry, 20(1) PTSD in Children and Adolescents (1<sup>st</sup> ed.)* Pages 59-86. Washington, DC: American Psychiatric Publishing.
- Austin, J., Johnson, K., & Weitzer, R. (2005). *Alternatives to the Secure Detention and Confinement of Juvenile Offenders*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.
- Belknap, J. (1996). *The Invisible Woman: Gender, Crime and Justice*. Belmont, CA: Wadsworth Publishing Company.
- Bell, N. & Shern, D. (2002). *State Mental Health Commissions: Recommendations For Change And Future Directions*. Washington, DC: National Technical Assistance Center for State Mental Health Planning.
- Bernstein, D., Ahluvalia, T., Pogge, D., & Handelsman, L. (1997). Validity of the Childhood Trauma Questionnaire in adolescent psychiatric population. *Journal of the American Academy of Child and Adolescent Psychiatry* 36(3): 340-348.
- Bilchik, S. (1998). *Mental Health Disorders and Substance Abuse Problems Among Juveniles*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Blanton, S. (2005). Emily J. settlement agreement provides \$8.5 million for new services for children in the juvenile justice system who have mental health needs. *Kids Counsel Newsletter* 5(2).
- Blau, G., Coccozza, J., Bernstein, D., Williams, J., & Canary, P. (2004, May). *Implementation of Evidence-Based Practices for Youth: Lessons from the Field*. Presentation at the National GAINS Center Conference, Las Vegas, NV.
- Bogie, D., Sedano, F., & Jones, N. (2005). *Recidivism Patterns for Juvenile Offenders Released from the Alabama Department of Youth Services During 2001 and 2002*. Montgomery, AL: Children First Foundation and VOICES for Alabama's Children.

- Borum, R. (2003). Managing at-risk juvenile offenders in the community: Putting evidence based principles into practice. *Journal of Contemporary Criminal Justice* 19 (1): 114-137.
- Briere, J. & Spinazzola, J. (2005). Phenomenology and psychological assessment of complex posttraumatic states. *Journal of Traumatic Stress* 18:401-412.
- Browne, J. (2003). *Derailed: The Schoolhouse To Jailhouse Track*. Washington, DC: Advancement Project.
- Burns, B. & Hoagwood, K. (2002). *Community Treatment For Youth: Evidence-Based Interventions For Severe Emotional And Behavioral Disorders*. New York, NY: Oxford University Press.
- Burns, B., Hoagwood, K., & Mrazek, P. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review* 2(4):199-254.
- Burrell, S. & Warboys, L. (2000). *Special Education and the Juvenile Justice System*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.
- Butterfield, F. (2000, December 5). Concern rising over use of juvenile prisons to 'warehouse' the mentally ill. *New York Times*, A14.
- Butts, J. & Adams, W. (2001). *Anticipating Space Needs In Juvenile Detention And Correctional Facilities*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Butts, J. & Harrel, A. (1998). *Delinquents or Criminals: Policy Options for Young Offenders*. Washington, DC: Urban Institute.
- Caffo, E., & Belaise, C. (2003). Psychological aspects of traumatic injury in children and adolescents. *Child and Adolescent Psychiatric Clinics of North America* 12: 493-535.
- Campaign for Mental Health Reform. (2005). *Emergency Response: A Roadmap for Federal Action on American's Mental Health Crisis*. Washington, DC: Campaign for Mental Health Reform.
- Caporino, N., Murray, L., Jensen, P. (2003). The impact of different traumatic experiences in childhood and adolescence. *Emotional and Behavioral Disorders in Youth* (Summer): 63-64, 73-76.
- Center on Crime, Communities and Culture. (1997). *Education as crime prevention; providing education to prisoners*. Research Brief. September. (online).
- Center for Substance Abuse Treatment. (2005). *Definitions and Terms Relating to Co-Occurring Disorders*. COCE Overview Paper No. 1. Rockville, MD: Substance Abuse and Mental Health Services Administration Co-Occurring Center for Excellence.
