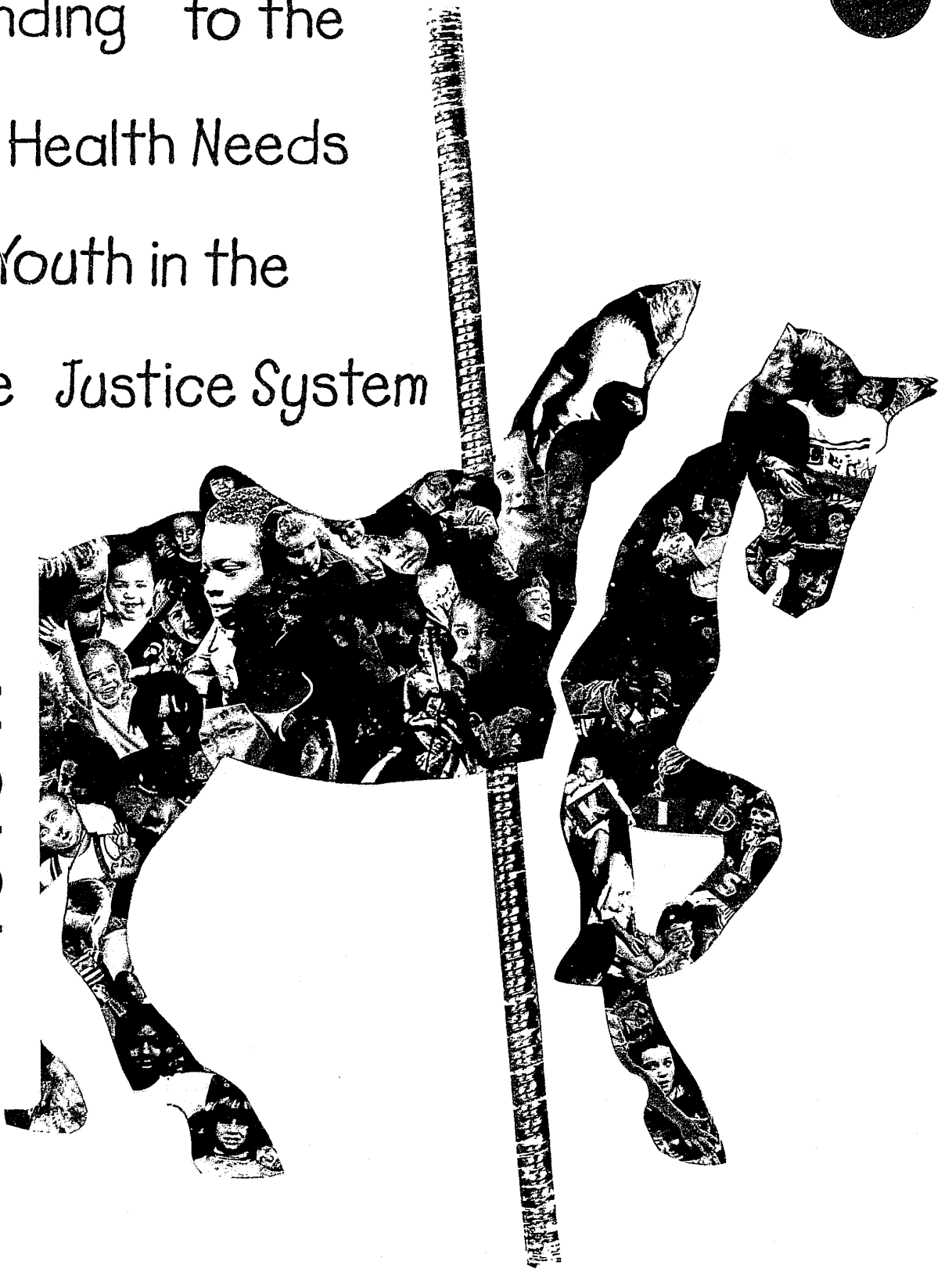
If you have issues viewing or accessing this file contact us at NCJRS.gov.

Responding to the Mental Health Needs of Youth in the Juvenile Justice System



151847

The National Coalition
for the Mentally Ill
in the Criminal Justice System

151847

Responding to the Mental Health Needs of Youth in the Juvenile Justice System

edited by:

Joseph J. Cocozza, Ph.D.

NCJRS

JAN 11 1995

ACQUISITIONS

November 1992

This monograph is being produced as part of a larger effort to address and improve the provision of mental health services to youth in the juvenile justice system. The overall project is being conducted by:

The National Coalition for the Mentally Ill in the Criminal Justice System

Project Director:

Susan Rotenberg

151847

U.S. Department of Justice
National Institute of Justice

This document has been reproduced exactly as received from the person or organization originating it. Points of view or opinions stated in this document are those of the authors and do not necessarily represent the official position or policies of the National Institute of Justice.

Permission to reproduce this copyrighted material has been granted by
Public Domain/Center for Substance Abuse Treatment
to the National Criminal Justice Reference Service (NCJRS).

Further reproduction outside of the NCJRS system requires permission of the copyright owner.

This publication is part of the Center for Substance Abuse and Treatment technical assistance program. Other contributors to this monograph are the National Institute of Drug Abuse and the National Institute of Mental Health. All material appearing in this volume except quoted passages from copyrighted sources is in the public domain and may be reproduced or copied without permission from the Center for Substance Abuse Treatment (CSAT) or the authors. Citation of the source is appreciated.

This publication was written under contract number ADM 270-91-0007 from CSAT. Nicholas Demos, Branch Chief; Criminal Justice Systems served as the CSAT project officer. Grant #1H87T100290-01.

Others who supported this monograph by offering financial support include: the Washington Division of Mental Health, Children's Hospital of Seattle's Department of Child and Adolescent Behavioral Medicine, King County Regional Support Network, Washington State Division of Juvenile Rehabilitation, and Community Action for the Mentally Ill Offender.

The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of CSAT or any other part of the U.S. Department of Health and Human Services (DHHS). No official support or endorsement of the Substance Abuse Mental Health Services Administration (SAMHSA) or DHHS is intended or should be inferred.

The U.S. Government does not endorse or favor any specific commercial product or company. Trade, proprietary, or company names appearing in this publication are used only because they are considered essential in the context of this publication.

Additional copies of this monograph may be ordered from:

The National Coalition for the Mentally Ill
in the Criminal Justice System
2470 Westlake Avenue North, Suite 101
Seattle, WA 98109-2282
(206) 285-7422

CONTRIBUTORS

RICHARD BARNUM, M.D.
Boston Juvenile Court Clinic
Boston, Massachusetts

JOSEPH J. COCOZZA, Ph.D.
Policy Research Associates, Inc.
Delmar, New York

ROBERT M. FREIDMAN, Ph.D.
Department of Child and Family Studies
Florida Mental Health Institute
University of South Florida
Tampa, Florida

JONATHAN J. GREENSTEIN, Ph.D.
Department of Child and Family Studies
Florida Mental Health Institute
University of South Florida
Tampa, Florida

SHARON L. GROSS, J.D.
Department of Psychology
University of Virginia
Charlottesville, Virginia

MAREASA R. ISAACS, Ph.D.
The Isaacs Group
Washington, DC

MICHAEL K. JOHNSON, Ph.D.
Department of Child and Family Studies
Florida Mental Health Institute
University of South Florida
Tampa, Florida

INGO KEILITZ, Ph.D.
Institute for Court Management
National Center for State Courts
Williamsburg, Virginia

GARY B. MELTON, Ph.D.
Center on Children, Families, and the Law
University of Nebraska-Lincoln
Lincoln, Nebraska

EDWARD P. MULVEY, Ph.D.
Western Psychiatric Institute and Clinic
University of Pittsburgh
Pittsburgh, Pennsylvania

RANDY K. OTTO, Ph.D.
Department of Law and Mental Health
Florida Mental Health Institute
University of South Florida
Tampa, Florida

PAULINE M. PAGLIOCCA, Ph.D.
Center on Children, Families, and the Law
University of Nebraska-Lincoln
Lincoln, Nebraska

N. DICKON REPPUCCI, Ph.D.
Department of Psychology
University of Virginia
Charlottesville, Virginia

JOHN WHITBECK, Ph.D.
Division of Mental Health
Washington State Department of
Social and Health Services
Olympia, Washington

JENNIFER L. WOOLARD
Department of Psychology
University of Virginia
Charlottesville, Virginia

FORWARD

The National Coalition for the Mentally Ill in the Criminal Justice system is a unique non-profit organization founded in 1989 to deal with the growing national crisis of increasing numbers of offenders who are mentally ill or dually-diagnosed and who are in the custody of criminal justice agencies. The Coalition is the only organization that has developed a national agenda focused on the mental health needs of this underserved population. Within this agenda are the following objectives: to develop effective models for screening, diverting, and treating offenders who are mentally ill or dually-diagnosed, and to establish comprehensive community-based systems of care to facilitate the rehabilitation of these individuals.

The coalition's mission is based on the premise that proper screening and handling by criminal justice agencies of offenders who are mentally ill or dually-diagnosed is a significant issue that has substantial public safety, health, economic, and moral implications. It is believed that problems related to offenders who are mentally ill or dually-diagnosed is a serious issue not only for criminal justice agencies but for a number of agencies at every level of government. Three specific offender groups have been targeted as priorities: detainees in local jails who are mentally ill, inmates in prison who are mentally ill, and youthful offenders who are emotionally disabled.

Through a series of innovative national forums, the Coalition seeks to build consensus and craft strategic solutions to impact the problems it addresses. Participants at these forums are stakeholders and experts from national organizations including corrections professionals, judges, court administrators, adolescent and adult treatment providers, legislative leaders, policy makers, families, clinical and policy researchers, and federal agencies involved in mental health, juvenile justice, and drug and alcohol treatment. By enlisting top researchers, policy-makers and advocates who deal with these issues on a daily basis, the Coalition develops relevant literature that reflects the current status and realities of the corrections field. In calling on these leading experts, the Coalition seeks to motivate technology adoption efforts, and to influence the directions of policy making.

The Coalition is committed not simply to the growth and synthesis of knowledge in the field, but also to its dissemination and diffusion to those who can utilize the information within various sectors of society to strengthen families and communities. It is believed that by targeting youth while they are still within the context of their home communities and while they are most responsive to the least restrictive and least intrusive interventions, future problems would be prevented.

Perhaps the only public system in the United States that is in worse shape than education and health care is criminal justice. Since 1960, the rate of violent crimes have increased 12 times faster than the population. Furthermore, juvenile crime accounts for a significant proportion of this increase; in 1991, youth under the age of 18 accounted for 16% of all the arrests in the U.S., (17.2% of violent crime arrests) reflecting a 3.2% increase since 1990. Moreover, the population between the ages of fourteen and seventeen is projected to increase from 13.2 million in 1990 to 15.3 in the year 2000. If these trends continue, the population in facilities can be expected to well outstrip the capacity of the system as it is currently configured.

It has been estimated that many of the youth who become involved with the juvenile justice system suffer from an emotional disability (perhaps as many as 20 to 60%). However, due to the relative lack of attention paid to this group of youth by researchers, service providers, advocates,

and policy makers, it is not known what the true magnitude of this problem is, and what the subsequent needs for service are among these youth. Youth of color appear to be adversely victimized by the juvenile justice system, particularly African American youth who are disproportionately represented at all levels of the system. Although issues of cultural sensitivity and ethnicity have mostly been ignored by researchers and policy makers who have studied youth in correctional settings, it is widely believed that the juvenile justice system suffers from many of the same deficiencies related to cultural sensitivity and the provision of culturally appropriate services that many sectors of the mental health, education, and social services system have been charged with lacking.

The problems stem in part from an outmoded way of approaching the problem. That is, in the early 1900's the Juvenile Court/Justice System was created to maintain "benevolent oversight" of wayward youth. In this spirit, juvenile programs were established to rehabilitate, re-educate, and resocialize troublesome youth. However, in response to increasing trends in juvenile crime, the juvenile justice system has evolved into a system designed to incapacitate and punish youth who are believed to be deserving of society's wrath. Nevertheless, while public safety and retribution are of increasing concern, recidivism data, cost, population trends, over crowding and offense data indicate a need to reevaluate the juvenile justice system's efficacy in serving the nations' youth.

In 1991 and 1992, at three separate work sessions, representatives from universities, national associations, families, mental health, and criminal justice agencies gathered to discuss the challenges faced by youthful offenders in the juvenile justice system who are emotionally disabled and to help develop this monograph. In May 1992, at a National Work Session, Chapter Seven of this monograph was drafted by work session participants. Its purpose is to delineate our responses to these challenges which can be implemented at national, state and local levels.

Participants discussed many of the tragedies and challenges that face youth with mental illness who are caught up in a juvenile justice system that is often unresponsive to their needs. Many examples were shared of personal experiences involving family members. On the positive side, there were also some encouraging examples of truly caring, effective, and cost efficient service programs that exist in certain communities. Legislative alternatives and methods of sharing information and innovative service practices for mental health and juvenile justice professionals also were discussed.

Eleven major priorities emerged from the National Work Session to shape the agenda with respect to improving services and guiding policy and future efforts in response to the challenges of youth with emotional disabilities in the juvenile justice system. These were:

1) **Research** is needed to develop screening and assessment tools to determine mental health intervention needs of youth as they enter the juvenile justice system.

2) **Inter-agency Collaboration** is needed to provide an expanded range of services and to bring agencies together in a collaborative effort, in addition to developing new financing mechanisms.

3) **Neighborhood-Driven Programs** are needed within communities to play a catalytic role with other sectors of society, including involving families in management and decision-making.

4) **Education** for juvenile justice and mental health personnel is necessary to increase awareness on the special needs of youth with mental illness, including culturally competent evaluations and treatment.

5) **Assessment of Amenability to Treatment** is a critical issue. The courts' decisions are typically based on whether a child can fit into existing treatment models, not whether or not the mental illness is treatable. The issue is complicated by determinations being based on the variability of expertness of mental health professionals and availability of resources.

6) **Treatment Specificity** must be determined. That is, differentiation of solutions from successful models that meet the needs of inner city youth and those that meet the needs of suburban or rural youth must be found.

7) **Funding Mechanisms** must be re-tooled. A major barrier to the provision of services for this population group is the categorical nature of federal, state, and local funding. Successful models have been achieved only when funding is adapted to the needs of the youthful offender and their families.

8) **Diversion Programs** must be developed as alternatives to incarceration. A major emphasis is needed on programs that keep youth out of the juvenile justice system in the least restrictive setting that is clinically appropriate, while at the same time protecting public safety.

9) **Stigma** must be reduced. To make the most progress, we need to "put a human face" on this issue. One speaker suggested that the audience "visualize our friend or their child as the person with mental illness or child in trouble." This will help to reduce the terrible stigma faced by families in general, and those who end up in the juvenile justice system in particular.

10) **Dissemination of Information** must be increased. Emerging trends and challenges impact the retention of youth in trouble. New paradigm for knowledge dissemination and utilization must be moved into the field to maximize the impact.

11) **Participatory Treatment** must be emphasized. Youth and families must be involved with treatment providers in assessing service needs and developing strategies for service provision.

The emerging knowledge base regarding how to best serve youthful offenders in the juvenile justice system from this monograph will have maximum national impact only if what is being learned is widely disseminated. Further improvement in how youth with emotional disabilities are treated will occur only if the program innovations which are emerging in the field get applied in new settings. Often, those working with this population are not aware of what is happening in the next state, or even the next county. When innovative and effective service programs can be identified, there may be many organizational and financial problems/barriers to overcome before such a model program can be implemented.

As a new century approaches, change is all around us. It is hoped that this monograph will identify new means which are being developed, often in fits and starts, across America to help to address the mental health needs of youth who are seriously emotionally disturbed and mentally ill in the juvenile justice system.

There are many people who have been absolutely crucial to the completion and success of this monograph. It represents the culmination of a project spanning over a year. It has been an ambitious undertaking to develop and describe the critical problems confronting youth in the juvenile justice system who are emotionally disabled.

In Joe Cocozza, we had the guidance of an editor of extraordinary gifts. From the onset, his knowledge and insightful comments helped us to improve the structure and contents of the monograph.

Special thanks to Mike Johnson for his expertise and unflagging support of this project.

Thanks to Joel Dvoskin, whose boundless energy provided us valuable and generous support.

We are grateful for the outstanding devotion to this population group, despite their busy schedules, of Eric Trupin and Jana Ewing, who served as facilitators at the National Work Session. A special thank you to Pauline Pagliocca for agreeing, at the last minute, to present Chapter Four, and to Tom Backer for helping wherever needed at the work sessions.

We thank all the writers of the chapters who unselfishly served as facilitators and whose labors significantly contributed to the success of the work groups: Mareasa Isaacs, N. Dickon Reppucci and Richard Barnum. Also, we appreciate the special assistance provided by Randy Otto, Sharon Gross, Jennifer Woolard and John Whitbeck.

Many others made contributions to Chapter Seven, particularly Pat Arthur, Lynn Davidson and Rose Oreskovich. We are deeply indebted to Katherine Donner, who helped during the year of planning and contributed so much to the success of the advisory and national planning meetings.

A special note of gratitude to Marsha Glaziere for her artwork on the cover page.

Lastly, we owe a great deal to the stakeholders listed in the Appendix from all the national associations, universities, juvenile justice and mental health agencies, and the families that are graciously helping us to see with new eyes. To all of the above, we owe our heartfelt thanks.

Susan Rotenberg
Executive Director
National Coalition for the Mentally Ill
in the Criminal Justice System

TABLE OF CONTENTS

Chapter 4: continued

CHAPTER 1

INTRODUCTION

Joseph J. Cocozza

OVERVIEW

A decade ago, Jane Knitzer wrote in her study Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services (1982):

> Children who are charged with status offenses or delinquent acts and show a range of emotional or behavioral disorders pose a complex and unsolved challenge for the juvenile justice and mental health systems.

The title of the relevant section of her work, "Juvenile Justice and Mental Health: The Forgotten Mandate," captures her primary conclusion -- these youth and their needs have been consistently neglected.

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

What we do know is that this population places great stress on the system and that their needs have been largely ignored. These are the youth who are seen as "bad" and "mad," both delinquent and mentally ill. As such, they are youth who cause uncertainty for the service delivery systems, frequently bouncing back and forth between systems, and often being rejected as inappropriate for care by all given their multiple and complex needs. Occasionally, special programs and efforts will be undertaken, particularly for highly visible sub-groups of the population such as the violent juvenile offender (Cocozza, Hartstone and Braff, 1981). In general, however, little attention has been given to them. As Fagan (1991) points out, "research over the past 10 years has found few efforts to develop programs and services for mentally disordered juvenile offenders." As he and others have discussed, there are probably a number of factors that contribute to this service gap. But regardless of the reasons, the consequences of this neglect are clear: their needs remain unmet by a confused system of care that lacks the ability to adequately assess and address the youth who come in contact with the juvenile justice system and who require mental health services.