- Center for Substance Abuse Treatment. (2005). *Screening, Assessment, and Treatment Planning for Persons with Co-Occurring Disorders*. COCE Overview Paper No. 2. Rockville, MD: Substance Abuse and Mental Health Services Administration Co-Occurring Center for Excellence.
- Chamberlain, P. (1998). *Treatment Foster Care*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.
- Coalition for Juvenile Justice. (2000). *Handle With Care: Serving The Mental Health Needs Of Young Offenders. Annual Report*. Washington, DC: Coalition for Juvenile Justice.
- Coalition for Juvenile Justice. *Issues and Facts: Understanding The System*. Retrieved March 15, 2005 from <http://www.juvjust.org/resources/glossary/html>
- Coalition for Juvenile Justice. (2003). *Unlocking The Future. Annual Report*. Washington, DC: Coalition for Juvenile Justice.
- Cocozza, J. (1992). *Responding to the Mental Health Needs of Youth in the Juvenile Justice System*. Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice System.
- Cocozza, J. & Stainbrook, K. (1998). *The Ohio Linkages Project: Final Evaluation Report*. Delmar, NY: Policy Research Associates, Inc.
- Cocozza, J. & Skowrya, K. (2000). Youth with mental health disorders: Issues and emerging responses. *Office of Juvenile Justice and Delinquency Prevention Journal* 7(1): 3-13.
- Cohen, J., Mannarino, A., & Deblinger, E. (2003). *Child and Parent Trauma Focused Cognitive-Behavioral Therapy Treatment Manual*. Unpublished manuscript.
- Colorado Regional Community Policing Institute. (2004). *Colorado Crisis Intervention Team Fact Sheet*. Golden, CO: Colorado Regional Community Policing Institute.
- Cottle, C., Lee, R., & Heilbrun, K. (2001). The prediction of criminal recidivism in juveniles: A meta analysis. *Criminal Justice and Behavior* 28: 367-394.
- Council of State Governments. (2002). *Criminal Justice/Mental Health Consensus Report*. New York, NY: Council of State Governments.



- Elliot, D., Henggeler, S., Mihalic, S., Rone, L., Thomas, C., & Timmons-Mitchell, J. (1998). *Blueprints For Violence Prevention: Book Six – Multisystemic Therapy*. Boulder, CO: Center for the Study and Prevention of Violence.
- Federation of Families for Children's Mental Health. (2001). *Blamed and Ashamed: The Treatment Experiences of Youth with Co-Occurring Substance Abuse and Mental Health Disorders and Their Families*. Washington, DC: Federation of Families for Children's Mental Health.
- Federation of Families for Children's Mental Health. (2005). *Definition of Family Driven Care*. Retrieved from www.ffcmh.com on October 17, 2005.
- Flaherty, M. (1983). The national incidence of juvenile suicide in adult jails and juvenile detention centers. *Suicide and Life Threatening Behavior* 13(2): 85-94.
- Gavazzi, S., Slade, D., Buettner, C., Partridge, C., Yarcheck, C., & Andrews, D. (2003). Toward conceptual development and empirical measurement of global risk indicators in the lives of court-involved youth. *Psychological Reports* 92:599-615.
- Gies, S. (2003). *Aftercare Services*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Goldstein, A., Glick, B., Reiner, S., Zimmerman, D., Coultry, T., & Gold, D. (1986). Aggression Replacement Training: A comprehensive intervention for the acting-out delinquent. *Journal of Correctional Education* 37(3): 120-126.
- Greene, Peters, & Associates. (1998). *Guiding Principles for Promising Female Programming: An Inventory of Best Practices*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Greenwood, P., Model, K., Rydel, C., & Chiesa, J. (1996). *Diverting Children From a Life of Crime: Measuring Costs and Benefits*. Arlington, VA: RAND Corporation.
- Griffin, P. & Bozynski, M. (2004). *National Overviews: State Juvenile Justice Profiles*. Pittsburgh, PA: National Center for Juvenile Justice.
- Grisso, T. (2004). *Double Jeopardy: Adolescent Offenders With Mental Disorders*. Chicago, IL: University of Chicago Press.
- Grisso, T. & Barnum, R. (2000). *Massachusetts Youth Screening Instrument-2: User's Manual and Technical Report*. Worcester, MA: University of Massachusetts Medical School.
- Grisso, T. & Underwood, L. (2002). *Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System*. Delmar, NY: National Center for Mental Health and Juvenile Justice.
- Grisso, T. & Underwood, L. (2004). *Screening And Assessing Mental Health And Substance Use Disorders Among Youth In The Juvenile Justice System: A Resource Guide For Practitioners*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Grisso, T., Vincent, G., & Seagrave, D. (2005). *Mental Health Screening And Assessment In Juvenile Justice*. New York, NY: Guilford Press.
- Harms, P. (2003). *Detention in Delinquency Cases, 1990-1999*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Harris, E. & Seltzer, T. (2004). *The Role Of Specialty Mental Health Courts In Meeting The Needs Of Juvenile Offenders*. Washington, DC: Bazelon Center for Mental Health Law.
- Hayes, L. (2000). Suicide prevention in juvenile facilities. *Juvenile Justice Journal* 7(1): 24-32.
- Hayes, L. (2004). *Juvenile Suicide in Confinement: A National Survey*.
- Mansfield, MA: National Center on Institutions and Alternatives. Henggeler, S. (February, 1997). *Family Services Research Center New Projects*. Introduction to Symposium at 10<sup>th</sup> Annual Research and Training Center Conference, Tampa, Florida.
- Henggeler, S. (1997). *Treating Serious Anti-Social Behavior in Youth: The MST Approach*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention
- Hennessey, M., Ford, J., Mahoney, K., Ko, S., & Siegfried, C. (2004). *Trauma Among Girls in the Juvenile Justice System*. Los Angeles, CA: National Child Traumatic Stress Network.
- Hoagwood, K. (2005). *Research And Policy Update: Evidence-Based Practices for Youth With Mental Health Problems and Implications for Juvenile Justice*. Unpublished manuscript. Delmar, NY: National Center for Mental Health and Juvenile Justice.
- Hoagwood, K., Burns, B., Kiser, L., Ringeisen, H., & Schoenwald, S. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services* 52 (9): 1179-1189.

- Howell, J. (1998). NCCD's survey of juvenile detention and correctional facilities. *Crime & Delinquency* 44(1): 102-109.
- Jenson, J. & Potter, C. (2003). The effects of cross-system collaboration on mental health and substance use problems of detained youth. *Research on Social Work Practice* 13(5): 588-607.
- Juvenile Rehabilitation Administration. (2002). *Integrated Treatment Model Report*. Olympia, WA: Washington State Department of Social and Health Services.
- Kelly, W. & Mears, D. (1999). *An Evaluation of the Efficiency and Effectiveness of Juvenile Justice Initial Assessment and Referral Process in Texas*. Austin, TX: Hogg Foundation for Mental Health.
- Kelly, B., Thornberry, T., & Smith, C. (1997). *In the Wake of Childhood Violence*. Washington, DC: National Institute of Justice.
- Konrad, E. (1996). A multidimensional framework for conceptualizing human services integration initiatives. *New Directions for Evaluation* 69: 5-19.
- Koppelman, J. (2005). *Mental Health and Juvenile Justice: Moving Toward More Effective Systems of Care*. Washington, DC: National Health Policy Forum.
- Koyanagi C. & Feres-Merchant D. (2000). For the long haul: maintaining systems of care beyond the federal investment. *In Systems of Care: Promising Practices in Children's Mental Health, 2000 Series, Vol. III*. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.
- Krisberg, B., Austin, J., & Steele, P. (1991). *Unlocking Juvenile Corrections*. San Francisco, CA: National Council on Crime and Delinquency.