This monograph is a part of an effort by the National Coalition for the Mentally Ill in the Criminal Justice System to respond to this complex and unresolved challenge by developing and advocating a national policy for improving the delivery of mental health services to youth in the juvenile

justice system. Organized in June 1989, the National Coalition has been working over the past several years to inform a wide range of policy makers and administrators in criminal justice and mental health at the state, local, and federal levels about the needs of the adult mentally ill offender and to advocate for needed changes. With this current effort, the National Coalition is attempting to bring the same kind of attention to the mental health needs of youth in the juvenile justice system. This monograph is the starting point for this work.

The monograph represents an attempt to systematically review, summarize and assess in a single document what we know, and what we do not know, about mentally disordered youth in the juvenile justice system. It provides a comprehensive, state-of-the-art picture of the available body of research on this population.

The comprehensiveness of this monograph further underscores the lack of prior research on this group of youth. When the National Coalition brought together a number of national experts to seek their advice on the Coalition's planned activities, most of them suggested that, given the paucity of research on this topic, the monograph should focus on addressing a series of basic questions. The key issues they raised included questions such as: Who are these youth and how many of them are there?; What key legal issues effect their care and treatment?; Are there certain service models which are more effective for these youth?; and What cultural and racial variations exist in the types of services needed and provided? Based on these questions and discussions, the main topics to be covered in the monograph were identified.

ORGANIZATION OF THE MONOGRAPH

In addition to this introductory section, the monograph consists of five main review chapters. As described later, the last chapter, Chapter 7, presents issues and recommendations that resulted from a National Work Session sponsored by the National Coalition.

Each of the five main chapters focuses on a different topic. These topics are:

- **The Population.** The definition and prevalence of mental illness among the population of youth involved with the juvenile justice system.
- **Service Systems.** The various structural, organizational, and funding arrangements currently used to support services for this population.
- **Legal Context.** The critical legal issues surrounding their identification and treatment.
- **Program Models.** Available service models throughout the country that represent effective and innovative models.
- **Cultural Competence.** Cultural and racial variations in the type of services needed and delivered.

The author of these chapters were provided with three guidelines:

1. - to focus on youth with mental disorders in the juvenile justice system;
2. - to identify, summarize and integrate available studies and findings in order to describe what we know and what we don't know about each topic; and,
3. - to assess the research in terms of its implications for policies, programs and future research.

The purpose of the first of these guidelines was to attempt to narrow the focus of the work to a specific population of youth -- those involved with the juvenile justice system who require mental health services -- while at the same time recognizing that youth with similar characteristics and problems can be found in a variety of settings (e.g., foster care and special education programs).

The phrase "the juvenile justice system" is meant to include youth who have formal contact with some component of the system including juvenile correctional agencies and family courts. Phrases such as "mentally ill youth" or alternatives such as youth with serious emotional disturbances, mental disorders, or mental health problems are meant to include primarily youth with serious disturbances (e.g., those admitted to a psychiatric program or facility, or those meeting DSM-IIIR diagnosis criteria). At the same time, given the lack of consistency in the use of these terms in the research literature and the relevance of other issues such as prevention, information and studies were included even though they employed broader definitions of the target population.

The first of the review chapters by Otto, Greenstein, Johnson and Friedman addresses the parameters of the problem -- what is the prevalence of mental disorders among youth in the juvenile justice system? This work highlights how little we know. Their chapter includes a review of prevalence estimates for the general population of youth, and an analysis of 34 identified research studies conducted between 1975 and 1992 that provide information on the prevalence of mental disorder specifically on youth in the juvenile justice system. The authors discuss their findings within the context of the serious inadequacies they find in the existing body of research. An important part of this chapter is the detailed recommendations the authors offer for the type of research needed to more accurately establish prevalence rates for this population and for the development of systematic procedures for screening and evaluation of this population.

Barnum and Keilitz in their chapter help us to understand the organizational functions and structures that are involved in addressing the mental health needs of youth in the juvenile justice system by describing the complex patterns of interactions and the overlapping functions of the relevant agencies. The authors also review a series of issues, such as defining mental illness and assessing appropriateness for care, in a way which is both enlightening and practical. Also noteworthy is their discussion of four common patterns or models of organizing services: agency - centered, collaborative, child-centered and family-centered. Finally, they describe what they judge to be the components for ideal systems of care for this population. Interestingly, they view this ideal approach not as eliminating the conflict between the goals and practices of the involved systems but as developing "fair and reliable means of resolving such conflicts, in accordance with law and explicit public policy."

The next chapter by Woolard, Gross, Mulvey and Reppucci articulates a reality that underlies many of the issues raised throughout the monograph -- the currently confused mission of the juvenile justice system that seeks to balance the often conflicting goals of individual treatment and community

safety. Most of this chapter is a careful review of the adequacy of existing legal provisions for addressing the variety of mental health issues encountered by juveniles as they move from intake to placement and service provision. The relevance and adequacy of various rights and legal standards such as Miranda, waiver to adult courts, competency, insanity defenses, and amenability to treatment are examined and, in general, found to be in need of improvement and clarification. Of particular importance are the authors' recommendations, especially regarding the need to establish a legal right to treatment for these youth.

Given the documented failure of most intervention strategies to demonstrate any success with this type of population, are there any approaches which are being implemented in the country that appear to be providing effective treatment? In a very important piece, Melton and Pagliocca convincingly argue in Chapter 5 that the answer may be yes. Not only do they describe concrete examples of promising treatment models, but these innovative approaches share common characteristics. Furthermore, as they point out, these characteristics are consistent with a set of principles of effective treatment which are being recognized by both mental health and juvenile justice professionals. These promising models emphasize flexible, integrated approaches that maximize individualized, home-and neighborhood-based services.

The last of the research review chapters focuses on a sub-group of the target population -- children and adolescents of color. As Isaacs clearly demonstrates, these youth are overrepresented in the juvenile justice system and underserved in the mental health system. She documents the findings of racial discrepancies in placement decisions and the provision of mental health services and argues that both systems fail youth of color for exactly the same reasons, "the lack of culturally appropriate and competent tools, staff and programs." While this chapter's topic is different in scope from the others, it is clearly as critical. Many of the issues raised in the other chapters, such as the inadequacy of data on prevalence rates and the absence of screening instruments, are even more severe for this group of youth. Finally, the chapter identifies several developing concepts and models that show some promise for more effectively addressing the needs of youth of color.

As described in the final chapter, the National Coalition, in the Spring of 1992, brought together a group of national experts for a three-day National Work Session. The task of the attendees was to review an earlier draft of this monograph, identify the key issues facing mentally ill youth in the juvenile justice system based on the information contained in the monograph and on their own expertise, and recommend actions and strategies for more effectively responding to the needs of these youth. The chapter by Whitbeck represents a summary of the results of this three-day session. The work of each of the groups that were formed to address the five review chapter topics is described with an emphasis on the critical issues discussed and the group's recommendations for action. In addition, the chapter includes the series of steps identified by the group that were seen as forming the beginnings of a National Policy Action Plan.

COMMON THEMES

The chapters in this work vary significantly not only in their topics but also in their perspectives, reflecting the different backgrounds and priorities of the authors. At the same time, there is a remarkably high degree of consistency across all of the chapters around a number of common findings.

Among the common themes that emerge from these chapters are the following:

- Because of the complex needs of these youth and their impact on the service delivery systems, significantly more attention must be given to clarifying and strengthening the legal, programmatic, administrative and policy framework that affects them.
- The existing body of research is inadequate and frustrates attempts both to understand this population and to establish responsive service delivery systems for effectively meeting their needs.
- There continues to be much confusion and conflict within individual systems and across multiple systems regarding the goals and responsibilities for this population of youth.
- Despite the limitations of the research, findings indicate that the prevalence of mental disorders for youth in the juvenile justice system is significant and appears to be substantially higher than the rate for the general population of youth, for whom estimates range from 14% to 22%.
- There is a growing recognition of the high degree of comorbidity that exists between mental disorders and substance abuse disorders for these youth and of the significant implications of this trend for assessment and treatment services.
- The relevant systems of care tend to be culturally-biased from the point of assessment through treatment, resulting in inadequate responses to the needs of youth of color.
- For the most part, current mechanisms and instruments for systematically screening and evaluating these youth are nonexistent and current treatment approaches are ineffective.
- There are a number of promising, innovative models being tested and implemented across the country that appear to successfully respond to the needs of these youth by incorporating key design elements such as individualized care, integrated services, flexible funding, family involvement and community-based services.

It is clear from the work contained in this monograph and from this overview of common themes that much more must be done if the needs of these youth are to be effectively addressed. This monograph represents a very important step in meeting the challenge by filling a knowledge gap that has existed for too long. However, many more steps must be taken not only by researchers, but also by advocates, public officials, service providers, policymakers, families, and others in order to successfully respond to the mental health needs of these youth in the juvenile justice system.

REFERENCES

Cocozza, J.J., Hartstone, E., & Braff, J. Mental health treatment of violent juveniles: An assessment of need. Crime and Delinquency. 17, 487-496, 1991.

Fagan, J. Community-based treatment for mentally disordered juvenile offenders. Journal of Clinical Psychology. 20, 42-50, 1991.

Knitzer, J. Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services. Washington, D.C: Children's Defense Fund, 1982.

CHAPTER 2

PREVALENCE OF MENTAL DISORDERS AMONG YOUTH IN THE JUVENILE JUSTICE SYSTEM

Randy K. Otto
Jonathan J. Greenstein
Michael K. Johnson
Robert M. Friedman

INTRODUCTION

The purpose of this chapter is to review the research literature on the prevalence of mental disorders among youth in the juvenile justice system, and to discuss some of the critical issues related to determining prevalence rates for this population. From the outset it should be noted that the research literature on the prevalence of mental disorder among children and adolescents in the juvenile justice system is not well-developed and the quality of work varies considerably. The number of studies is fewer than might be expected given the number of youth in the juvenile justice system and their needs.

Following a discussion of general issues, including factors which might explain the inadequacies in the research literature, a summary of the literature addressing the prevalence of mental disorders among the general population of children and adolescents is presented. Prevalence rates among the general population of youth are viewed as providing minimum estimates of mental disorder among youth in the juvenile justice system. They are considered minimum estimates because there is little reason to believe that youth with mental disorders are under-represented in the juvenile system. In fact, the currently available prevalence data indicate that mentally ill children are over-represented in the juvenile justice system.

After summarizing the findings, recommendations are offered for improving the nature and scope of prevalence research. A strong call is made for a multi-state study examining the prevalence of mental disorders among children involved at various points in the juvenile justice system. Finally, recommendations for mental health screening and evaluation of juveniles at various points in the system are presented.

GENERAL ISSUES

There are a number of general issues that must be addressed in order to set the context for understanding the findings on prevalence presented later in the chapter. The first four of these issues relate to the definition and measurement of mental disorders, the next two help to clarify the scope of this review and the last discusses the status of research on this population.

Definitions and Terms

First and foremost, the use of the term "mental disorder" should not be taken to indicate any kind of assumptions regarding the etiology of the various disorders discussed. "Mental disorder" could be interchanged with a variety of terms such as "mental illness," "emotional difficulties," "psychopathology," "emotional disorders," or "behavior disorders."

For purposes of this chapter, the term mental disorder is used very broadly. The review covers the broad spectrum of mental disorders that can affect children and adolescents, ranging from more severe and pervasive disorders (e.g., psychotic disorders, major affective disorders, pervasive developmental disorders, mental retardation) to more circumscribed disorders (e.g., attention deficit disorder, conduct disorders, specific developmental disorders).

This broad spectrum of disorders are included for two reasons. First, many disorders, including the less severe or pervasive ones, have the potential to be inextricably linked to a particular child's involvement with the juvenile justice system. Indeed, it is this assumption that in many ways forms the basis for the traditional, treatment-based juvenile justice-social service system.[1] For example, a child with a learning disability might have difficulty performing in school. He or she might begin to exhibit externalizing behaviors which translate into delinquent acts outside of school. In this case, the specific developmental disorder is an issue with respect to this child's delinquent behavior and subsequent involvement in the juvenile justice system.

Second, it is reasonable to expect that there are a large number of youth who, while their mental disorder is not causally linked to their delinquent behavior, nonetheless, must be treated while they are in the juvenile justice system. For example, an older adolescent may engage in a pattern of assaultive behavior directed towards both peers and adults. In response to incarceration for this behavior, the adolescent may experience a severe depression. In this case, the depression may be more related to the arrest and incarceration than the actual delinquent behavior but it still must be identified and treated. Thus, for purposes of this chapter, "mental disorder" is defined broadly.

This review is guided by the most recent diagnostic and statistical manual of the American Psychiatric Association, DSM-III-R (American Psychiatric Association, 1987), and covers the range of disorders included in DSM-III-R. However, much of the research received in this chapter was conducted prior to the development of the DSM-III-R (using DSM III, American Psychiatric Association, 1980). Certainly, the use of different diagnostic systems over time is one of the impediments to drawing firm conclusions from the research particularly with regard to determining the

---

[1] It is acknowledged, however, that the juvenile justice system appears to have shifted from this traditional paternalistic, treatment orientation to a more retribution and rights-based model over the past two decades.

extent to which prevalence rates for mental disorders in the juvenile justice population have changed across the years. For example, important changes were made in the categories of conduct disorder, and the criteria, between the earlier manual, DSM-III, and the revised version, DSM-III-R, creating a special problem since this diagnosis is one of the most prevalent in the juvenile justice population.

From a clinical, epidemiological, and policy perspective, it is important to determine whether obtained rates of a particular disorder in recent studies indicate a pattern of increasing (or decreasing) prevalence for that particular disorder, or simply reflect a higher rate because of changed definitions and criteria. The absence of a consistent diagnostic system over time makes this especially difficult.

Specific Diagnoses and Co-Morbidity

Many of the studies that have been conducted report only a single diagnosis for each youth. Yet, the research is increasingly indicating that there is a high rate of co-occurrence or comorbidity of mental disorders in children and adolescents (Anderson, Williams, McGee, & Silva, 1987; Caron & Rutter, 1991; Greenbaum, Prange, Friedman, & Silver, 1991; Kashani, Beck, Hoeper, Fallahi, Corcoran, McAllister, Rosenberg, & Reid, 1987; & Silver, Duchnowski, Kutash, Friedman, Eisen, Prange, Brandenburg, & Greenbaum, 1992). For example, in a group of youngsters identified by public mental health or education systems as having a serious emotional disturbance, Silver et al. (1992) found that the mean number of diagnoses per youngster, using a structured diagnostic interview that permitted multiple diagnoses per youngster, was 1.38 at the severe level and 3.56 at the mild level. In this study, approximately half of the youngsters with a conduct disorder diagnosis had at least one other diagnosis in the emotional domain. Anderson et al. (1987) reported that of 14 children in their general population sample with a depressive disorder, 11 had at least one other psychiatric condition.

As Caron and Rutter (1991) indicate, the results of epidemiological research in child mental health indicate that the observed rate of comorbidity exceeds the rate that would be expected by chance alone. Given this, research that reports only on a single diagnosis per youngster may be misleading. There is a need to understand comorbid patterns and not just single diagnoses.

Developmental Pathways, Risk Factors, and Protective Factors

In addition to the increased epidemiological focus in recent years on research that examines comorbid patterns, another significant change has been the evolution of the related fields of developmental psychopathology and developmental epidemiology. Within these fields, the basic research paradigm is longitudinal with a particular emphasis on prospective longitudinal research.

Such research has the potential to identify specific and general risk factors, as well as protective factors for different mental disorders and delinquent patterns. Thus, common developmental pathways leading to particular disorders can sometimes be identified. Information on such pathways, and the associated risk and protective factors, is of critical importance in developing early intervention programs, and in increasing attention to the full range of needs of children and families.

Loeber (Loeber, 1982, 1988, 1990, & 1991b) is engaged in a prospective longitudinal study in Pittsburgh, beginning with children as young as the first grade. He indicates that, within developmental pathways, behaviors often become more organized and differentiated over time, and more serious behaviors typically take place further into the pathway rather than in the early stage. As part of this developmental perspective, Loeber identifies separate risk factors for disruptive behaviors that occur at different developmental stages. For example, he identifies baseline risk factors such as exposure to

neurotoxins and neurological insult, as being a risk factor in infancy, disruptions in caretakers' socialization practices as being one of the risk factors from the toddler years onward, and poor academic achievement as being a risk factor from mid-childhood onward.

Although it is beyond the scope of this paper to review, in detail, the findings on risk factors, protective factors, and developmental pathways, it is important to recognize the contribution that this type of research can make to understanding youth in the juvenile justice system, and to developing effective prevention programs and intervention strategies.

Changes Over Time

Lee Robins (1988), one of the most noted researchers on antisocial behavior, has specifically examined changes in the rate of conduct disorder over time. She did this based on retrospective data from adults who were studied as part of the NIMH-sponsored Epidemiological Catchment Area (ECA) Program. Since the adults included in the ECA study were of all ages, they represented a succession of historical cohorts. Participants were asked to report whether they had engaged in particular behaviors as children. Robins found that the proportion qualifying as having had conduct disorder was greater in the younger birth cohorts than in the older ones. Of the males in her youngest cohort group (aged 18-29), 36% would have earned a label of conduct disorder based on their adolescent behavior while only 6% of the males in her oldest cohort group (65 and over) would have earned such a label based on their adolescent behavior. For females, the youngest cohort group (18-29) had a rate of 13% while the oldest cohort group (65 and over) had a rate of 0.5%.

Earls (1989) indicated that "cultural changes in the United States also seem to have brought on new vulnerabilities in children, reflected in higher rates of completed suicide and an early age of onset for some types of psychiatric disorders." He included in this category such problems as depression, bipolar affective disorder, and alcohol and drug abuse. Thus, there is at least some epidemiological research which suggests that the rates of some disorders have increased considerably over the years.

Other Characteristics of Youth Served in the Juvenile Justice System

As indicated above, the specific purpose of this chapter is to review the literature on prevalence of mental disorders among children and adolescents in the juvenile justice system. This focus is not intended to diminish the importance of other factors which contribute to a full understanding of youth in the juvenile justice system. These other factors include strengths and special interests of the child, educational abilities, physical health, and social and adaptive behaviors. A full understanding of the children served in this system also requires an understanding of each child's family, including factors such as the family's structure, strengths, culture, history, and their perception of the situation.

Models of Delinquency

The focus of this paper is on the psychological characteristics of youth in the juvenile justice system; it is not intended to be a review of alternative models of delinquency (e.g., psychological versus sociological). It is recognized that there are a variety of social factors that affect delinquency directly and also that affect it indirectly by creating risks for psychological dysfunction. The chapter's focus is not intended to diminish the importance of social factors.

Loeber (1991a) included in his list of risk factors, for example, exposure to violence on television and association with delinquent peers. Quay (1987), in discussing the problem of conduct disorders, has made the distinction between "socialized" conduct disorders, where the antisocial

behavior seems to be largely a result of social and cultural influences, and "unsocialized" conduct disorder, where antisocial behavior is more likely to be the result of psychological and/or neurological factors. There are also models of delinquency based on factor analytic procedures. These often build on dimensional systems of describing youngsters, based on instruments such as those developed by Achenbach (1991) and Quay and Peterson (1987). The information from these models is useful but a full discussion of them is beyond the scope of this paper.

Current Research

A review of the literature addressing the issue of youth with mental disorder in the juvenile justice system suggests that little more attention has been paid to this population in the past 15 years than was paid in the 15 years prior to that. This can be explained by a number of factors. Perhaps most important, is the issue of crime. The claims regarding how the needs of youth with mental disorders who are in the juvenile justice system are largely understudied and ignored parallel the observations made by authorities addressing the needs of adults who have mental disorders and are in criminal justice system. It is generally agreed that adults who have mental disorder and are in the criminal justice system are provided with inadequate mental health services (e.g., Otto & Ogloff, 1988; Ogloff & Otto, 1989; Steadman, McCarty & Morrissey, 1989).

Various reasons for this lack of adequate attention and care have been identified. These include: 1) persons with mental illness, in general, suffer from stigmatization in the eye of the public, 2) persons with mental illness who are in the criminal justice system are not of immediate concern to the public because they are out of view, 3) persons who commit crimes and are mentally ill are considered less deserving of treatment than their non-criminal counterparts, and 4) the public's general dissatisfaction with the rehabilitation model of corrections. Put more simply, adults who are mentally ill and involved in the criminal justice system suffer on two counts with respect to receiving adequate study and treatment — they are mentally ill and they have been accused or convicted of committing crimes.

The lack of attention to youth with mental disorder in the juvenile justice system may be influenced not only by the above factors but also by issues relevant to children more specifically. It has been established that the needs of children with mental disorder who have no involvement with the juvenile justice go unmet in many ways (Knitzer, 1982; Office of Technology Assessment, 1986). There is no reason to expect any better for their counterparts in the juvenile justice system, given the added stigma associated with criminal activity.

PREVALENCE OF MENTAL DISORDERS IN THE GENERAL POPULATION OF YOUTH

The ECA program (Eaton, Holzer, Von Korff, Anthony, Helzer, George, Burnam, Boyd, Kessler, & Locke, 1984; Regier, Myers, Kramer, Robins, Blazer, Hough, Eaton, Locke, 1984) was established to determine prevalence rates of mental disorders among adults in the United States. It has made significant contributions in the areas of case definition, methodology, and instrumentation, and has clearly moved the field of psychiatric epidemiology forward with respect to adult populations. Consistent point prevalence estimates, incidence rates, and lifetime risk estimates for most of the major categories of mental disorder have been established as a result of the ECA efforts and related studies. Children's mental health, however, has not benefitted from such a coordinated epidemiologically

focused study or series of studies. While epidemiological research focused on children and adolescents not only exists but has improved in recent years, there is a general lack of consistency across studies regarding definitions of disorders, methods, and data analysis.

Prevalence Estimates of Mental Disorders

In their review of 25 studies conducted in the U.S. from 1928 to 1975 involving "school age" children, Gould et al., 1981 reported the median prevalence rate of "childhood maladjustment" to be 11.8%. They concluded, however, that this figure underestimated the true prevalence rate. Prevalence rates in studies that reported parents' estimates of childhood maladjustment ranged from 10.9% to 37%, while studies that used teachers' ratings ranged from 6.6% to 22%. The studies reviewed by Gould et al. were based almost exclusively on teacher reports although they used a variety of sampling techniques, instruments, and definitions of maladjustment. Rather than presenting information on prevalence rates for specific diagnostic conditions, or comorbid relationships, Gould et al. presented estimates of a global condition called "childhood maladjustment."

Links (1983) reviewed 16 community surveys, which represented a heterogeneity of methods, definitions, and data sources. Although these studies included widely diverse cultures (e.g., inner-city Chicago, the Sudan, the Isle of Wight), and a wider age range (0 to 18 years), the prevalence rates, again for a global condition, were approximately equal to those obtained by Gould et al. As shown in Table 1, Costello (1989), in a review of six recent studies, found higher rates, ranging from 17.6% to 22%.

In a review of eight more recent studies which involved samples of children whose ages ranged from four to 16, Brandenburg, Friedman, and Silver (1990) found general prevalence estimates of mental disorders that were higher, ranging from 14% to 20%. These authors noted that estimates across studies were remarkably consistent, despite quite heterogeneous samples, methods, and measures in some instances. These estimates were based on research conducted in the 1980s using general community samples.

Based on the most recent estimates offered by Brandenburg et al. (1990) of the prevalence of disorders found in the general child population (14% to 20%) and a child population of approximately 68 million (Bureau of the Census, 1991), it can be concluded that between 9.5 and 13.6 million children in the United States suffer from a diagnosable mental disorder at any given time. Using Costello's (1989) somewhat higher upper figure (22%) would result in an estimate of as many as 15 million children suffering from a diagnosable mental disorder at any given time.

Most reviewers who have addressed the issue of prevalence of mental disorders among youth have provided only global estimates of "maladjustment." Several studies conducted over the last decade, however, have attempted to identify prevalence rates of specific disorders among community samples of youth who ranged in age from four to 20. These studies represent significant advances in the field, in that the investigators uniformly sought similar sets of multiple informants, relied upon sophisticated sampling techniques, and utilized a variety of standardized measures.

Table 1

Prevalence Rates of DSM-III Diagnoses in Nonclinic Samples[δ]						
	Anderson et al. (1987)	**Bird et al. (1988)**	**Velez et al. (1989)**	**Costello et al. (1989)**	**Offord et al. (1989)**	**Kashani et al. (1987)**
Informants	Child (Interview) Parent (Checklist) Teacher (Checklist)	Child (Interview) Parent (Interview)	Child (Interview) Parent (Interview)	Child (Interview) Parent (Interview)	Parent (Checklist) Teacher (Checklist) Child (Checklist)	Parent (Interview) Child (Interview)
N	782	777	776	789	2,679	150
Sample Ages	11	4-16	11-20	7-11	4-16	14-16
Diagnoses: Attention deficit disorder (w/wo hyperactivity)	6.7%	9.9%	4.3%	2.2%	6.2%	2.0%
Oppositional disorder	5.7%	9.5%	6.6%	6.6%	NA	6.0%
Conduct disorders (all types)	3.4%	1.5%	5.4%	2.6%	5.5%	8.7%
Separation anxiety	3.5%	4.7%	5.4%	4.1%		8.7%#
Overanxious disorder	2.9%	NA	2.7%	4.6%	9.9%*	.7%
Simple phobia	2.4%	2.3%	NA	9.2%		
Depression, dysthymia	1.8%	5.9%	1.7%†	2.0%		8.0%
Functional enuresis	NA	4.7%	NA	4.4%	NA	.7%
One or more diagnoses	17.6%	18.0% ± 3.4%	17.7%	22.0% ± 3.4%	18.1%	18.7%

* "Emotional disorder."

† Major depression.

\# Anxiety disorder.

δ *Note.* From "Developments in Child Psychiatric Epidemiology." by E.J. Costello, 1989, Journal of the American Academy of Child and Adolescent Psychiatry, 28, p.838. Copyright American Academy of Child and Adolescent Psychiatry. Reprinted and adapted by permission.

Based on the high and low estimates of the prevalence rates for specific DSM-III disorders summarized in Costello (1989), and Kashani et al. (1987), the following figures can be offered:

Attention deficit disorder with/without hyperactivity
1.4 to 6.7 million (2.0% to 9.9%),

Oppositional disorder
3.6 to 6 million (5.7% to 9.5%),

Conduct disorder, all types
1 to 5.9 million (1.5% to 8.7%),

Over-anxious disorder
.5 to 6.7 million (0.7% to 9.9%),

Affective disorders, depression/dysthymia
1.2 to 5.4 million (1.7% to 8%),

Phobias
1.5 to 6.2 million (2.3% to 9.2%),

It should be noted, however, that these rates vary with age. Conduct disorder and depressive disorders were reported by Costello (1989) to be greater in adolescents than in young children, while anxiety disorders decrease after puberty. These age differences are important to keep in mind since youth in the juvenile justice system are primarily adolescents.

Prevalence Estimates of Substance Abuse

Several investigators have studied the prevalence of alcohol and drug use and abuse among youth in the United States. Johnston et al. (1991) found that 90% of high school seniors reported that they had consumed alcoholic beverages at least once in their lives. Occasions of heavy drinking (defined by reports of having consumed five or more drinks in a row at least once during the previous two week period) were reported by 32% of the high school seniors. A substantial gender difference was noted in the prevalence of heavy drinking with 39% of males versus 24% of females reporting heavy drinking. Johnston and his colleagues also indicated that the use of any illicit drug among high school seniors declined from 1989 levels by three percent to 33% in 1990, continuing a longer term gradual decline. This study sampled a representative number of high schools from across the country. As a result, high school dropouts are not included and there may be reason to believe that rates of abuse may be substantially higher in this group.

The National Household Survey on Drug Abuse (National Institute on Drug Abuse, 1991) selected a probability sample of households from across the United States. Forty-eight percent of the surveyed youth between the ages of 12 and 17 reported using alcohol on one or more occasions. Twenty four percent of this age cohort reported that they had used alcohol within the previous month, with 2% of the cohort being identified as heavy drinkers (five or more drinks at one sitting or within a couple of hours). Within this group of heavy drinkers, males were approximately four times more likely to be identified than females. Of those respondents 12 to 17 years old, 8.1% reported some illicit drug use within the previous month, while 23% reported some use of illegal drugs in their lifetime.

The National Youth Survey (Elliot, Huizinga & Menard, 1990) is a longitudinal study of delinquent behavior, alcohol and drug use, and problem-related substance use among American youth. For the years 1976 through 1980, Elliot et al. present age specific trends of substance use for youth ages 15 to 17. The mean prevalence rates for these youth were: alcohol use, 74%, marijuana use, 37%, and polydrug use, 11%.

Using the prevalence rate of heavy drinking (2%) reported in the National Household Survey (National Institute on Drug Abuse, 1991) and the prevalence reported by Johnston et al. (1990, 32%) as ranges of alcohol abuse among youth in the United States, it is estimated that between 480,000 and 7,700,000 youth between the ages of 11 and 18 may abuse alcohol in some way. Using the data reported by Elliott et al. (1990) regarding polydrug use (11%) as a gross estimate of the level of substance abuse, it is estimated that approximately 1.1 million youth between the ages of 15 and 17 may suffer from a diagnosable substance abuse problem.

Greenbaum et al. (1991) have examined comorbidity of substance abuse and other mental disorders. They sought to determine rates of comorbidity in a sample of youth that had originally been selected because of emotional disorders. They found a significantly increased likelihood of a diagnosis of marijuana or alcohol abuse/dependence if the youngster also had a diagnosis of conduct disorder or depression. Amongst youngsters with a severe conduct disorder, as measured on the Diagnostic Interview Schedule for Children, the prevalence rate for either a marijuana or alcohol disorder was 36.1% compared to a prevalence rate of 9.3% for youngsters without a conduct disorder diagnosis. Similarly, for youngsters with a diagnosis of depression, the prevalence rate for marijuana or alcohol abuse/dependence was 48.3% compared to 17.4% in youngsters without a diagnosis of depression.

The study conducted at the Florida Mental Health Institute, which provides the data base for the above work by Greenbaum et al. (1991), and Silver et al. (1992) includes a longitudinal component. It is noteworthy in this regard, that in this sample of children with serious emotional disorders, none of whom were in a juvenile justice facility at the start of the study, 10% were residing in some type of juvenile justice placement after three years.

Extrapolating from the General Population: Prevalence Estimates of Mental Disorders Among Youth in the Juvenile Justice System

Estimates from the National Juvenile Court Data Archives maintained by the National Center for Juvenile Justice (Synder et al., 1992) indicate that there were approximately 1,265,900 cases that were referred to juvenile courts in 1989, the last year for which data are available. This figure includes all delinquency and status offense cases that were handled by juvenile courts regardless of the referral agent (e.g., police, schools, social services) or the outcome (e.g., dismissed, waived, adjudicated) and represents court cases not individual youths.

The National Center further estimates that these cases represent approximately 848,100 individual juveniles who came in contact with the court each year. Using Brandenburg et al.'s (1990) general prevalence rates of psychiatric disturbance of 14% to 20%, and Costello's (1989) upper limit of 22%, it can be assumed that at a most conservative level, between 118,700 and 186,600 youth who come in contact with the juvenile justice system meet diagnostic criteria for at least one mental disorder. It is also estimated that between 17,000 and 271,400 of these youth suffer from a diagnosable alcohol abuse or dependence disorder, while approximately 93,300 youth may suffer from a diagnosable substance abuse/dependence disorder at any given time.

National Juvenile Custody Trends 1978-1989

(Krisberg, DeComo, & Herrera, 1992) reports that 94,000 juveniles were being held in public and private juvenile justice facilities on any given day in 1989. With the general prevalence rates of psychiatric disturbance

offered by Brandenburg et al. (1990) (14 to 20%) and the upper limit offered by Costello (1989) (22%), it is conservatively estimated that, on a daily basis, between 13,200 and 20,700 youth who are in custody in the juvenile justice system meet diagnostic criteria for at least one mental disorder, and between 1,900 and 30,100 of these youth suffer from a diagnosable alcohol abuse or dependence disorder, and approximately 10,300 youth may suffer from a diagnosable substance abuse/dependence disorder.

PREVALENCE OF MENTAL DISORDERS AMONG YOUTH IN THE JUVENILE JUSTICE SYSTEM

There have been a number of studies that have attempted to estimate the prevalence of mental disorders among youth in the juvenile justice system. There are considerable differences across these studies. The research methods, assessment techniques, and settings in which they have taken place vary considerably. While this provides a wealth of data, it also makes drawing general conclusions about prevalence rates for this population very difficult. Among the most important factors influencing the findings of these studies are:

1) when the study was conducted (as conceptualizations of mental disorder change over time, the identification of particular disorders and their corresponding prevalence rates will vary; similarly, rates of disorders will also vary as social systems and social factors, such as the incidence of child abuse change over time),
2) demographics of the samples (e.g., age, race, gender),
3) setting in which the study took place (e.g., "outpatient" court clinic, community-based detention center, foster care, halfway house, state training school, special mental health program/unit within an institution),
4) status of subjects (i.e., pre-adjudication versus post-adjudication),
5) length of time in facility/setting when subjects were evaluated (e.g., 24 hours versus 12 months),
6) sampling procedure (e.g., evaluation for suspected mental health problems versus random sample of institutionalized juveniles),

The factors identified above can be expected to affect prevalence rates. That is, we might expect different prevalence rates across different settings, at different times in a juvenile's processing, and with different sub-populations (e.g., higher rates of mental disorder among juveniles referred for evaluation because of suspected disorder than among the general population of juvenile offenders).

Another factor that affects the interpretability of existing studies is the variation in the methods used to assess subjects. This is particularly important with regard to:

1) the assessment approaches used (e.g., record review, clinical interview, structured diagnostic interview, general disorder/behavioral instruments, focused assessment instruments, caretaker interview), and
2) the classification or analysis of mental disorders employed (DSM-III-R diagnoses, educational classification, behavioral descriptions, mean test score differences)

Such variations limit the descriptions that can be offered generally about this population of youth. Some classification schemes are so broad and vague that they are of little use in documenting and describing the problems, abilities, and deficits of this population (e.g., the educational classifications of "severely emotionally disturbed." Other approaches are more precise, yet still fail to provide detailed behavioral description of the

population (e.g., DSM-III-R diagnoses), and other measures, while they provide more specific descriptions of behaviors and adjustment of a particular sample, do not facilitate discrete classifications (e.g., mean test profiles).

Table 2, presented at the end of the chapter, summarizes the methodological design and primary findings of 34 studies conducted between 1975 and 1992. These 34 studies represent documented research efforts that provide information about the prevalence of mental disorder among youth in the juvenile justice system. While all of these provide important information, the following review will emphasize those that either employed a random sampling procedure or implemented a comprehensive procedure for obtaining data such as including all cases admitted during a certain period of time. The results of these studies should be interpreted in light of the issues noted above. Included below is a summary of the findings and a discussion of their significance. The diagnostic categories in the table were chosen based on our review of the research. First reviewed are prevalence rates for different diagnoses. Subsequently, other findings relevant to mental disorder and emotional adjustment, but not specific to diagnosis, are considered.

Diagnostic Categories

Conduct Disorder

As might be expected, conduct disorder is more prevalent than any other diagnosis among youth in the juvenile justice system. Of the studies reviewed, eight employed random or comprehensive sampling procedures and provided rates for conduct disorder (Cairns et al., 1988; Cocozza & Ingalls, 1984; Davis et al., 1991; Friedman & Kutash, 1986; Halikas et al., 1990; Hollander & Turner, 1985; McPherson, 1991; Student & Myhill, 1986). The rates reported vary considerably — from 10% to 91%. Five of the nine studies report rates of 81% or above. The two studies which reported the lowest estimates (Friedman & Kutash, 1986 — 10%; Cocozza & Ingalls, 1984 — 30%) did not employ interviews with the subjects in their assessment techniques. Also, the large discrepancies between the findings is partly due to the lack of clarity and consistency over time in the definition and criteria of conduct disorder. Overall, higher rates for conduct disorder were generally more likely to be found among juveniles in institutional setting than juveniles in community settings. For example, Cocozza and Ingalls reported rates that varied from a high of 46% among youth in secure institutions to a low of 10% for delinquent youth placed in foster family care.

Despite the diagnostic discrepancies, it is clear that, relative to the general population, high rates of conduct disorders were reported in all of these studies, with a large number of studies reporting prevalence rates between 50% and 90%.

Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder

Of the nine studies which examined ADD/ADHD among youth in the juvenile justice system, seven employed random or comprehensive sampling procedures (Cairns et al., 1988; Cocozza & Ingalls, 1984; Cohen et al., 1990; Davis et al., 1991; Friedman & Kutash, 1986; Halikas et al., 1990; Hollander & Turner, 1985; McPherson, 1991; Student & Myhill, 1986). It is important to note that none of these studies employed instruments specifically designed to assess for attention deficit or hyperactivity (e.g., Connors Parent/Teacher Rating Scales; Connors, 1970). Reported prevalence rates ranged from 0% to 46%. The New York Out of Home Study conducted by Cocozza & Ingalls (1984) found uniformly low rates (0% to 3%) across five different settings. Relatively low rates (2% for females and 6% for males) were also reported by Cairns et al., (1988) in their review of Willie M. cases in North Carolina. Both of these studies relied predominantly on case review methods. The low rates may also be a reflection of the tendency to develop only one diagnosis per youngster. When this

is done, the diagnosis of attention deficit disorder may either not be detected or may not be included because other diagnoses are considered to be more primary. In the Student and Myhill study (1986), where each youngster could receive more than one diagnosis, 38% of the sample was identified as having an attention deficit disorder. Four of the five studies in which higher rates were found (19% to 46%) employed a clinical interview of the youth (Davis et al. 1991; Halikas et al. 1990; Hollander & Turner, 1985; Student & Myhill, 1986).

Substance Abuse and Dependence

A relatively small number of studies address the issue of alcohol and drug use, abuse, or dependence in any way. Among those studies that do address this issue, there is a great deal of variability with respect to differentiating alcohol from other drugs and differentiating use, abuse, and dependence. The studies that address the issue of substance abuse are generally more recent.