- Lipsey, M., Chapman, G., & Landenberger, N. (2001). Cognitive-behavioral programs for offenders. *The Annals of the American Academy of Political and Social Science* 578: 144-157.
- Lynagh, S. & Mancuso, E. (2004). *Arrested Development: Students With Disabilities And School Referrals To Law Enforcement In Pennsylvania*. Harrisburg, PA: Pennsylvania Protection and Advocacy, Inc.
- Lyons, J., Griffin, G., Quintenz, S., Jenuwine, M., & Shasha, M. (2003). Clinical and forensic outcomes from the Illinois Mental Health Juvenile Justice Initiative. *Psychiatric Services* 54: 1629-1634.
- McCord, J., Spatz-Widom, C., & Crowell, N. (2001). *Juvenile Crime, Juvenile Justice: Panel on Juvenile Crime: Prevention, Treatment and Control*. Washington, DC: National Academy Press.
- Mahoney, K., Ford, J., Ko, S., & Siegfried, C. (2004). *Trauma-Focused Interventions for Youth in the Juvenile Justice System*. Los Angeles, CA: National Child Traumatic Stress Network.
- Mears, D. & Travis, J. (2004). *The Dimensions, Pathways, And Consequences Of Youth Reentry*. Washington, DC: Urban Institute.
- Melton, G. & Pagliocca, P. (1992). Treatment in the juvenile justice system: Directions for policy and practice. In J. Cocozza (Ed.) *Responding to the Mental Health Needs of Youth in the Juvenile Justice System*. Seattle, WA: National Coalition for the Mentally Ill in the Criminal Justice System.
- Melton, G., Petrila, J., Poythress, N., & Slobogin, C. (1997). *Psychological evaluations for the courts (2<sup>nd</sup> ed.)*. New York, NY: Guilford.
- Memory, J. (1989). Juvenile suicides in secure detention facilities: Correction of published rates. *Death Studies* 13: 455-463.
- Mendel, R. (2000). *Less Hype, More Help: Reducing Juvenile Crime, What Works, And What Doesn't*. Washington, DC: American Policy Forum.
- Mihalic, S., Irwin, K., Fagan, A., Ballard, D., & Elliot, D. (2004). *Successful Program Implementation: Lessons From Blueprints*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Narrow, W., Regier, D., Goodman, S., Rae, D., Roper, M., Bourdon, K., Hoven, C., & Moore, R. (1998). A comparison of federal definitions of severe mental illness among children and adolescents in four communities. *Psychiatric Services* 49 (12): 1601-1608.
- 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.
- National Association of State Mental Health Program Directors Research Institute. (2005). State mental health agency organization and structure. *State Profile Highlights Newsletter* 5(2).
- National Center for Mental Health and Juvenile Justice. (2005). [Results from the OJJDP Multi-State Prevalence Study]. Unpublished raw data.
- National Center for Mental Health and Juvenile Justice. (2005). *The MacArthur Initiative on Mental Health and Juvenile Justice*. Retrieved November 7, 2005 from [www.ncmhjj.com](http://www.ncmhjj.com)

- National Center for Juvenile Justice. (2004). *State Juvenile Justice Profiles*. Pittsburgh, PA: National Council on Juvenile Justice. Retrieved April 11, 2005 from <http://www.ncjj.org/stateprofiles/asp/using.asp>
- National Council on Disability. (2003). *Addressing the Needs of Youth With Disabilities in the Juvenile Justice System: The Current Status of Evidence-Based Research*. Washington, DC: National Council on Disability.
- National Center on Education, Disability and Juvenile Justice. *Special Education in Juvenile Correctional Facilities*. Retrieved from [www.edji.com](http://www.edji.com) on October 21, 2005.
- National Clearinghouse on Child Abuse and Neglect Information. (2005). *Long-term consequences of Child Abuse and Neglect*. Retrieved from <http://nccanch.acf.hhs.gov> on December 5, 2005.