Eight of the twelve studies which provide estimates of substance abuse and dependence employed random or comprehensive sampling methods (Davis et al., 1991; Dembo et al., 1990; Friedman & Kutash, 1986; Halikas et al., 1990; McPherson, 1991; Student & Myhill, 1986; Westendorp et al., 1986). While Friedman and Kutash reported an astonishingly low rate of 0%, the majority of estimates ranged between 25% and 50%. Halikas et al. (1990) reported a rate of 67%. Together, the data indicate that between one-quarter and one-half of the youth involved in the juvenile justice system have some history of substance abuse, and this rate may be as high as 67%.
Interesting insights into the comorbidity of substance abuse and other mental disorders are provided by the works of Milin et al. (1991) and Rosenthal et al. (undated), which report data regarding the number of subjects with substance abuse/dependence diagnoses that had additional psychiatric diagnoses. Milin and his colleagues found that 75% of the subjects with a substance abuse/dependence diagnosis had at least one other diagnosis while Rosenthal and his colleagues reported a figure of 95%.

Work done by Richard Dembo (Dembo et al., 1990) is worthy of mention because of his use of collateral information (i.e., urinalysis) and his high compliance rate among potential subjects (98%). Dembo and his colleagues have studied randomly selected youth entering a local detention center in Florida, interviewing them extensively about their use of legal and illegal substances. Dembo's estimates suggest that 25% or more of the youth in detention had significant histories of substance abuse or dependence; indeed, 13% of his sample of 399 youth reported prior treatment for alcohol or drug abuse. Dembo's use of urinalysis indicated that some youth were motivated to deny or minimize their use suggesting that the actual rate of abuse may be higher than reported.

Personality Disorders

Eight of the studies reviewed provided prevalence estimates of personality disorders; five of these studies employed random or comprehensive sampling (Cairns et al., 1988; Cocozza & Ingalls, 1984; Davis et al., 1991; Friedman & Kutash, 1986; Hollander & Turner, 1986). Most investigators did not separate personality disorders into distinct subtypes. Prevalence estimates varied considerably. While four studies reported rates ranging between 2% and 17%, Hollander and Turner (1985) reported a rate of 46%.

Mental Retardation

Rates of mental retardation for this population have been reviewed in detail by staff of the Institute on Mental Disability and the Law at the National Center for State Courts (1987). Their comprehensive review of the literature, concludes that the prevalence of mental retardation among juvenile offenders is approximately 13%.

Ten of the studies examined for this review reported prevalence rates for mental retardation. Of the six studies that used random or comprehensive sampling (Cairns et al., 1988; Cocozza & Ingalls, 1984; Day & Joyce, 1982; Friedman & Kutash, 1986; Prescott & Van Houten, 1979; Smyklen & Willis, 1981) prevalence rates ranged from 1% to 23%, with most studies providing estimates between 7% and 15%. The variability of rates may be due to a number of factors including the tests used to assess intellectual functioning and the criteria for diagnosing mental retardation (i.e., low intellectual functioning versus low intellectual functioning and deficits in adaptive behavior).

Learning Disabilities and Specific Developmental Disorders

These disorders were also comprehensively reviewed by staff of the Institute on Mental Disability and the Law at the National Center for State Courts (1987) who concluded the prevalence of learning disabilities/specific developmental disorders among juvenile offenders to be approximately 36%.

Five of the seven studies, reviewed here, that provided prevalence estimates of learning disabilities employed random or comprehensive sampling procedures (Davis et al., 1991; Hollander & Turner, 1985; Robbins et al. 1983; Smyklen & Willis, 1981; Waite, 1992). Reported prevalence rates varied considerably — between 17% and 53%.

Affective Disorders

Eleven of the studies reviewed provided estimates of the prevalence of affective disorders (for purposes of this review, the following were considered affective disorders: major depression, dysthymic disorder, bipolar disorder, cyclothymic disorder, and adjustment disorder with depressed mood). Seven of the eleven studies providing estimates employed random or comprehensive sampling (Cairns et al., 1988; Cocozza & Ingalls, 1984; Davis et al., 1991; Friedman & Kutash, 1986; McPherson, 1991; Student & Myhill, 1986; Winter, 1991). Reported rates varied widely. In four of the studies, rates between 2% and 12% were reported — these studies did not employ interviews with the youth. The three remaining studies reported much higher rates — 32%, 48%, 78%; all of these studies employed clinical interviews with the subjects.

Anxiety Disorders

In only seven studies were estimates of anxiety disorder prevalence rates presented; six of these studies employed random or comprehensive sampling (Cairns et al., 1988; Cocozza & Ingalls, 1984; Davis et al., 1991; Friedman & Kutash, 1986; McPherson, 1991; Student & Myhill, 1986; Winter, 1991). Higher prevalence rates were generally reported by investigators who employed clinical interviews (6%, 9%, 25%/41%), rather than record reviews on other approaches (0-3%, 0-1%, 3-7%).

In the only study examining the prevalence of Post Traumatic Stress Disorder (PTSD) in this population, McPherson (1991) interviewed children in a southwestern detention center. She reported a rate of 41%.

Psychotic Disorders

Nine studies reported prevalence rates for psychotic disorders (for purposes of this review psychotic disorders included schizophrenia and autism/pervasive developmental disorder). Of these nine studies, five employed random or comprehensive sampling techniques (Cairns et al., 1988; Cocozza & Ingalls, 1984; Hollander & Turner, 1985; Rosenthal et al., undated; Winter, 1991). Reported prevalence rates were generally higher than those reported for the general population of youth, ranging from 1% (Cocozza & Ingalls, 1984) to 6% (Winter, 1991).

Other Indicators / Measures of Mental Disorder

Some of the reviewed studies reported information which provides some additional insight into the adjustment and problems of youth in the juvenile justice system. Some of the more important factors presented in Table 2 are highlighted below.

Prior Mental Health Treatment and Psychiatric Hospitalization

A gross measure of adjustment and needs of youth in the juvenile justice system can be obtained by determining the number who have received mental health treatment in the past. Of course, this must be considered a general estimate of youth with "mental disorders" in the juvenile justice system since a number of youth in the juvenile justice system who are relatively free of mental disorder and psychopathology might be referred for "mental health treatment" solely because of their delinquent or troubling behavior (see e.g., Weithorn, 1988), and others with legitimate needs for treatment may not be referred.

Higher rates of psychiatric hospitalization are observed among randomly selected youth in the juvenile justice system than in the general population. Reported rates varied considerably — from 3% to 26%. Five of the seven studies including such information reported rates of 12% or above.

Similarly, many more youth in the juvenile justice system report a history of outpatient contact or treatment. Five studies that employed random or comprehensive sampling procedures provided information about mental health treatment prior to contact with the juvenile justice system (Dembo et al., 1991; Friedman & Kutash, 1986; McPherson, 1991; Rosenthal et al., undated; Westendorp et al., 1986). Reported rates ranged from 38% to 66%.

History of Child Abuse

Children involved in the juvenile justice system are also more likely to have a history of child abuse and neglect than those outside the system. The emotional effects of abuse have been well-documented and this increased prevalence suggests that the adjustment of youth in the juvenile justice system will be affected accordingly. Four studies that employed random or comprehensive sampling procedures provided information about abuse and neglect of the youth (Dembo et al., 1991; Friedman & Kutash, 1986; Report of the Juvenile Justice System, 1988; Student & Myhill, 1986). Reported rates of documented abuse in randomly selected juvenile justice samples are relatively consistent. Rates ranging between 25% and 31% were reported in the fours studies.

History of Suicide Attempts

Also important in understanding the adjustment and needs of youth in the juvenile justice system is their history of self-injurious behavior. Reported estimates of previous suicide attempts among randomly selected juveniles in the juvenile justice system are relatively consistent, with the exception of the New York study (Cocozza & Ingalls, 1984) which reported an extremely low rate (1%). Most

investigators reported rates that are substantially higher, and range between 6% and 28% (Cairns et al., 1988; Davis et al., 1991; Dembo et al., 1990; McPherson, 1991; Ohio Department of Human Services, 1987; Report of Juvenile Justice Committee, 1988; Waite, 1992; Winter, 1991). These estimates are both derived from juveniles' self-reports as well as record reviews. There is some variability among investigators with respect to what constitutes a suicide attempt, and these rates might be artificially high as a result. Nonetheless, the findings suggest that the problems of suicide, self-injurious behavior, and affective disorders are significant among youth in the juvenile justice system.

Summary of Prevalence Findings

Despite the limitations of the available data reviewed in these studies, it is possible to draw several conclusions. First, while it is not possible to offer an exact prevalence rate of mental disorders for youth in the juvenile justice system, it is clear that the prevalence rate is substantially higher than in the general population. While the estimates for the general population ranged as high as 22% (Costello, 1989), it is likely that the prevalence rate for youngsters in the juvenile justice system is considerably higher.

Second, although information on the specific types of conduct disorder are typically lacking, it seems safe to assume that at least one-fifth, and perhaps as much as 60%, of the youth in juvenile justice system can be diagnosed as having a conduct disorder.

Third, the rate of psychotic disorders was generally found to be greater than that found in the general population, ranging between 1% and 6%. Although this still represents a relatively small number of children, it is an important group of youngsters because of the severity of their problems, and the inappropriateness of many correctional placements for responding to their needs.

Fourth, it is obvious that attention deficit disorders and affective disorders are a significant problem in this population. However, there seems to be less clarity about the prevalence of these disorders than there is about other disorders, largely because of the measurement procedures used and the typical focus on only one diagnosis per youngster.

Fifth, it is also clear that substance abuse disorders represent an important problem, and that there is a high degree of comorbidity between mental disorders and substance abuse disorders.

Sixth, it is clear that many of the youngsters have multiple diagnoses, and that more attention has to be paid to the issue of comorbidity. Unless this is done, information on the rates of specific disorders may be misleading.

Seventh, as conceptualizations of mental disorder and diagnosis change, prevalence estimates of specific disorders will change. For example, only one investigator reported prevalence rates for post-traumatic stress disorder, despite the large number of youth in the juvenile justice system that have been severely abused or otherwise traumatized (McPherson, 1991). Estimates of the prevalence of this diagnosis will most likely increase over time.

In addition to these conclusions, there are several other points which emerge from this review that may help to guide future research. First, the emerging area of developmental psychopathology would seem to have great potential for helping understand the characteristics of youth in the juvenile justice system, and the types of services that may be needed to prevent and/or treat their disorders. The

focus on developmental pathways, risk factors, and protective factors appears to be of great potential for advancing the field.

Although it is always useful to have data on overall prevalence rates, it is likely that in the future the areas of research that may prove most fruitful will focus on the development of specific disorders, and the co-occurrence of varying problems.

Another area that appears to hold much promise for understanding youth with emotional disorders is that of individual strengths, family strengths, and social competence. In understanding the nature of this population, and in developing prevention and treatment strategies, it is essential that a holistic perspective be considered that examines not only the presence or absence of disorders but also strengths, and that incorporates not only a diagnostic perspective but also an ecological perspective on family issues, cultural issues, and social issues.

RESEARCH ON THE PREVALENCE OF MENTAL DISORDERS AMONG YOUTH IN THE JUVENILE JUSTICE SYSTEM: LIMITATIONS AND RECOMMENDATIONS

Limitations of Existing Research

The existing studies have a number of limitations which must be re-emphasized. First, in many of the studies, only a single diagnosis was reported. Since many youth have multiple diagnoses (Silver et al., 1992; Student & Myhill, 1986), this tendency results in an under-identification of particular diagnoses that may not be typically classified as primary such as attention deficit disorder, affective disorders, and anxiety disorders.

Second, the research has paid very little attention to the issue of comorbidity. As a result, it is difficult to have a complete understanding of the nature of the disorders of the youth, and to effectively project treatment needs.

Third, the methods used for gathering data have not always been appropriate for identifying particular problems. For example, none of the studies employed those instruments that have been most widely used to determine the presence of an attention deficit disorder.

Fourth, the changing diagnostic systems make it difficult to compare results over time. This is particularly the case with the disruptive behavior disorders. Since it is likely that there will be further changes in the disruptive behavior disorders in DSM-IV (Loeber, Lahey, & Thomas, 1991), the problem of comparing results will be even greater in the future.

Fifth, there continues to be an over-reliance on retrospective record reviews as the exclusive or primary assessment technique. There are many potential sources of bias and unreliability in this approach including lack of specificity regarding definitions of symptoms and disorders and sampling problems. Probably the second most common assessment technique employed in the studies reviewed is the unstructured clinical interview that relies on self-reporting. The criticisms noted above also apply to this technique.

A more promising trend in recent investigations is the use of structured or semi-structured diagnostic interviews (DICA, Herjanic & Reich, 1982; DISC, Costello, Edelbrock, Kalas, Kessler, &

Klaric, 1984). These interview instruments, which produce DSM-III diagnoses, can be administered by non-doctoral-level professionals and have demonstrated levels of reliability. They also have the advantage of providing multiple diagnoses per youngster, when appropriate.

Some investigators have also used structured instruments of psychopathology, personality, and behavior (e.g., MMPI, SCL-90-R, MAPI), which are economical to administer and provide norms for comparison. A number of these instruments also include validity measures which assess the subject's test-taking set. This appears to be particularly important with this population since there are a number of reasons to suspect that arrested or adjudicated juveniles might be less than honest with an interviewer, even when the content of the interview is non-threatening, e.g., for research purposes.

Sixth, there is often an inadequate description of the sample (e.g., insufficient information on age, gender, race, etc.) and little detail on how the sample was selected. Studies range from those that studied every child or adolescent that entered a particular facility, to those that studied a much more select sample of those referred for a psychiatric evaluation. In the latter case the criteria for the referral is not typically described.

Seventh, it is often unclear at what point in the juvenile's retention in the system they are being evaluated. While this is sometimes made explicit in particular investigations, there is a lack of consistency across the epidemiological studies. Finally, surprisingly little attention is paid in the current literature to separating mental illness from what may be reactive behaviors in response to being incarcerated and separated from one's family.

Recommendations for Future Research

With the above criticisms in mind, the following recommendations for research are offered to more accurately establish prevalence rates in this population. The recommendations offered below are not for purposes of clinical evaluation. Clinical needs and research needs are very different, particularly when logistical and economic considerations of clinical services are taken into account. Recommendations for clinical screening and identification are included in the next section. A state-of-the-art epidemiological study of prevalence rates of mental disorders in the juvenile justice system would begin with a standard assessment protocol utilizing multiple sites across several states. Investigators cannot rely solely on retrospective reports, but must collect current data in the most reliable manner possible. The following components should be included in such a study.

Random Selection of Subjects

Subjects must be randomly selected from the general population of youth in the juvenile justice system in order to provide useful estimates of prevalence rates of mental disorder. Descriptions of special sub- populations (e.g., youth referred for psychiatric evaluation, youth in a special mental health treatment program), while useful in some ways, do not provide necessary information about the characteristics and needs of the population as a whole.

Detailed Description of Subjects with Respect to Important Variables

Samples should be fully described in terms of age, gender, race, SES, status in the system, and familial variables. Data should be analyzed for differences between groups on these variables. For example, few of the studies reviewed reported information separately for males and females, despite the numerous differences between the two groups on important factors (e.g., prevalence of different disorders, crimes committed leading to incarceration).

Investigators have also paid relatively little attention to the role age may play. We recommend that two categories be independently studied--those below age 16 and those above age 16. Juveniles below age 16 are more likely to be appropriately placed into a child diagnostic system, and youth 16 years of age and above are more likely to receive Axis II personality disorders or be diagnosed with adult disorders.

Recognition of the Effects of Placement in the System

With respect to status in the system, it would appear that prevalence rates may vary among groups of youth depending on their location in the juvenile justice system. Different prevalence rates for mental disorder may occur at different places in the juvenile justice system (e.g., probation services, diversion/community programs, detention, training school) and the adjustment of juveniles in the system may also be affected by how long they have been in the system (e.g., less than 24 hours versus 24 months). Thus, we recommend that juveniles in these different situations be studied at different points in time in order to identify acute, short-term situational disorders and needs, as well as more chronic, longer-term needs. By doing so investigators may finally be able to document these differences.

Utilization of a Multi-Method/Multi-Source Assessment Approach

A multi-method/multi-source assessment approach is necessary given the limitations of any single technique. The assessment protocol should include:

Standard Record Review. A scoring system and decision making protocol should be developed so that the record review can be systematic, operationally defined for other researchers, and yield reliability estimates. Critical events in the records should be assigned weights or values on an a priori basis and then "added up" to help accept or rule out particular diagnoses.

Structured Diagnostic Interviews. A structured diagnostic interview (e.g., DISC, DICA) should be completed with all subjects. As described earlier, these instruments produce DSM-III/DSM-III-R diagnoses, have proven reliable, and can be administered by non-doctoral-level research assistants.

Prevalence studies that did not employ some kind of interview of subjects generally reported lower rates of mental disorder than those studies which employed some kind of structured or unstructured interview. Face-to-face contact via a clinical interview may be important in identifying youth experiencing some type of mental disorder which may not be identified by other methods (e.g., record review, psychological testing, report by caretakers).

Self-Report Measures of Psychopathology, Personality, and Adjustment. Inclusion of norm-based, self- report instruments (e.g., MAPI, MMPI-A, SCL-90-R) should be considered. These instruments are economical to administer and score, have validity measures, and may prove useful with respect to providing descriptive information about this population.

Corroborative Measures of Psychopathology, Personality, and Adjustment. Again, the use of standard instruments completed by parents and teachers, particularly with the younger population of juveniles, is critical. Instruments such as the CBCL (Achenbach, 1991) can be completed by parents and teachers, and yield a profile of a child or adolescent that compares their symptomatology on several internalizing and externalizing factors relative to one another and to a normative sample.

The Personality Inventory for Children-Revised (PIC-R; Wirt, Lachar, Klinedinst, & Seat, 1984) is another assessment instrument that might be useful in describing the population of youth in the juvenile justice system. The PIC-R is an extensive true-false inventory completed by parents describing their children. It yields a profile based on parental perceptions and includes scales which reflect general family dysfunction, learning impairments, and social difficulties in addition to the more traditional categories of childhood psychopathology.

Structured interviews with the subjects' parents and/or family members should also be considered. This would provide detailed and helpful information about the developmental history of the subjects, and would also help corroborate reports in the subjects' records or offered by the subjects. Of course, researchers using such interviews would have to demonstrate the reliability of such a technique.

Specific/Focused Measures of Psychopathology, Behavior, and Adjustment. The measures described above should lead to a preliminary diagnostic impression, to be followed up with measures that are more specific and sensitive to the particular disorder thought to be present. For example, the Connors Rating Scales (Connors, 1970) or the ACTeRS (Ullman, Sleator, & Sprague, 1984) could be used to confirm ADHD and the Children's Depression Inventory (Kovac, 1981) or Beck Depression Inventory (Beck & Steer, 1987) could be used in a similar way for affective disorders.

Measures of Intellectual Functioning, Academic Functioning, and Adaptive Behavior. Standard measures of intelligence (e.g., WISC-III, WAIS-R), adaptive behavior (Adaptive Behavior Scale, American Association on Mental Deficiency, 1975) and academic achievement (e.g., Woodcock-Johnson Psycho-Educational Battery, 1989) must be administered if accurate rates of mental retardation and learning disability/specific developmental disorder are to be obtained.

Collection of Data Over Time. The ideal study would also follow subjects longitudinally, so effects of movement through the system could be measured. Such an undertaking, of course, increases considerably the expense of such an investigation.

Discussion

A protocol incorporating the above suggestions will provide reliable and structured diagnoses and thus would establish the prevalence rates of mental disorder among youth in the juvenile justice system and among specific sub-populations (e.g., males, females, those under 16, those above 16, juveniles in detention centers, juveniles in training schools). It would also provide descriptive information about the behaviors and adjustment of children in the juvenile justice system. The protocol also has the potential to document the effects of different parts of the system on juveniles' mental health and adjustment; this could have implications for different kinds of screening and treatment needs.

The rigor of our recommended technique might result in estimates of "mental disorder" lower than those previously reported by some investigators. With more explicit criteria and systematic assessment, many children who are having emotional and behavioral difficulties but where those difficulties are not primarily related to the presence of a mental disorder may be eliminated from the estimates. This should not be interpreted to mean that only those with a clear diagnosis are in need of or would benefit from mental health services. In fact, there is a large subset of the child population who are in need of mental health services, broadly conceived, but who do not meet the criteria for any

mental disorder. More importantly, the majority of those with diagnosable disorder will need more than traditional services (e.g., psychotherapy and medication). A multi-systemic assessment and treatment approach is needed with this population. Information gathered through such assessments may offer alternative (and more parsimonious) explanations for a child's current functioning (other than a mental disorder). Second, a broader systems evaluation will certainly aid in individualized treatment planning and cooperation between systems in which the child is involved, for both those with and without diagnosable mental disorders.

RECOMMENDATIONS FOR CLINICAL SCREENING AND EVALUATION

The review of literature undertaken for this chapter highlights not only the inadequacies of existing research but also the critical need for improving the screening and evaluation of youth who come in contact with the juvenile justice system. In all likelihood, the implementation of systematic procedures for screening and evaluation would have a positive impact on our understanding of the prevalence of mental disorders among this population. More importantly, however, it would result in better and more appropriate services to the individual youth within the system. In considering recommendations for clinical screening and evaluation, it is helpful to divide screening and evaluation tasks into two functions: 1) identification of acute disorders that need immediate treatment, and 2) identification of non-acute, mental disorders requiring longer- term treatment. Recommendations for each type of screening are presented separately below.

Acute Screening Functions

All parts of the juvenile justice system must have the capacity to identify acutely disordered youth as well as juveniles with severe mental disorders in need of ongoing treatment and care. All points in the system need to have in place cost-efficient, time-efficient, and effective screening mechanisms to identify juveniles with no pre-existing mental disorders who may be in crisis as the result of their entry into the system, and juveniles with pre-existing mental disorders who require continued treatment. This screening mechanism must be in place so that all juveniles entering the system are evaluated.

The system must be time-efficient because of temporal realities (e.g., juveniles may be held in a detention center for a short period of time but they may nonetheless be in need of evaluation and treatment) and cost-efficient given economic realities (intensive psychological / educational / social evaluations of all youth when they first enter the juvenile justice system is not financially feasible given the numbers that are eventually diverted in some way, or who have been evaluated at some earlier point in time).

Thus, we recommend that immediate entry points in the system (e.g., probation intake, child welfare/social service offices, detention centers) have qualified persons in place who can conduct a routine mental health screening that is largely guided by a structured interview/questionnaire. Such a screening mechanism should be incorporated into the standard intake procedure, and could be administered by a nurse (RN or LPN) with special mental health training and experience or a bachelors/masters level mental health professional with special training and experience. The screening technique could be incorporated into a health screening that might take place in some facilities (e.g., detention centers) or it could be administered independently. Psychological testing would not be part of such an evaluation procedure.

The structured interview should gather relevant historical information (e.g., past outpatient treatment, past inpatient treatment, past medications, past suicide attempts) and relevant current information (e.g., current treatment, current medications, suicidal ideation, assessment of mood, assessment of mental status, recent drug or alcohol use). A parent or caretaker should also be interviewed (in person or via telephone) about the juvenile's mental health history and more recent adjustment in order to verify the juvenile's accounts.

The mental health screener has a number of options to pursue with a particular juvenile. Many youth will not be involved in any current mental health treatment, will not be in any distress, and will not be in need of referral for further evaluation or treatment. Others will be involved in treatment which will not be necessary to continue during the juvenile's initial contact with the juvenile justice system. Others will be receiving ongoing care that must be continued (e.g., medication) and referral to a qualified mental health professional for a more detailed evaluation will be necessary. Other juveniles will be in acute distress (e.g., suicidal, under the influence of alcohol or drugs) and in need of immediate attention (e.g., transfer to another facility or referral to a mental health professional for some kind of immediate intervention or further evaluation).

It is stressed that this evaluation task serves a triage function, and is designed to identify juveniles in need of immediate attention; it is not designed to be an all-encompassing evaluation that makes recommendations regarding long term treatment needs. As such, it is important to emphasize that this kind of screening must be available at all points in the system, not solely at the entry point (i.e., police stations, detention centers, and juvenile justice agencies). Since movement from one part of the system to another can have a significant impact on the person (e.g., transfer from a detention center to a training school) all facilities must have a fast, efficient, and reliable screening system in place which identifies, refers, and provides services to juveniles in need of immediate treatment.

Longer Term Evaluation and Examination

It is also recommended that a subset of juveniles entering the juvenile justice system undergo a comprehensive psychological, medical, and social evaluation to identify medical, psychological, academic, and social factors that may be related to their adjustment and delinquent behavior. Ideally, a state would be able to designate a uniform point at which all juveniles would undergo such an evaluation (e.g., a court clinic). But the logistical realities of many state systems and the funding mechanisms of many services make implementation of such a uniform system difficult. Such a system would be cost efficient insofar as it would prevent multiple evaluations. Additionally, these evaluations, completed upon entry into the system, could follow the juvenile through the system. A system of comprehensive, uniform evaluations is not without shortcomings, however. Uniform evaluations might mean that some juveniles are evaluated on factors that are largely irrelevant to their case. Uniform evaluations also have the potential to ignore individual factors that may be relevant in a particular case, but are generally not relevant. However, an individualized, multi-source multi-method evaluation will minimize these risks.

A thorough clinical assessment would require multiple sources of data (e.g., parents/caretakers, the youth themselves, teachers, and other individuals who may have relevant input with respect to the individual youth's treatment needs). Such a process may seem to be costly and time consuming; however, if its purpose is to produce a comprehensive treatment plan designed to rehabilitate the youth to prevent future involvement in the juvenile or adult justice system, such an evaluation is necessary.

Depending upon their level of involvement with the youth, these sources/individuals may also be important agents in developing and implementing a comprehensive, individualized treatment plan.

Multiple methods will also be necessary to produce a comprehensive assessment of the youth. These methods should include interviews and traditional psychological assessment measures which can evaluate the youth's clinical functioning and behavioral/emotional adjustment (i.e., intellectual functioning, personality functioning, adaptive behavior/social skills, substance abuse/dependence issues, levels of psychopathology), academic achievement, vocational interests, and strengths. Structured and/or semi-structured clinical interviews used with other sources (parents, etc.) will be helpful in corroborating information reported by the youth. It is particularly important to determine what a youth's strengths and interests are as this information is often helpful in developing treatment plans which are designed to both ameliorate problems and enhance adaptive functioning. Additionally, the incorporation of individuals from the community who may not be at all related to the youth's problems (e.g., job training instructors, GED program directors, etc.) may be helpful in the enhancement of adaptive functioning.

It is acknowledged that this type of evaluation and treatment planning goes well beyond the scope of assessing for the presence of mental disorders among youth. However, it is clear that targeting one domain of functioning (i.e., psychopathology) does not sufficiently address the needs of these youth with multiple problems who are likely to have significant histories of involvement with multiple service systems. In all probability, unidimensional assessment will do little to stem the growing tide of youth revolving in and out of our juvenile and adult criminal justice systems.

Table 1

Prevalence Rates of DSM-III Diagnoses in Nonclinic Samples[δ]						
	Anderson et al. (1987)	**Bird et al. (1988)**	**Velez et al. (1989)**	**Costello et al. (1989)**	**Offord et al. (1989)**	**Kashani et al. (1987)**
Informants	Child (Interview) Parent (Checklist) Teacher (Checklist)	Child (Interview) Parent (Interview)	Child (Interview) Parent (Interview)	Child (Interview) Parent (Interview)	Parent (Checklist) Teacher (Checklist) Child (Checklist)	Parent (Interview) Child (Interview)
N	782	777	776	789	2,679	150
Sample Ages	11	4-16	11-20	7-11	4-16	14-16
Diagnoses: Attention deficit disorder (w/wo hyperactivity)	6.7%	9.9%	4.3%	2.2%	6.2%	2.0%
Oppositional disorder	5.7%	9.5%	6.6%	6.6%	NA	6.0%
Conduct disorders (all types)	3.4%	1.5%	5.4%	2.6%	5.5%	8.7%
Separation anxiety	3.5%	4.7%	5.4%	4.1%		8.7%#
Overanxious disorder	2.9%	NA	2.7%	4.6%	9.9%*	.7%
Simple phobia	2.4%	2.3%	NA	9.2%		
Depression, dysthymia	1.8%	5.9%	1.7%†	2.0%		8.0%
Functional enuresis	NA	4.7%	NA	4.4%	NA	.7%
One or more diagnoses	17.6%	18.0% ± 3.4%	17.7%	22.0% ± 3.4%	18.1%	18.7%

* "Emotional disorder."

† Major depression.

\# Anxiety disorder.

δ *Note.* From "Developments in Child Psychiatric Epidemiology." by E.J. Costello, 1989, Journal of the American Academy of Child and Adolescent Psychiatry, 28, p.838. Copyright American Academy of Child and Adolescent Psychiatry. Reprinted and adapted by permission.

TABLE 2 - PREVALENCE STUDIES OF MENTAL DISORDERS IN THE JUVENILE SYSTEM 1975 - 1992

STUDY	METHODOLOGY			
	Sample	Setting	Inclusion Criteria	Assessment Techniques
Lewis, Balla, Sack, & Jekel (1975)	N = 40 Age range = 8-17	Juvenile court clinic	First 40 juveniles referred to clinic staff because of suspected mental health involvement	1. Clinical interview 2. Psychological testing
King & Young (1978)	N = 749	State juvenile correctional institutions	Comprehensive	1. Record Review
Lewis, Shanok, Pincus, & Glaser (1979)	N = 97 100% male	Secure state institution for juveniles	Apparently randomly selected	1. Psychiatric interview 2. Neurological evaluation 3. Psychological testing 4. Review of prior IQ testing
Prescott & Van Houten (1979)	N = 950	Various (institutional) correctional facilities	Comprehensive	1. Record Review
Chiles, Miller, & Cox (1980)	N = 120 23% female, 77% male 83% white, 15% other Mean age = 14.01	State correctional facility	Between 13 and 15 years of age; excluded adolescents who were psychotic, mentally retarded or had a history of seizure disorder; were interviewed within 48 hours of admission	1. Clinical Interview 2. Beck Depression Inventory 3. Behavior Inventory for Depressed Adolescents
Lewis, Shanok, Cohen, Kligfeld, & Frisone (1980)	N = 63 17% female, 83% male 67% black, 33% white Mean age = 15.56	Secure state institution for juveniles	Consecutive admissions to facility from an urban catchment area over the course of one year	1. Record review
Broder, Dunivant, Smith, & Sutton (1981)	N = 633 males 41% white, 42% black, 8% hispanic, 9% other	Community (56%) and one of 6 state training schools (44%)	Adjudicated as delinquent or status offenders; males with mental retardation, seriously emotionally disturbed, or physical handicaps were excluded	1. Record Review 2. WISC-R 3. Woodcock Reading 4. Key Math Diagnostic Arithmetric Test 5. Bender Visual Motor Gestalt Test
Smyklen & Willis (1981)	N = 30	State juvenile institutions	Randomly selected	1. WISC-R 2. WRAT 3. Bender Visual Motor Gestalt Test 4. D&E Behavior Rating Scale
	N = 30	Adjudicated, but in community	Matched to confined juveniles for geographic location and age	Same as above
	N = 30	Status offenders in community (CHINS)	Matched to confined juveniles for geographic location and age	Same as above

FINDINGS									
Conduct Disorder	ADHD	Drug and/or Alcohol Abuse	Personality Disorder	Mental Retardation	LD/ SDD	Affective Disorder	Anxiety Disorder	Psychotic Disorder	Other Findings
	15%		25%	10%		5%			- 25% displayed "psychotic" symptomatology;
									- 3% received anti-convulsant medications suggesting seizure disorders;
									- Subjects who committed more violent crimes generally showed more psychotic symptomatology; - 35% reported displayed symptoms of depression; - 21% reported visual hallucinations; - 31% reported auditory hallucinations; - 11% reported olfactory/gustatory hallucinations; - 6% reported tactile hallucinations; - 59% reported current or past paranoid symptomatology; - 33% displayed loose, rambling, illogical thought processes;
				6%					
									- Majority of subjects (96%) had spent approximately 4 weeks at a diagnostic center prior to entering this facility; - 61% of depressed subjects reported using drugs and alcohol to relieve depression;
									- 61% of subjects for whom information was available had histories suggesting perinatal problems; - 39% of adolescents displayed "psychiatric symptoms";
					37%*				*Tests were only administered to subjects whose records suggested a learning disability;
				23% 20% 13%	37% 40% 53%				- No significant difference between the 3 groups on any diagnosis; - 38% of all subjects were neither learning disabled or mentally retarded;

STUDY	METHODOLOGY			
	Sample	Setting	Inclusion Criteria	Assessment Techniques
Davoli & Stock (1982)	N = 71 44% female, 56% male, 55% white, 37% black, 4% hispanic, 4% "mixed" Mean age = 16.28	2 state training schools	For inclusion subjects must have history of: - violent felonies or multiple non-violent factors; - prior training school placements; - psychiatric hospitalization; - assaultive training school behavior;	1. Structured Interview (Schedule for Affective Disorders and Schizophrenia & Diagnostic Interview for Borderlines 2. Mental Status Examination 3. Delinquency Checklist 4. Behavior Checklist 5. Record Review
Day & Joyce (1982)	N = 202 96% females, 4% males 56% black, 44% white	Juvenile court cases	Randomly selected with the exception of 40 low IQ cases selected to guarantee size of borderline retarded & mentally retarded groups	1. Record Review
Lewis, Shanok, & Pincus (1982)	N = 54, 35% female, 65% male 100% white	State correctional institution	Referral for mental health evaluation because of disruptive behavior in the institution	1. Psychiatric interview 2. Neurological evaluation 3. Review of prior psychological testing 4. EEG 5. Review of records
Miller, Chiles, & Barnes (1982)	N = 50 79% white Mean age = 14	State correctional institution	150 consecutive admissions	1. Structured interview
Wilgosh & Paitich (1982)	N = 27 females Mean age = 14.51 N = 72 male Mean age = 14.27	Court clinic Court clinic	Referred to court clinic for assessment	1. Raven Progressive Matrices 2. WRAT 3. WISC Vocabulary Subtest

FINDINGS									
Conduct Disorder	ADHD	Drug and/or Alcohol Abuse	Personality Disorder	Mental Retardation	LD/ SDD	Affective Disorder	Anxiety Disorder	Psychotic Disorder	Other Findings
87%		23%	55%	7%		63%		8%	- Mean IQ = 85.15; - Mean WRAT reading grade level = 6.98; - Mean WRAT spelling grade level = 5.65; - Mean WRAT math grade level = 5.54;
				7%					- 31% were "borderline mentally retarded;"
									- Mean Full Scale IQ for females = 97.00, males = 94.26; - Mean reading and math grade levels ranged from 2.49 to 3.62; - 25% of females and 21% of males showed abnormal EEG; - 74% of females and 71% of males reported a history of head injury; - 61% of females and 55% of males displayed paranoid symptomatology; - 35% of females and 29% of males evidenced visual hallucinations; - 38% of females and 40% of males evidenced auditory hallucinations; - 36% of females and 33% of males evidenced loose, rambling, illogical thought processes; - 48% of females and 26% of males had prior psychiatric hospitalization;
									- 20% reported a past suicide attempt;
					63% 61%				

STUDY	METHODOLOGY			
	Sample	Setting	Inclusion Criteria	Assessment Techniques
Robbins, Beck, Pries, Jacobs, & Smith (1983)	N = 25 adjudicated males 80% white, 20% black Mean age = 15.9	Court clinic	Referred for evaluation by judge or probation officer	1. Structural Interview 2. WISC-R/WAIS 3. WRAT 4. Physical Examination by MD 5. Goldman, Fristoe, Woodcock, Auditory Skills Battery 6. Purdue Perceptual Motor Chalkboard Task 7. Neurological Screening
	N = 25 adjudicated males 88% white, 12% black Mean age = 15.7	Court clinic	Not referred for evaluation by judge or probation officer	
Cocozza & Ingalls (1984)	N = 101 15% female, 85% male 15% white, 59% black, 25% Hispanic, 19% other	Highly secure institutions, non-community based	Randomly selected	1. Record review 2. Interview with facility employee "familiar with the case"
	N = 110 100% female 42% white, 47% black, 10% Hispanic, 1% other	Secure institutions, non-community based	Randomly selected	1. Record review 2. Interview with facility employee "familiar with the case"
	N = 106 79% female, 21% male 40% white, 47% black, 12% Hispanic, 1% other	Non-secure institutions, non-community based	Randomly selected	1. Record review 2. Interview with facility employee "familiar with the case"
	N = 64 72% female, 28% male 17% white, 77% black 5% Hispanic, 2% other	Youth Development Centers (community-based residential centers)	Randomly selected	1. Record review 2. Interview with facility employee "familiar with the case"
	N = 105 66% female, 34% male 48% white, 36% black, 12% Hispanic, 4% other	Group homes	Randomly selected	1. Record review 2. Interview with facility employee "familiar with the case"
	N = 103 59% female, 41% male 48% white, 41% black, 9% Hispanic, 2% other/unknown	Foster/family care	Randomly selected	1. Record review 2. Interview with facility employee "familiar with the case"
McManus, Alessi, Grapentive, & Brickman (1984)	N = 71 44% female, 56% male 55% white, 37% black, 8% other	State training schools	For inclusion, subjects must have history of: - violent offenses, or - multiple non-violent offenses; - prior training school placement; - assaultive training school behavior	1. Record review 2. Delinquency Checklist 3. Two clinical interviews 4. Scheduled for Affective Disorders and Schizophrenia 5. Hamilton Rating Scale for Depression 6. Carrol Self-Rating Scale for Depression
Hollander & Turner (1985)	N = 200 57% black, 36% white, 6% hispanic, 2% other Mean age = 15.5	New Jersey juvenile court system	All commitments over 10 week period	1. Clinical Interview 2. Intellectual Testing (varied) 3. MMPI 4. Projective Testing (varied) 5. Record review
Friedman & Kutash (1986)	N = 325 36% female, 64% male 47% white, 51% black, 2% other Mean age = 15 yrs,11 mos.	3 state training schools	Random selection or all cases in a particular training school	1. Record Review 2. Interview with staff member familiar with the child 3. Quay Revised Behavior Checklist 4. Jesness Behavior Checklist
Student & Myhill (1986)	N = 58 24% females, 76% males 33% white, 67% black Age range: 11-18	Two state training schools	1/3 of population, randomly selected	1. Psychiatric Interview Using Kiddie-Schedule for Affective Disorders and Schizophrenia 2. Million Adolescent Personality Inventory 3. Hamilton Rating Scale for Depression 4. Chart Review 5. Cottage Behavior Rating Scale