- National GAINS Center for People with Co-Occurring Disorders in the Justice System. (1999). *The Courage to Change: A Guide for Communities to Create Integrated Services for People with Co-Occurring Disorders in the Justice System*. Delmar, NY: The National GAINS Center for People with Co-Occurring Disorders in the Justice System.
- Neighbors, B., Kempton, T., & Forehand, R. (1992). Co-occurrence of substance abuse with conduct, anxiety, and depression disorders in juvenile delinquents. *Addictive Behaviors* 17:379-386.
- New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: New Freedom Commission on Mental Health.
- Office of Justice Programs. (2002). *Serious And Violent Offender Reentry Initiative*. Washington, DC: U.S. Department of Justice, Office of Justice Programs.
- Office of Juvenile Justice and Delinquency Prevention. (2004). *Statistical Briefing Book*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Oregon Department of Human Services. (2005). *Implementation of Evidence-Based Practices in Oregon Fact Sheet*. Salem, OR: Office of Mental Health and Addiction Services.
- Osher, T. & Hunt, P. (2002). *Involving Families of Youth Who are in Contact With the Juvenile Justice System*. Delmar, NY: National Center for Mental Health and Juvenile Justice.
- Otto, R., Greenstein, J., Johnson, M., & Friedman, R. (1992). Prevalence of mental disorders among youth in the juvenile justice system. In J. Coccozza (Ed.). *Responding to the Mental Health Needs of Youth in the Juvenile Justice System*. Seattle, WA: National Coalition for the Mentally Ill in the Criminal Justice System.
- PACE Center for Girls. Retrieved November 7, 2005 from <http://www.pacecenter.org>
- Parent, D., Lieter, V., Kennedy, S., Livens, L., Wentworth, D., & Wilcox, S. (1994). *Conditions of Confinement: Juvenile Detention and Corrections Facilities – Research Summary*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Penn, J. & Thomas, C. (2005). Practice parameters for the assessment and treatment of youth in juvenile detention and correctional facilities. *Journal of the American Academy of Child and Adolescent Psychiatry* 44(10): 1085-1098.
- Prescott, L. (1997). *Adolescent Girls with Co-Occurring Disorders in the Juvenile Justice System*. Delmar, NY: The National GAINS Center for People with Co-Occurring Disorders in the Justice System.
- Pynoos, R., Goenjian, A., & Steinberg, A. (1998). A public mental health approach to the postdisaster treatment of children and adolescents. *Child and Adolescent Psychiatric Clinics of North America* 7(1): 195-210.
- Redding, R. (2000). *Graduated and Community-Based Sanctions for Juvenile Offenders*. Juvenile Justice Fact Sheet. Charlottesville, VA: Institute of Law, Psychiatry & Public Policy, University of Virginia.
- Reuland, M. (2004). *A Guide To Implementing Police-Based Diversion Programs For People With Mental Illness*. Delmar, NY: TAPA Center for Jail Diversion.
- Rimer, S. (2004, January 4). *Unruly Students Facing Arrest, Not Detention*. New York Times, A1.
- Rogers, K. (2003). Evidence-based community-based interventions. In A. Pumariaga & N. Winters (Eds.), *The Handbook Of Child And Adolescent Systems Of Care* (pp. 149-170). San Francisco, CA: Jossey-Bass.
- Rohde, P., Clarke, G., Mace, D., Jorgensen, J., & Seeley, J. (2004). An efficacy/effectiveness study of cognitive-behavioral treatment for adolescents with comorbid major depression and conduct disorder. *Journal of the American Academy of Child and Adolescent Psychiatry* 43(6): 660-668.
- Roskes, E., Feldmen, R., Arrington, S., & Leisher, M. (1999). A model program for the treatment of mentally ill offenders in the community. *Community Mental Health Journal* 35(5): 461-472.