FINDINGS									
Conduct Disorder	ADHD	Drug and/or Alcohol Abuse	Personality Disorder	Mental Retardation	LD/ SDD	Affective Disorder	Anxiety Disorder	Psychotic Disorder	Other Findings
					40% 48%				- Mean Full Scale IQ = 90.4; - 3 subjects had Full Scale IQ < 70; - Mean Full Scale IQ = 94.2; - 1 subject had Full Scale IQ < 70;
46%	0%		13%	12%		2%	0%	0%	- 1% attempted suicide Primary diagnosis with exception of mental retardation;
43%	2%		6%	9%		8%	0%	3%	- 1% attempted suicide; Primary psychiatric diagnosis with exception of mental retardation;
24%	1%		9%	4%		5%	2%	0%	- 2% attempted suicide; Primary psychiatric diagnosis with exception of mental retardation;
19%	0%		11%	10%		6%	0%	0%	- 0% attempted suicide; Primary psychiatric diagnosis with exception of mental retardation;
17%	1%		8%	8%		12%	3%	0%	- 0% attempted suicide; Primary psychiatric diagnosis with exception of mental retardation;
10%	3%		8%	4%		4%	2%	0%	- 0% attempted suicide; Primary psychiatric diagnosis with exception of mental retardation;
11%		13%	50%	4%		18%		4%	
85%	19%		46%		19%			2%	- Adjustment disorder = 9%; - "Other" disorders = 4%;
10%		0%	2%	1%		2%		1%	- 13% had IQ < 70; - 96% on no psychotropic medications; - 62% reported receiving some type of mental health service prior to entering training school; - 27% had documented histories of abuse;
91%	38%	50%				78%	9%		- 26% had history of at least 1 psychiatric hospitalization; - 31% had histories of documented abuse;

STUDY	METHODOLOGY			
	Sample	Setting	Inclusion Criteria	Assessment Techniques
Westendorp, Brink, Roberson, & Ortiz (1986)	N = 51 7% female, 93% male 58% white, 36% black, 6% other Mean age = 15.2	Juvenile court	55 consecutive placements from juvenile court	1. Structured Interview 2. MMPI, Adolescent Norms 3. PIAT 4. Child and Adolescent Adjustment Profile (Parent or Courtworker completed)
Lewis, Pincus, Lovely, Spitzer, & Moy (1987)	N = 31 39% female, 61% male 48% white, 32% black 19% Hispanic	State secure institution	No report on criteria, appeared to be randomly selection	1. Structured psychiatric interview 2. Neurological evaluation
Ohio Department of Human Services (1987)	N = 520 59% white, 39% black 1% hispanic, 1% other	All juveniles ages 12 through 17 who were adjudicated delinquent and in an out-of-home placement	Random sample	1. Record review
Report of the Juvenile Justice Subcommittee of the Interdepartmental Council's Children's Policy Committee (1988)	N = 639 15% female, 85% male Mean age = 16.3	74% adjudicated, but in community; 26% Maine Youth Center (Residential Program)	All youth in the Maine Youth Center (MYC); Others considered "at risk" for out-of-home placement or in need of additional services.	1. Record review 2. Survey of caseworkers
Cairns, Peterson, & Neckerman (1988)	N = 520 19% female, 81% male 48% black, 48% white, 4% other or unclassified	Variety of settings	First 800 cases identified as qualifying for the Willie M. vs. Hunt class action law suit	1. Record review
Zagar, Arbit, Hughes, Busell, & Busch (1989)	N = 1,956 20% female, 80% male Mean age = 13.9	Juvenile court clinic	Adjudicated delinquent and referred for evaluation of emotional, behavioral, medical, and educational problems; Juveniles who had symptoms of psychosis were excluded	1. Psychiatric interview 2. Medical history 3. Physical exam 4. WISC-R 5. Bender Visual Motor Gestalt Test 6. Gates McGenitie Stanford Achievement Test

FINDINGS									
Conduct Disorder	ADHD	Drug and/or Alcohol Abuse	Personality Disorder	Mental Retardation	LD/ SDD	Affective Disorder	Anxiety Disorder	Psychotic Disorder*	Other Findings
									- 60% reported regular to excessive drug use; - 44% reported prior contact with mental health system; - group mean of 23rd percentile on PIAT; - most frequent 2-point MMPI code was 4-9/9-4 (22%);
									- 74% endured severe head injury; - 39% reported severe headaches; - 32% reported visual hallucinations; - 35% reported auditory hallucinations; - 61% reported paranoid ideas; - 30% reported loose, illogical thought processes; - 55% reported past suicide attempts; - 77% reported history of physical and emotional abuse;
									- 14% of subjects were identified as having some kind of mental health problem, broadly conceived; - 27% of subjects displayed symptoms of depression; - 13% of subjects displayed symptoms of hyperactivity; - 49% had history of substance abuse; - 3.3% of subjects displayed symptoms of thought disorder; - 18% had history of suicide attempts;
									- 58% had "drug problems" - 25% were physically abused - 22% were sexually abused - 20% were "suicidal" - 28% were "assaultive"
57% female 66% male	2% female 6% male		4% female 2% male	3% female 6% male		5% female 1% male	0% female 1% male	*4% female *5% male	- Adjustment disorder = 9% of females, 4% of males; - "Other behavioral" problems = 12% of females, 5% of males; - 24% of females and 11% of males reported past suicide attempts; * Includes PDD
	9% ADHD 46% ADD			15%					- Mean Full Scale IQ = 83.6; - Mean grade in school = 8.0; - Mean reading speed and accuracy grade level = 4.1; - Mean vocabulary grade level = 4.1; - Mean reading composition grade level = 4.3; - Mean math grade level = 3.6;

STUDY	METHODOLOGY			
	Sample	Setting	Inclusion Criteria	Assessment Techniques
Cohen, Parmelee, Irwin, Weisz, Howard, Purcell, & Best (1990)	N = 35 25% female, 75% male 36% white, 64% black Mean age = 14.1	State juvenile corrections facility	All admissions over a 5 month period	1. Child Behavior Checklist
Dembo, Williams, Wish, Berry, Getrey, Washburn, & Schmeidler (1990)	N = 399 28% female; 72% male 51% white, 41% black, 6% hispanic, 2% "other" Mean age = 15.4	Local detention center	- Half of incoming males (randomly sampled) and all of incoming females over an 8 month period - (98% of juveniles approached participated in study)	1. Structured Interview 2. SCL-90-R 3. Urinalysis 4. Review of HRS Records
Halikas, Meller, Morse, & Lyttle (1990)	N = 114 22% female, 78% male	Juvenile court, all subjects were in detention	Not stated, appeared to be random selection	1. DICA
Davis, Bean, Schumacher, & Stringer (1991)	N = 173 9% female, 91% male 49% white, 51% "non-white"	Residential facilities	Random selection (10% of youth in state residential facilities)	1. Structured interview 2. Record review 3. Revised Behavior Problem Checklist 4. Matson Evaluation of Social Skills 5. Hopelessness Scale for Children 6. Children's Global Assessment Scale 7. Brief Psychiatric Rating Scale for Children
McPherson (1991)	N = 64	Detention center	All detainees admitted during a 5 week period	1. Structured interview

FINDINGS									
Conduct Disorder	ADHD	Drug and/or Alcohol Abuse	Personality Disorder	Mental Retardation	LD/ SDD	Affective Disorder	Anxiety Disorder	Psychotic Disorder	Other Findings
									- No significant differences on major CBCL scores between this sample and a comparison sample from a state hospital;
		25%*							* estimate, based on authors' reports - 55% reported prior mental health contact; - 9% reported prior psychiatric hospitalization; - 10% reported ever taking psychiatric medications prior admission; - 16% reported prior attempts to "hurt them-selves"; - 11% reported suicidal ideation during incarceration; - 13% reported prior treatment for drug/ alcohol abuse; - 29% had records indicating 1 or more investigations for physical abuse; - 42% reported prior enrollment in special education programs; - 25% reported that alcohol/drug use resulted in their being referred to juvenile or adult court;
81%	19%	67%							
81%	19%	46% ETOH abuse & dependence; 64% drug abuse & dependence	17%		17%	32%	6%		- 14% displayed "active suicidal behavior" - 21% reported suicidal threats in the past - "nearly 20%" had at least one psychiatric hospitalization
50%						48%	41% PTSD; 25% Phobias		- 25% reported past suicide attempts - 26% reported prior psychiatric hospitalization - 66% reported prior outpatient psychotherapy - 16% reported auditory hallucinations - 3% reported visual hallucinations - 16% reported regular use of crack cocaine - 13% reported regular use of heroin - 56% reported using alcohol at least once a week - 38% reported smoking marijuana daily 1 month prior to admission

STUDY	METHODOLOGY			
	Sample	Setting	Inclusion Criteria	Assessment Techniques
Milin, Halikas, Meller, & Morse (1991)	N = 111 23% female, 77% male, 66% white, 28% black, 6% "other" Mean age = 15.5	Local detention center	Referred for evaluation because of suspected mental health or substance abuse involvement	1. DICA
Winter (1991)	N = 851 20% female, 80% male Age range = 14-24	Two reception centers for males; State training school for females	Comprehensive	1. MMPI/MMPI-2 2. Jesness Inventory 3. Youth Authority Ward Profile
Waite (1992)	N = 3662 11% female, 89% male 63% black, 36% white 1% "other"	State Reception and diagnostic Center	All committed youth undergoing evaluation prior to placement in a state training school.	1. Clinical interview
Rosenthal, Viale-Val, Clay, Moss-Zerwic, Stapleton, & Curtiss (undated)	N = 102 males 60% black, 40% white Mean age = 15.4	Reception and classification center	All admissions over a 2 month period	1. Schedule for Affective Disorders and Schizophrenia-Lifetime (SADS-L) 2. Select item from DIS-C and Diagnostic Interview for Borderlines 3. Carroll Rating Scale for Depression 4. Delinquency Checklist

FINDINGS									
Conduct Disorder	ADHD	Drug and/or Alcohol Abuse	Personality Disorder	Mental Retardation	LD/ SDD	Affective Disorder	Anxiety Disorder	Psychotic Disorder	Other Findings
91%	19%	81%				17%	10%	7%	- 75% of subjects with some kind of diagnosis of substance abuse had some other kind of psychiatric diagnosis; - Mean number of diagnoses per subject = 2.05;
						2% female 4% male	3% female 7% male	6% female 3% male	- 3% of females & 4% of males had prior psychiatric hospitalization; - 28% of females & 6% of males had past suicide attempts * Diagnosis based on MMPI/MMPI-2 and Jesness Inventory clustering
					21%				- 20% had prior pyschiatric hospitalization - 14% had been placed on psychotropic medications in past while outside of a hospital setting - 20% had documented history of suicidal ideation - 6% had documented history of suicide attempts
								3%	- 12% had previous psychiatric hospitalization; - 38% had at least one prior session of outpatient psychotherapy; - 95% of subjects with diagnoses of alcohol abuse/dependence had at least one other diagnosis; - 28% had diagnosis of adjustment disorder;

REFERENCES

Achenbach, T.M. Manual for the Child Behavior Checklist. Burlington, VT: University of Vermont, Department of Psychiatry, 1991.

American Association on Mental Deficiency. Adaptive Behavior Scale: 1975 Revision. Washington, D.C., 1975.

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (3rd ed.). Washington, D.C., 1980.

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (3rd ed. Revised). Washington, D.C., 1987.

Anderson, J.C., Williams, S., McGee, R., & Silva, P.A. DSM-III disorders in preadolescent children: Prevalence in a large sample from the general population. Archives of General Psychiatry, 44, 69-76, 1987.

Beck A.T. & Steer, R.A. Manual for the Revised Beck Depression Inventory. San Antonio, TX: Psychological Corp., 1987.

Bird, H.R., Canino, G., Rubio-Stipec, M., Gould, M.S., Ribera, J., Sesman, M., Woodbury, M., Huertas-Goldman, S., Pagan, A., Sanchez-Lacay, A., & Moscoso, M. Estimates of the prevalence of childhood maladjustment in a community survey in Puerto Rico. Archives of General Psychiatry, 45, 1120-1126, 1988.

Brandenburg, N.A., Friedman, R.M., & Silver, S.E. The epidemiology of childhood psychiatric disorders: Prevalence findings from recent studies. Journal of the American Academy of Child and Adolescent Psychiatry, 29, 76-83, 1990.

Broder, P.K., Dunivant, N., Smith, E.C., & Sutton, L.P. Further observations on the link between learning disabilities and juvenile delinquency. Journal of Educational Psychology, 73, 838-850, 1981.

Bureau of Justice Statistics. Sourcebook of Criminal Justice Statistics - 1990. Washington, DC: U.S. Government Printing Office, 1990.

Bureau of the Census. Statistical Abstract of the United States - 1991: The National Data Book. Washington, DC: U.S. Government Printing Office, 1991.

Cairns, R.B., Peterson, G., & Neckerman, H.J. Suicidal behavior in aggressive adolescents. Journal of Clinical Child Psychology, 17, 298-309, 1988.

Caron, C. & Rutter, M. Comorbidity in child psychopathology: Concepts, issues and research strategies. Journal of Child Psychology and Psychiatry, 32, 1063-1080, 1991.

Chiles, J.A., Miller, M.L., & Cox, G.B. Depression in an adolescent delinquent population. Archives of General Psychiatry, 37, 1179-1184, 1980.

Cocozza, J.J. & Ingalls, R.P. Characteristics of Children in Out of Home Care. Albany, NY: New York State Council on Children and Families, 1984.

Cohen, R., Parmelee, D.X., Irwin, L., Weisz, J.R., Howard, P., Purcell, P., & Best, A.M. Characteristics of children and adolescents in a psychiatric hospital and a correction facility. Journal of the American Academy of Child and Adolescent Psychiatry, 29, 909-913, 1990.

Connors, C.K. Symptoms patterns in hyperkinetic, neurotic, and normal children. Child Development, 41, 667-682, 1970.

Costello, E.J. Developments in child psychiatric epidemiology. Journal of the American Academy of Child and Adolescent Psychiatry, 28, 836-841, 1989.

Costello, A., Edelbrock, C., Kalas, R., Kessler, M., & Klaric, S. NIMH Diagnostic Interview Schedule for Children (DISC). Rockville, MD: National Institute of Mental Health, 1984.

Davis, D. L., Bean, G. J., Schumacher, J. E., & Stringer, T. L. Prevalence of emotional disorders in a juvenile justice institutional population. American Journal of Forensic Psychology, 9, 1-13, 1991.

Davoli, C.R. & Stock, H. Report of the Task Force on the Mentally Ill Adolescent Offender. Lansing, MI: Departments of Management and Budget, Mental Health, and Social Services, 1982.

Day, E. & Joyce, K. Mentally retarded youth in Cuyahoga County Juvenile Court: Juvenile court work research group. In M.B. Santamour & P.S. Watson (eds.) The Retarded Offender (pp. 141-165). New York, NY: Praeger, 1982.

Dembo, R., Williams, L., Wish, E.D., Berry, E., Getreu, A.M., Washburn, M., & Schmeidler, J. Examination of the relationships among drug use, emotional/psychological problems, and crime among youths entering a juvenile detention center. The International Journal of the Addictions, 25, 1301-1340, 1990.

Eaton, W.W., Holzer, C.E., Von Korff, M., Anthony, J.C., Helzer, J.E., George, L., Burnam, A., Boyd, J.H., Kessler, L.G., & Locke, B.Z. The design of the epidemiologic catchment area surveys. Archives of General Psychiatry, 41, 942-948, 1984.

Earls, F. Epidemiological strategies in child mental health. In P. Greenbaum, R. Friedman, A. Duchnowski, K. Kutash, & S. Silver (eds.) Childrens Mental Health Policy: Building a Research Base. Proceedings from the Second Annual Conference. Tampa, FL: Florida Mental Health Institute, University of South Florida, 1989.

Elliott, D.S., Huizinga, D., & Menard, S. Multiple Problem Youth: Delinquency, Substance Use, and Mental Health Problems. New York, NY: Springer-Verlag, 1990.

Friedman, R.M. & Kutash, K. Mad, Bad, Sad, Can't Add? Florida Adolescent and Child Treatment Study (FACTS). Tampa, FL: University of South Florida, Florida Mental Health Institute, 1986.

Gould, M.S., Wunsch-Hitzig, R., & Dohrenwend, B. Estimating the prevalence of childhood psychopathology. Journal of the American Academy of Child Psychiatry, 20, 462-476, 1981.

Greenbaum, P.E., Prange, M.E., Friedman, R.M., & Silver, S.E. Substance abuse prevalence and comorbidity with other psychiatric disorders among adolescents with severe emotional disturbances. Journal of the American Academy of Child and Adolescent Psychiatry, 30, 575-583, 1991.

Halikas, J.A., Meller, J., Morse, C., & Lyttle, M.D. Predicting substance abuse in juvenile offenders: Attention deficit disorder vs. aggressivity. Child Psychiatry and Human Development, 21, 49-55, 1990.

Herjanic, B. & Reich, W. Development of a structured psychiatric interview for children: Agreement between child and parent on individual symptoms. Journal of Abnormal Child Psychology, 10, 307-324, 1982.

Hollander, H.E. & Turner, F.D. Characteristics of incarcerated delinquents: Relationship between development disorders, environmental and family factors, and patterns of offense and recidivism. Journal of the American Academy of Child Psychiatry, 24, 221-226, 1985.

Institute on Mental Disability and the Law. The Prevalence of Mental Disabilities and Handicapping Conditions Among Juvenile Offenders. Williamsburg, VA: National Center for State Courts, 1987.

Johnston, L.D., O'Malley, P.M., & Bachman, J.G. Drug Use Among American High School Seniors, College Students and Young adults, 1975-1990: Volume 1. High School Seniors (pp. 1-24). Rockville, MD: National Institute on Drug Abuse, 1991.

Kashani, J.H., Beck, N.C., Hoeper, E.W., Fallahi, C., Corcoran, C.M., McAllister, J.A., Rosenberg, T.K., & Reid, J.C. Psychiatric disorders in a community sample of adolescents. American Journal of Psychiatry, 144, 584-589, 1987.

Kashani, J.H., Horwitz, E., & Daniel, A.E. Diagnostic classification of 120 delinquent boys. Bulletin of the American Academy of Psychiatry and the Law, 10, 51-60, 1982.

King, L.N., & Young, Q.D. Increased prevalence of seizure disorders among prisoners. Journal of the American Medical Association, 239, 2674-2675, 1978.

Knitzer, J. Unclaimed Children. Washington, DC: Children's Defense Fund, 1982.

Krisberg, B., DeComo, R., & Herrera, N.C. National Juvenile Custody Trends 1978-1989. Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, 1992.

Kovac, M. Rating scales to assess depression in school aged children. Acta Paedopsychiatrica, 46, 305-315, 1981.

Lewis, D.O., Balla, D.A., Sacks, H.L., & Jekel, J.F. Psychotic symptomatology in a juvenile court clinic population. Journal of the American Academy of Child Psychiatry, 12, 660-674, 1973.

Lewis, D.O., Pincus, J.H., Lovely, R., Spitzer, E., & Moy, E. Biopsychosocial characteristics of matched samples of delinquents and nondelinquents. Journal of the American Academy of Child and Adolescent Psychiatry, 26, 744-752, 1987.

Lewis, D.O., Shanok, S.S., Cohen, R.J., Kligfeld, M., & Frisone, G. Race bias in the diagnosis and disposition of violent adolescents. American Journal of Psychiatry, 137, 1211-1216, 1980.

Lewis, D.O., Shanok, S.S., Pincus, J.H., & Glaser, G.H. Violent juvenile delinquents. Journal of the American Academy of Child and Adolescent Psychiatry, 18, 307-319, 1979.

Lewis, D.O., Shanok, S.S., & Pincus, J.H. A comparison of the neuropsychiatric status of female and male incarcerated delinquents: Some evidence of sex and race bias. Journal of the American Academy of Child Psychiatry, 21, 190-196, 1982.

Links, P.S. Community surveys of the prevalence of childhood psychiatric disorders: A review. Child Development, 54, 531-548, 1983.

Loeber, R. The stability of antisocial and delinquent child behavior. Child Development, 53, 1431-1446. 1982.

Loeber, R. Natural histories of conduct problems, delinquency, and associated substance use: Evidence for developmental progressions. In B.B. Lahey & A.E. Kazdin (eds.) Advances in Clinical Child Psychology (Vol. 11). New York, NY: Plenum, 1988.

Loeber, R. Development and risk factors of juvenile antisocial behavior and delinquency. Clinical Psychology Review, 10, 1-41, 1990.

Loeber, R. Antisocial behavior: More enduring than changeable? Journal of the American Academy of Child and Adolescent Psychiatry, 30, 393-397, 1991a.

Loeber, R. Developmental Psychopathology of Conduct Disorders. Presented at the conference: Conduct Disorders: How Should Our Service Systems Respond?, Arlington, VA, May 7, 1991b.

Loeber, R., Lahey, B.B., & Thomas, C. Diagnostic conundrum of oppositional defiant disorder and conduct disorder.
Journal of Abnormal Psychology, 100, 379-390, 1991.

McManus, M., Alessi, N.E., Grapentine, W.L., Brickman, A.S. Psychiatric disturbance in serious delinquents. Journal of the American Academy of Child Psychiatry, 23, 602-615, 1984.

McPherson, P. Unpublished data, Department of Psychiatry, Case Western Reserve University, 1991.

Milin, R., Halikas, J.A., Meller, J E., & Morse, C. Psychopathology among substance abusing juvenile offenders. Journal of the American Academy of Child and Adolescent Psychiatry, 30, 569-574, 1991.

Miller, M.L., Chiles, J.A., & Barnes, V.E. Suicide attempters within a delinquent population. Journal of Consulting and Clinical Psychology, 50, 491-498, 1982.

National Institute on Drug Abuse. National Household Survey on Drug Abuse: Highlights 1990. (DHHS Publication No. ADM 91-1789). Washington, DC: U.S. Government Printing Office, 1990.

Office of Technology Assessment. Children's Mental Health: Problems and Services - A Background Paper. Washington, DC: U.S. Government Printing Office, 1986.

Offord, D.R., Boyle, M.H., Szatmari, P., Rae-Grant, N.I., Links, P.S., Cadman, D.T., Byles, J. A., Crawford, J.W., Blum, H.M., Byrne, C., Thomas, H., & Woodward, C.A. Ontario Child Health Study: II. Six-month prevalence of disorder and rates of service utilization. Archives of General Psychiatry, 44, 832-836, 1987.

Ogloff, J.R.P. & Otto, R.K. Mental health practice in jails. In P.A. Keller & L.G. Ritt (eds.) Innovations in Clinical Practice: A Sourcebook (Vol. 8) pp. 357-369. Sarasota, FL: Professional Resource Exchange, 1989.

Ohio Department of Human Services. Children in Out of Home Care. Columbus, OH: Author, 1987.

Otto, R.K. & Ogloff, J.R.P. A Manual for Mental Health Professionals Working with Jails. Lincoln, NE: Department of Public Institutions, 1988.

Prescott, M. & Van Houten, E. The retarded juvenile offender in New Jersey: A report on research in correctional facilities and mental retardation facilities. In M.B. Santamour & P.S. Watson (eds.) The Retarded Offender (pp. 166-175). New York, NY: Praeger, 1979.

Quay, H.C. Handbook of Juvenile Delinquency. New York, NY: Wiley, 1987.

Quay, H.C. & Peterson, D.R. Manual for the Revised Behavior Problem Checklist. Coral Gables, FL: University of Miami, 1987.

Regier, D.A., Myers, J.K., Kramer, M., Robins, L.N., Blazer, D.G., Hough, R.L., Eaton, W. W., & Locke, B.Z. The NIMH Epidemiologic Catchment Area Program. Archives of General Psychiatry, 41, 934-941, 1984.

Report of the Juvenile Justice Subcommittee of the Interdepartmental Council's Children's Policy Committee. Augusta, Maine: Department of Corrections, State of Maine, 1988.

Robbins, D.M., Beck, J.C., Pries, R., Jacobs, D., & Smith, C. Learning disability and neuropsychological impairment in adjudicated, unincarcerated male delinquents. Journal of the American Academy of Child Psychiatry, 22, 40-46, 1983.

Robins, L.N. Changes in conduct disorder over time. In D.C. Farran & J.D. McKinney (eds.), Risk in Intellectual and Psychosocial Development. Orlando, FL: Academic Press, 1988.

Rosenthal, R.H., Viale-Val, G., Clay, R., Moss-Zerwic, P., Stapleton, M., & Curtiss, G. Prevalence of Psychiatric Disorders in Incarcerated Juvenile Offenders. Chicago IL: Illinois State Psychiatric Institute, (undated).

Silver, S.E., Duchnowski, A.J., Kutash, K., Friedman, R.M., Eisen, M., Prange, M.E., Brandenburg, N.A., & Greenbaum, P.E. A comparison of children with serious emotional disturbance served in residential and school settings. Journal of Child and Family Studies 1, 43-59, 1992.

Smykla, J.O. & Willis, T.W. The incidence of learning disabilities and mental retardation in youth under the jurisdiction of the juvenile court. Journal of Criminal Justice, 9, 219-225, 1981.

Steadman, H.J., McCarty, D., & Morrissey, J.P. The Mentally Ill in Jail: Planning for Essential Services. New York, NY: Guilford, 1989.

Student, D & Myhill, J. Mental Health Needs at the Montrose and Hickey Schools: Models for Treatment. Unpublished manuscript, 1986.

Synder, H.N. et al., Juvenile Court Statistics, 1989, Washington , D.C.: Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, 1992.

Ullman, R. K., Sleator, E. K., & Sprague, R. A new rating scale for diagnosis and monitoring of ADD children. Psychopharmacology Bulletin, 20, 160 - 164, 1984.

Waite, D. Unpublished data, Department of Youth and Family Services, Commonwealth of Virginia, 1992.

Weithorn, L.A. Mental hospitalization of troublesome youth: An analysis of skyrocketing admission rates. Stanford Law Review, 40, 773-838, 1988.

Westendorp, F., Brink, K.L., Roberson, M.K., & Ortiz, I.E. Variables which differentiate placement of adolescents into juvenile justice or mental health systems. Adolescence, 21, 23-37, 1986.

Wilgosh, L. & Paitich, D. Delinquency and learning disabilities: More evidence. Journal of Learning Disabilities, 15, 278-279, 1982.

Winter, S. Youth Authority Treatment Needs Assessment. Sacremento, CA: Department of the Youth Authority, Research Division, 1991.

Wirt, R.D., Lachar, D., Klinedinst, J.K., & Seat, P.D. Multidimensional Description of Child Personality: A Manual for the Personality Inventory of Children, (1984 revision by D. Lachar). Los Angeles, CA: Western Psychological Services, 1984.

Woodcock, R.W. & Johnson, M.B. Woodcock-Johnson Psycho-educational Battery-Revised. Allen, TX: DLM, 1989.

Zagar, R., Arbit, J., Hughes, J.R., Busell, R.E., & Busch, K. Developmental and disruptive behavior disorders among delinquents. Journal of the American Academy of Child and Adolescent Psychiatry, 28, 437-440, 1989.

CHAPTER 3

ISSUES IN SYSTEMS INTERACTIONS AFFECTING MENTALLY DISORDERED JUVENILE OFFENDERS

Richard Barnum
Ingo Keilitz

INTRODUCTION

The juvenile justice system has always had a troubled relationship with the mental health system (Kalogerakis, 1992). Original assumptions supporting the development of a separate system of justice for juvenile offenders included a tendency to characterize all juvenile offenders as disturbed in some way, but the traditional approach to treatment for juvenile offenders tended to lack explicit psychiatric diagnosis and specific mental health services. Instead, juvenile offenders were seen generally as "troubled" and in need of "treatment." This tradition interferes with establishing clear relationships between specific mental illness in youth and juvenile offenders. In fact, though many juvenile offenders show indications of some kinds of psychological abnormality, most are not mentally ill (Rutter & Giller, 1984).

Juvenile offenders who show signs of serious mental disturbance are anomalies in both the juvenile justice and the mental health systems. Juvenile justice institutions have difficulty responding to the special behavioral and emotional problems of juvenile offenders who may be mentally disordered, and mental health agencies are often reluctant to become involved with youth whose behavior may have been violent or otherwise antisocial. Institutional responses are complicated further by the fact that these youth tend to have multiple serious problems in many areas of functioning, and these problems go beyond the usual functional boundaries of the institutions responsible for them (Steadman, 1992). Establishing useful interactions among these institutions - families, social service agencies, schools, mental health agencies, courts, and correctional institutions - can be a daunting task.

This chapter begins with a general analysis of organizational functions and structures that are involved in addressing the needs of any youth in the juvenile justice system. It then discusses in greater detail the issues that arise in dealing with mentally disordered juvenile offenders. It asserts that a clear understanding of systems issues in these relationships requires detailed attention to the specification of mental disorders, to the use of diagnostic services, and to clarifying organizational arrangements for evaluation and treatment services. The chapter explores these issues, describes some specific programs of mental health service to juvenile offenders of special interest, proposes characteristics of an ideal system of care, and suggests areas for analysis and research.

SYSTEMS OF INTERVENTION: FUNCTIONAL INTERACTIONS AND OVERLAPS

Every juvenile offender is involved with three institutions: the justice system, the family, and the educational system. Some offenders also become involved with the mental health system or the social service/child protective system (or both). Each of these systems has its own special mission, goals, and functions, whether these are articulated or not. Though each of these institutions focusses on its own special function in dealing with a youth, they frequently become involved in providing other functions as well. This overlap is one source of confusion in service delivery and assignment of institutional responsibility.

Justice functions include investigation and adjudication of offenses, and apprehension and containment of offenders in various settings. *Educational* functions for children and adolescents include instruction in a variety of prescribed topics, in order to develop in students certain basic knowledge and skills, taking into account the students' individual needs and capacities. *Family* functions include the provision of nurturance, protection, socialization and advocacy for children in their formative years. *Protective* or "social service" functions include discovering and serving abused and neglected children and their families. Finally, *mental health* functions include the recognition and differential diagnosis of mental disturbance, and the provision of treatment of various types in various settings.

Boundaries of the institutions responsible for these functions are fluid and variable. More than one kind of institution may become involved in the same function. For examples, special education programs often include both educational and mental health services. Prosecutors, courts, and corrections agencies frequently have intimate involvement with mental health providers, both for diagnostic and for treatment purposes. Courts, attorneys, and corrections agencies may frequently take over functions of decision-making, advocacy, and caregiving that are traditionally reserved for families (even in some cases where families are available and able to perform those functions, e.g. Cohen et al., 1991. Social service agencies, supporting or standing in for families, may also provide educational or mental health services. Mental health treatment providers increasingly aim to support families, sometimes by explicitly taking on family functions of decision-making and supervision, at least temporarily (Friesen & Korloff, 1990). Families frequently turn to the justice system (such as in runaway or stubborn child petitions) for help in providing functions of nurturance, supervision and protection. These are common overlaps that in many ways can be seen, however, as creative responses to difficult situations in which individuals have multiple needs. They always create the potential for ambiguity and conflict about who is doing what and why.

A wide variety of *individuals* and *agencies*, both public and private, have roles in the functions defined above. Some agencies seem devoted exclusively to one function, while others are more explicitly ambiguous and prone to overlapping functions.
Table 1 identifies various agents and agencies and classifies them according to functions performed on behalf of youth with actual or suspected disorders.

Justice Functions: Police, courts, prosecutors, defense attorneys, and probation officers are all primarily focused on the investigation, adjudication, and disposition of legal matters involving juvenile offenses. However, their work overlaps with some mental health functions, and with some traditional functions of the family.

Mental Health Functions: Individual mental health professionals, hospitals, and clinics all provide mental health assessment and treatment. They also routinely perform police functions in assessing and responding to potentially dangerous behavior by clients, provide evidence for other justice related activities, help to support effective education for clients through the use of consultation and various specific treatments within or in support of schools, discover and report child abuse, and may take on certain family executive, discipline, and nurturance functions either explicitly or implicitly.

Educational Functions: Individual teachers, public and private schools, local educational authorities, special education teachers and administrators, are all primarily in the business of providing education to schoolchildren. However, they also routinely take on the mental health roles of providing counseling and behavior management, the justice roles of identifying and even prosecuting those who offend in school, and the family roles of teaching values and providing supervision (Sametz, 1981; Knoff & Batsche, 1990). Providing education to multiply disordered youth in the juvenile justice system presents special challenges both in terms of individual service and especially in terms of clarifying agency responsibilities (Keilitz & Miller, 1980).

Family Functions: Parents, siblings, and extended family are routinely responsible for providing discipline, nurturance, and advocacy for their children. They may also be asked to take on certain mental health functions, especially in collaboration with a mental health professional in treating a difficult child (Friesen & Koroloff, 1990), educational functions in helping out at school and with projects at home, and justice functions in collaborating with courts and police in providing accountability and supervision for difficult kids.

Protective Functions: Social service or child protective agencies provide a state-based response to family insufficiency, such as manifested by child abuse or neglect. Their primary function is to provide care and protection to children when families are not able to do so. However, they also have major and explicit police functions in investigating and supporting prosecution of child abuse and neglect (Barnum, 1990a), and mental health functions in identifying and referring, and in some circumstances evaluating and treating, children and parents with mental health problems.

Table 1.
Functions of Individuals and Agencies Responsible for Juvenile Offenders

AGENTS	FUNCTIONS				
	Justice	Mental Health	Education	Social Services	Family
Police	Investigation, apprehension	Emergency commitment	Special programs, e.g., drug abuse	Identification of child abuse & neglect	Informal "adjustments"
Judge	Adjudication	Selection for evaluation; orders to treatment	Orders to attend school	Adjudication of parent fitness; orders to treatment & placement	Treatment and placement
Prosecutor	Investigation, prosecution	Evaluation of mental state treatment/victims	Orientation for victims & witnesses to legal system	Attention to welfare of child witnesses	Discipline accountability

Table 1.
Functions of Individuals and Agencies Responsible for Juvenile Offenders (cont'd)

AGENTS	FUNCTIONS				
	Justice	Mental Health	Education	Social Services	Family
Defense counsel	Defense, advocacy for services	Evaluation of mental state	Orientation for defendants to legal system	Advocacy for services	Advocacy, protection
Probation / intake	Investigation, supervision	Counseling, selection and referral, collaboration with treatment	Special tutoring and remedial programs	Support, supervision of intervention	Supervision, curfews
Diversion	Informal disposition	Counseling, mediation	Special school programs as with probation	Family conflict resolution & preservation	Support, supervision
Court clinics	Investigation, assessment of capacities & of dangerousness	Evaluation, referral, treatment	Some specialized informational programs; special education evaluation	Child abuse assessment; family conflict assessment & support	Support for family supervision, nurturance, advocacy
Detention	Protection of youth & public; ensuring return to court	Evaluation; containment for treatment	Containment for involvement in school special education evaluation	Protection, evaluation	Protection, nurturance, supervision
Mental health clinics	Assessment of danger, legal capacities, need for commitment	Evaluation, treatment	Special education services	Child abuse recognition, prevention & treatment	Support for family supervision, nurturance, advocacy, values
Mental hospitals	Containment, protection, assessment of risk & legal capacities	Evaluation, treatment	Containment & support for school; special education evaluation, support	Protection, assessment and treatment of child abuse	Protection, nurturance, values
Local schools	Investigation & prosecution of school offenses	Counseling, behavior management	Teaching	Recognition & reporting of child abuse	Supervision, articulation and conveying of values
Residential schools	Investigation & prosecution of school offenses	Counseling, behavior management	Teaching	Protection, assessment and support for family reunification	Nurturance, protection, supervision, values
Social service agencies	Investigation of child abuse; petition for child protection	Assessment of psychological condition of parents and children, support for treatment	Support for special school placements	Child protection and family support	Nurturance, protection, supervision

Systems difficulties stem not only from overlapping functions among agencies and institutions, but also from the fact that individuals' needs almost always involve more than one of these functions at any one time. As a result, they are simultaneously involved with different institutions for different reasons. Even when these institutions may be quite clear in what they are trying to provide, the demands of another institution may conflict. For example, a family may go to court for help with a runaway child, hoping for support in containing the child's behavior and protecting him or her from the dangers of the street. The court however may find that according to its rules, in order to protect the child it needs to find the parents negligent. A child with a mental health problem may need treatment that interferes with his school functioning; parents may believe that certain curriculum features of a school may be inappropriate for the moral education of their children; parents may take a child for mental health care, only to find themselves in disagreement with a child's therapist about the child's needs, and accused of neglect; a mental health provider may see a child as ill and in need of treatment when a court or corrections agency believes the child needs punishment; or perhaps just as commonly, the reverse: a mental health provider will want nothing to do with a child whom it sees as not sick but antisocial, while a court or corrections agency wants the child to be treated.

Ambiguities about which function an institution (or agencies within it) seeks to serve, and collisions between institutions serving the same or different functions in the process of caring for the same individuals, make the real interactions of these institutions exceedingly complex. Understanding and managing these interactions requires a continuing awareness of the differing, overlapping, and sometimes conflicting purposes of the individuals, agencies, and institutions involved with an individual offender.

JUVENILE OFFENDERS AND MENTAL HEALTH NEEDS

Basic Issues

Discussions of interactions between the juvenile justice system and the mental health system often focus on the concept of *appropriateness* (Bederow & Reamer, 1981). Whether attention is on an individual case, or on systems interactions as a whole, the issue of which youths are "appropriate" for placement in the mental health system and which are appropriate for juvenile justice attention is central. Understanding the issues surrounding the question of appropriateness involves appreciating how mental disturbance is identified and characterized in young offenders, what its relationship is with a youth's offensive behavior, and how these issues contribute to placement of the youth in one system or the other.