- Roy-Stevens, C. (2004). *Overcoming Barriers to School Reentry*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

- Rudolph, S. & Epstein, M. (2000). Empowering children and families through strength-based assessment. *Reclaiming Children and Youth* 8(4): 207-209.
- Saigh, P. A., Yasik, A. E., Sack, W. H., & Koplewicz, H. S. (1999). Child-Adolescent posttraumatic stress disorder: Prevalence, risk factors, and comorbidity. In P. A. Saigh, & J. D. Bremner (Eds.), *Posttraumatic Stress Disorder: A Comprehensive Text*. Boston: Allyn & Bacon.
- Selby, P., Trupin, E., McCauley, E., & Vander Stoep, A. (1998). The Prime Time Project: Preliminary review of the first year of a community-based intervention for youth in the juvenile justice system. In *Tenth Annual Research Conference Proceedings: A System Of Care For Children's Mental Health – Expanding The Research Base, February 1997*. Tampa, FL: Research and Training Center for Children's Mental Health.
- Sexton, T., Alexander, J. (2001). *Functional Family Therapy*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.
- Shaffer, D., Fisher, P., Dulcan, M., Davies, M., Piacentini, J., Schwab-Stone, M., Lahey, B., Bourdon, K., Jensen, P., Bird, H., Canino, G., & Regier, D. (1996). The NIMH Diagnostic Interview Schedule for Children Version 2.3(DISC-2.3): Description, acceptability, prevalence rates, and performance in the MECA study. *Journal of the American Academy of Child and Adolescent Psychiatry* 35(7): 865-877.
- Sickmund, M. (2004). *Juveniles In Corrections. Juvenile Offenders And Victims National Report Series*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Silverman, A. B., Reinherz, H. Z., & Giaconia, R. M. (1996). The long-term sequelae of child and adolescent abuse: A longitudinal community study. *Child Abuse and Neglect* 20(8): 709-723.
- Simourd, L. & Andrews, D. (1994). Correlates of delinquency: A look at gender differences. *Forum on Corrections Research* 6(1): 26-31.
- Smeltzer, I. (1999). *From A Parent's Perspective: A Handbook for Parents and Guardians Of Children Committed to the Commonwealth of Massachusetts Department of Youth Services*. Boston: Citizens for Juvenile Justice.
- Smith, B. (1998). Children in custody: 20-year trends in juvenile detention, correctional, and shelter facilities. *Crime & Delinquency* 44(4): 526-543.
- Snyder, H. (2003). *Juvenile Arrests 2001*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Snyder, H. (2004). *Juvenile Arrests 2002*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Snyder, H. & Sickmund, M. (1999). *Juvenile Offenders and Victims: 1999 National Report*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Substance Abuse and Mental Health Services Administration. (2005). *Transforming Mental Health Care in America. The Federal Action Agenda: First Steps*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Swenson, C., Torrey, W., & Koerner, K. (2002). Implementing Dialectical Behavioral Therapy. *Psychiatric Services* 53(2): 171-177.
- Teplin, L., Abram, K., McClelland, G., Dulcan, M., & Mericle, A. (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry* 59(12): 1133-1143.
- Texas Juvenile Probation Commission. (2003). *Mental Health and Juvenile Justice In Texas*. Austin, TX: Texas Juvenile Probation Commission.
- Torbet, P. (1996). *Juvenile Probation: The Workhorse Of The Juvenile Justice System*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Trupin, E., Turner, A., Stewart, D., & Wood, P. (2004). Transition planning and recidivism among mentally ill juvenile offenders. *Behavioral Sciences and the Law* 22(4): 599-610.
- Underwood, L. (2002). Screening and assessing the mental health and substance use needs of African-American Youth. *Juvenile Correctional Mental Health Report* 2(4): 49-50, 56-62.
- Underwood, L., Mullan, W., & Walte, C. (1997). We built them and they came: New insights for managing Ohio's aggressive juvenile offenders with mental illness. *Corrections Management Quarterly* 1(4): 19-27.
- U.S. Department of Health and Human Services. (2001). *Culture, Race, and Ethnicity: A Report of the Surgeon General*. Washington, DC: Office of the Surgeon General.
- U.S. Department of Health and Human Services. (2004). *Brief Strategic Family Therapy: SAMHSA Model Programs Fact Sheet*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

- United States Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
- United States Department of Health and Human Services. (2000). *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington, DC: Department of Health and Human Services.
- United States Department of Justice. (2003). Girls Study Group Program Announcement. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- 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. Retrieved July 15, 2005 from [http://www.usdoj.gov/crt/split/document/split\\_cripa04pdf](http://www.usdoj.gov/crt/split/document/split_cripa04pdf).
- United States Department of Labor. (2003). *Violent Offender Initiative*. Washington, DC: Office of Justice Programs.
- United States General Accounting Office. (2003). *Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services*. Washington, DC: United States General Accounting Office.
- United States House of Representatives. (2004). *Incarceration Of Youth Who Are Waiting For Community Mental Health Services In The United States*. Washington, DC: Committee on Government Reform.
- Veysey, B. (2003). *Adolescent Girls with Mental Health Disorders Involved with the Juvenile Justice System*. Delmar, NY: National Center for Mental Health and Juvenile Justice.
- Vilhauer, J., Wasserman, G., McReynolds, L., & Wahl, R. (2004). Probation officer's mental health knowledge and practices. *Perspectives* 28(3): 28-31.
- Washington State Institute for Public Policy. (2004). Outcome evaluation of Washington State's research-based programs for juvenile offenders. Olympia, WA: Washington State Institute for Public Policy.
- Wasserman, G., Jensen, P., Ko, S., Coccozza, J., Trupin, E., Angold, A., Cauffman, E., & Grisso, T. (2003). Mental health assessments in juvenile justice: Report on consensus conference. *Journal of the American Academy of Child and Adolescent Psychiatry* 42(7): 753-761.
- Wasserman, G., Ko, S., & Jensen, P. (2001). Columbia guidelines for child and adolescent mental health referral. *Emotional and Behavioral Disorders in Youth* (Winter); 9-13, 23.
- Wasserman, G., Ko, S., & McReynolds, L. (2004). Assessing the mental health status of youth in juvenile justice settings. *Juvenile Justice Bulletin* (August):1-7.
- Wasserman, G., McReynolds, L., Ko, S., Katz, L., & Schwank, K. (2005). Gender differences in psychiatric disorder for youths in juvenile probation. *American Journal of Public Health* 95(1): 131-137.
- 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(3): 314-321.
- Widom, C. (2000). Childhood victimization: Early adversity, later psychopathology. *National Institute of Justice Journal* (January): 3-9.
- Widom, C. S. & Maxfield, M. G. (2001). *An Update on the "Cycle of Violence."* Washington, DC: National Institute of Justice.
- Wiebush, R., McNulty, B., & Le, T. (2000). *Implementation of the Intensive Community-Based Aftercare Program*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Wierson, M., Forehand, R., & Frame, C. (1992). Epidemiology and treatment of mental health problems in juvenile delinquents. *Advances in Behaviour Research and Therapy* 14: 93-120.
- Wiig, J. & Tuell, J. (2004). *Guidebook for Juvenile Justice and Child Welfare System Coordination and Integration: A Framework for Improved Outcomes*. Washington, DC: Child Welfare League of America.
- Woolard, J., Gross, S., Mulvey, E., & Reppucci, N. (1992). Legal issues affecting mentally disordered youth in the juvenile justice system. In J. Coccozza (Ed.). *Responding to The Mental Health Needs of Youth in the Juvenile Justice System*. Seattle, WA: National Coalition for the Mentally Ill in the Criminal Justice System.
- Wyss, W. (2004). *DHS Implements Child Welfare and Juvenile Justice Mental Health Screening*. St. Paul, MN: Minnesota Department of Human Services.