Identifying Mentally Disordered Juvenile Offenders

In their overviews of systems issues involving mentally disordered juvenile offenders, Fagan (1991) and Hartstone (1986) indicate that the first issue requiring attention is the identification of the youths who belong to this special class. The issue includes both process features and definitional features. How do we go about discovering youth in need of special mental health attention? And more fundamentally, what kinds of psychological problems shall qualify as "mental disorder" for the purposes of legal process or special treatment programming?

Discovering Cases in Practice

One approach to the question of definition is to look at programs of mental health evaluation for juveniles involved in the legal system to see how they define appropriate cases. What institutions,

agencies, and agents refer youth with mental disorders? According to what criteria? By what mechanisms are they referred?

In the early years of court clinics in Massachusetts, Russell (1969a & b) indicated that one use of a court clinic was to provide diagnosis and treatment for a subgroup of clients selected for attention because of their apparent good potential to respond to treatment. These reports suggest that one approach to defining the mentally disturbed offender focusses on treatability. A more recent report from Massachusetts (Barnum et al., 1989) found in contrast that a juvenile court based selection of alleged delinquents for clinical evaluation more on impressions of high risk and need for intensive services than on impressions of "treatability." A crisis assessment program affiliated with the juvenile court in Detroit set explicit criteria for referral, including aggressive or self-destructive behavior, in an explicit attempt to capture youth with a high prevalence of clinical disturbance (Kelley, 1978). In the Coconino County (Flagstaff, Arizona) Juvenile Court, probation staff carry out a formal psychological screening process in order to determine if clinical evaluation is called for (Cady, 1990). Explicit criteria for referral to the court clinic relate mostly to the offense itself (violent, sexual, or pending transfer hearing), but they include indications of explicit suicidality, homicidality, or bizarre behavior. Finally, when Lewis et al. (1976) looked at the pattern of referral to their New Haven court clinic evaluation service, they found that referred youth tended to be younger, to have more offenses, and to have a high prevalence of psychotic symptoms. In later work (1979) they discovered significantly more physical trauma (including child abuse) and more state-sponsored parental psychiatric care in the referred group.

In a broad based survey, Grisso et al. (1988) explored the extent to which various features of juvenile offenders, including potential features of mental illness, appear to play a part in the decisions made by juvenile court professionals regarding detention, transfer to criminal court, and restrictiveness of disposition. The authors do not address processes that may lead explicitly either to formal mental health evaluation or treatment from a juvenile justice context, but they find that a "mental illness" factor appears to have some impact on decisions regarding detention and disposition. This factor includes features such as bizarre behavior and explicit self-destructiveness, but not less obvious features such as depression, aggressiveness, or hostility. Presence of this "mental illness" factor appeared to increase restrictiveness in both detention and disposition decisions. This suggests that juvenile courts tend to look at dramatic features of mental disturbance as they select cases for differential processing, but may miss less obvious ones.

Mental health professionals have paid considerable attention to the possibility that factors entirely unrelated to clinical disturbance may determine whether a youth is identified as appropriate for the juvenile justice system or for mental health intervention. Westendorp et al. (1986) compared adolescents at intake into either the juvenile justice system or the mental health system to see what variables might determine the system into which problem youth are placed. Although they found that the youth placed in the mental health system had more mental health symptoms (higher scores on MMPI schizophrenia, hysteria, and depression scales), most of these differences disappeared when they controlled for the impact of other variables. Further analysis revealed that the most important factor influencing the determination between systems was ethnicity, followed by gender. The MMPI depression scores, and the youth's previous mental health history (defined as "ever in contact with mental health service in the past"), were the only "mental illness" related factors that appeared to have any impact on their placement.

A series of studies by Lewis and colleagues further suggest the presence of significant systemic racial bias in recognizing and responding to mental health problems in juvenile offenders. Lewis et al. (1979; 1980; 1982) describe clinical impressions of black delinquent adolescents with serious psychopathology that was not recognized or was even actively denied by mental health professionals. They note a differential pattern of referral for treatment even when symptoms were recognized, with white youths and their parents more likely to be referred for mental health treatment than black.

Taken together, this work suggests that recent practice in juvenile courts' selection of cases for clinical evaluation is done on the basis of risk factors such as serious offenses; self-destructive, aggressive, or bizarre behavior; and possibly serious family discord factors such as a history of child abuse. These evaluation practices do not appear explicitly to seek "treatable" youth for mental health attention, as they may once have done. Further, there does appear to be some racial selection bias at work in differentiating between youth who become involved in the mental health rather than the juvenile justice systems. It is not clear whether this bias works prior to youths' presentation to courts and their evaluation clinics, possibly involving family or police discretion in presenting cases originally either to court or to the mental health system; in explicit court processing of cases; or at some other phase of case processing.

Defining Mental Disorder and Mental Health Services

Even more fundamental than the question of how cases are identified is the question of whether we should consider a specific problem to represent a "serious mental disorder" for the purpose of special programming for young offenders. Defining mental disorders, both in general and in individual cases, is not just a matter of clinical diagnosis (although with many juvenile offenders clinical diagnosis is not a simple matter). It is more basically a problem of defining what kinds of problems with cognitive, emotional, and behavioral functioning are *mental health* problems, and what are *other* kinds of problems, appropriate to other functional responses, such as educational problems, moral or justice problems, or social development or family problems. Formal diagnosis is no help with this issue, since virtually any kind of behavior problem can be characterized as a mental disorder according to DSM-IIIR. Applying a reliable diagnostic label to an emotional or behavioral condition does not solve the fundamental social value questions as to whether this condition should be understood to carry the curious combination of stigma and diminished moral responsibility that we tend to accord to those who are "mentally ill."

Despite fundamental philosophical questions (Szasz, 1961), in practice, there are probably some areas of consensus among professionals about what clearly represents mental disorder and what does not. Florid psychotic symptoms with a fundamental loss of accurate perception of reality that is consistent over time and across multiple situations means mental illness to almost anyone. Depression with suicidal preoccupations, sleeplessness, anorexia, and intrusive obsessions with one's own badness, especially in someone with a history of relatively normal past functioning, is also a syndrome that most mental health professionals have come to view as a form of mental illness, though there might still be greater disagreement on this definition among the general public.

There tends to be considerably less consensus about other common problems. Is a boy mentally ill if he is characteristically guarded and tense, and fights with someone who jostles him in a movie line because he feels purposefully provoked? How do we categorize the sort of disturbance involved in a girl running away from home and becoming involved in indiscriminate sexual activity after a long history of being sexually abused? If a boy is routinely beaten by his parents, is emotionally tense and

constricted but not psychotic or depressed, and becomes violent when he drinks, do we consider this to be mental disorder? What do we make of an adolescent who has always had difficulty learning and becomes increasingly bored and frustrated in school to the point of mutually provoking and ultimately fighting with a teacher?

These are the kinds of experiences of deviant emotional and social development, with resultant fluctuating and intermittent abnormalities in mood, perception, and behavior, that are more common in juvenile offenders than are classic presentations of major psychotic or mood disturbance. They certainly include manifestations of emotional disturbance, but they also include significant aspects of deviant family socialization, educational weakness, and moral failures as well. The extent to which we focus on the "mental disorder" element of any of these presentations is a fundamental social and moral judgement, not only an empirical epidemiological question.

It is important to note that very many juvenile offenders who come to the attention of the mental health system have personal histories which include repeated serious physical and psychological trauma (Lewis et al., 1976). They show a high prevalence of variable anxiety, suspiciousness, agitation, impulsiveness, and depression, interspersed with periods of apparently normal perception, affect, and social functioning. Increasingly, clinicians are recognizing that the variability in clinical presentation that these youth show is often a sign of post-traumatic psychopathology. Though it is not the case that these youth all suffer from mental illness, generally, or from Post Traumatic Stress Disorder, specifically, it is probably true that all children who have been abused or otherwise traumatized have been affected by the experience, many in a manner that contributes to a variable and confusing clinical presentation. It is important for both mental health and justice institutions to appreciate the variety of children's responses to abuse, and the implications of those responses for mental health classification, prognosis, and treatment.

The emotional and perceptual instability that such youth show is often a contributing factor in clinical disagreements about the nature of their psychological functioning, and thus about the appropriateness of special mental health programming for such youth. Youth with traumatic pasts may show specific features of dissociation, such as flashbacks, other suddenly erupting behavioral changes, or even whole personality changes. They are also at risk for developing borderline personality disorders which may be marked by significant emotional and behavioral variability, as well as other anxiety and affective symptoms. Because they are so prone to change from time to time and especially from situation to situation, they tend to generate confusion and conflict among professionals dealing with them about what they are "really" like. Disagreements over whether such youth consistently show the sort of emotional disturbance that would qualify for a finding of serious mental disorder are frequent and difficult, and contribute to considerable confusion in determining what should be the appropriate placements and dispositions for them.

Currently, one popular way of conceiving of mental illness is as a "brain disease." By this conception, the psychological conditions that appear most clearly to represent abnormal biological functioning in the brain are those which would tend to be considered serious mental illness. It is important to be cautious about accepting this vision uncritically as a basis for determining which juvenile offenders should be seen as suffering from serious mental disorder. Many biological characteristics which are not routinely considered to represent mental illness are associated with delinquent and antisocial behavior (Barnum, 1987b; Wilson & Herrnstein, 1985). If we were to decide that we should pay special treatment attention to a contributing condition because it is a physical one,

then we might find that we need to consider youth to have special entitlements on the basis of such conditions as mesomorphic somatotype or male gender. Lewis' (1992) recent review of physiological correlates of violence finds broad evidence of biological abnormalities contributing to antisocial behavior, some in ways that we tend to think of as relating to mental illness, and others of which we may not. In principle, the "physicalization" of symptoms may be useful in helping us to think of some syndromes as illness rather than as moral flaws; but most (if not all) patterns of behavior have their physical correlates, and it is not clear that this approach to prioritization provides a way of discriminating between serious mental disorders and other kinds of problems in a way that will ultimately be meaningful and helpful.

Assessing Appropriateness for Emergency Mental Health Care

Most juvenile justice institutions - police lockups, detention centers, juvenile courts, and secure and non-secure youth corrections centers - identify youth who appear to be suicidal or psychotic as being in need of emergency mental health care, usually hospitalization (McNiel, 1991). Conflicts may arise from their requests for such care because of differing functional agendas in differing institutions. Justice institutions typically see kids behaving in a manner that they do not understand, or doubt their own capacity to manage successfully; mental health institutions typically see these young offenders as different from the patients with whom they are accustomed to dealing, and as less than fully welcome in either inpatient or outpatient settings.

Mental health professionals may be reluctant to admit such youth to hospitals either because of their perceptions that they are not mentally ill (but rather only conduct disordered or personality disordered), or because they perceive such youth as being too difficult to manage. This reluctance can result in no mental health service being provided. In other circumstances it can lead to justice institutions pursuing what mental health institutions perceive as *inappropriate hospital commitments* .

A common inappropriate hospital admission is the commitment for forensic evaluation of a patient for whom there are no significant forensic questions. Courts or other legal institutions may pursue such commitments because they have the power to order them, when their real agenda is to obtain clinical care, containment, or non-forensic clinical evaluation, which they may not have the power to order. The result may be an expensive inpatient stay which may include a careful but unnecessary forensic evaluation, and which does not address the true need for clinical treatment, because no one asked for it. Furthermore, to the extent that such commitments are made without the advice of mental health professionals, they may in fact be clinically inappropriate as well. Such commitments expose youth without substantial mental disorder to hospitalization, and the hospital to a youth whose antisocial behavior may not be what the hospital is well equipped to deal with. These sorts of commitments will not be satisfying interactions for either the mental health or the justice institutions, or for the patients who move between them.

Where courts or corrections agencies do have the power to commit to mental health institutions directly for clinical purposes, the mental health response may be a passive disapproval of the admission, and a tendency to minimize the patient's psychopathology. One example of the tendency to minimize is the practice of using conduct disorder as a diagnostic label, and thinking that the diagnostic job is complete. It rarely is. The various conduct disorder subtypes describe different combinations of bad behavior, but they do not explicitly account for any of the problems in mood, affect, or perception which are usually part of the clinical picture for the kind of multiply impaired adolescents who end up being hospitalized. Though it seems obvious that for such an adolescent to be hospitalized, significant

problems, usually thought of as signs of mental illness, will have been present, it is remarkable how often clinicians who are not familiar with such youth (and some who are) will be satisfied to apply a conduct disorder label, without seeming to explore the presence of co-morbid conditions (Ewing, 1991; Hutchinson, 1991).

Another kind of minimization stems from the fact that the youth being evaluated by the hospital has become a different patient from the one initially referred by the justice community. It is common for these youth to show dramatic symptoms of behavioral, affective, and perceptual disturbance, and to have those symptoms disappear equally dramatically soon after entering the structured environment of the hospital. When adults show the same course, they tend to be seen as intermittently psychotic or depressed, or borderline, or suffering from some other syndrome with a recognized presentation of variable symptomatology. With conduct disordered adolescents, there may be more of a tendency to discount the history of dramatic symptoms with labels such as "manipulative" or "acting out," losing track of the potential syndromal significance of the clinical history.

These youths' quick stabilization tends to confirm clinicians' original impressions that they do not in fact belong in a mental health facility. Inpatient clinicians readily fall into the trap of believing that whoever referred this obviously healthy patient for hospitalization made a mistake. As already noted, it sometimes does happen that patients are hospitalized inappropriately from justice institutions. However, mental health settings do everyone a disservice when they assume that, because a patient rapidly improves in the hospital, he or she is there inappropriately, without taking time to understand how the patient got there, and what was going on to make that happen. As noted above, dramatic variations in functioning, including rapid stabililization after a change in placement, are characteristic of post-traumatic psychopathology and of some personality disorders. Such changes should be an occasion for careful diagnostic assessment and characterization rather than for clinical dismissal.

Identifying the Appropriate System for Long-Term Care

When juvenile offenders appear to be mentally disturbed, the central question in the interaction of justice, mental health, and educational institutions is what sort of long term placement they should receive, under whose auspices, and by what funding. For those who appear to need months or years of institutional care on the basis of impaired functioning and risk to themselves or to the community, the question addresses the nature of their disturbance. Do their impairments represent such serious mental health problems as to justify long term hospital care? Is the difficulty something that should really be understood as an educational disability, for which a residential school should be provided with special education funding? Or is it a fundamental problem with socialization and moral development, for which a correctional placement is an appropriate response? Different jurisdictions answer these questions in different ways, depending on their institutions, including their structures, organization, missions, goals, and resources, as well as on the social values embodied in their laws, regulations, and policies for dealing with these youth. As Melton points out (1990), the differences in agency placement appear to have to have little to do with any differences in intrinsic clinical features of the youth themselves.

The default institution for such youth is the juvenile justice system. Delinquent or status offenders end up placed primarily in long term placement in corrections or court-ordered social service group care programs. When they demonstrate high levels of behavioral or emotional instability prior to their justice system involvement, or after justice system placement, the justice system may then move

to place them in the mental health system. At this point, conflicts regarding diagnosis and entitlement may arise, similar to those described in emergency situations, but they may be handled in more bureaucratic fashion. Generally, it is the mental health agencies which resolve the question of long term placement, by either accepting youth for long term inpatient programs, or rejecting them, based on criteria that reflect judgements of either need for or amenability to treatment. Some youth remain in juvenile justice institutions, but receive special mental health services in these placements. Some find themselves in special programs within the juvenile justice system for mentally disturbed offenders, while others remain in routine placements but receive added mental health services in those programs. Some remain in correctional facilities with no substantial mental health care at all.

Sometimes youth in mental health treatment programs who have not been adjudicated begin to appear inappropriate for those programs, often as a result of aggressive or other antisocial behavior that is disruptive to the program. Sometimes mental health practitioners initiate prosecution of these youth in order to have them removed from the mental health program and placed in a juvenile justice program. An exploratory study of the extent of this practice in Massachusetts (Greenberg, 1992) found that about half the programs responding to the survey had used this practice as a response to misbehavior of program residents. Most notably, 16% of the respondents indicated that "incapacitation" was a goal of the prosecution, and 8% of the agencies indicated that a justification for using prosecution was in order to access services that were not available for the youth in question without prosecution. Presumably these were services available only through the juvenile justice system, and included the capacity to provide security and explicitly punitive responses.

In summary, the primary issue in the relationships among mentally disordered juvenile offenders, the juvenile justice system, and the mental health system is *appropriateness*: what kind of problems does the offender have, and what system is appropriate for responding to them. Although, in theory, it may be possible to imagine one offender with the kind of problems that clearly would be appropriate for a justice response, and another offender with problems appropriate to a mental health response, in practice things are not so clear. The capacities of individual systems to provide for the needs of youths who are unfamiliar to them and difficult for them to manage are limited, and their need to protect themselves from the disruptions that such youth may present is significant. Diagnostic uncertainty clouds the picture. Racial and gender biases seem to have some impact on placement decisions. Indeed, the notion of appropriateness in placement of juvenile offenders may be to some extent mythical, as youth in mental health facilities may differ more from those in juvenile justice facilities on demographic variables than on diagnostic ones.

Comparisons with the Adult System

Professionals in mental health and law in the adult area are paying increasing attention to issues of systems interaction between criminal justice and mental health, after a period of preoccupation with concerns about the specifics of mental health laws in statute and appellate caselaw (Petrilla, 1992). Wexler's development of "therapeutic jurisprudence" (1991; 1992) is consistent with a broadening of attention from a sole focus on the rights of the mentally ill to a more careful examination of the nature of mental health services and legal processes, and especially to the mental health consequences of actions in the justice system.

Differences in the Juvenile System

Current attention in the adult system to process and systemic interactions is practical and worthwhile in its focus on identifying and responding to the needs of adult offenders with serious mental

illness. Applying the same approach to systems issues for mentally ill offenders in the juvenile area is more complex, because of two important differences. First, the nature of psychopathology in childhood and adolescence is somewhat different from that in adulthood, and mental health professionals have tended to take a somewhat broader and more inclusive view of what sorts of difficulties call for mental health attention in childhood. The use of the term "emotional disturbance" (with its connotations of broadly varying deviations in emotional and social development) in preference to "mental illness" (with its connotations of more explicit psychotic and affective disturbances) when discussing children and adolescents reflects this difference. This makes the definition of the target population more difficult. Second, the juvenile justice system has traditionally maintained a more explicitly rehabilitative vision of its relationship to young offenders than the criminal justice system has held in its dealings with adult offenders. As a result, rehabilitative treatment, usually focussing more on broad deviations in emotional and social development than on explicit mental illness, has (at least theoretically) been integrated into justice responses to juvenile offenders. It has not been a part of ordinary criminal justice responses to adult offenders. These two differences are closely related to each other, in that the tradition of rehabilitative focus in the juvenile justice system stems, at least in part, from the recognition that offensive functioning in the young usually represents a less fixed condition than it does in adults.

In part because of these differences, much analysis of mental health issues in the juvenile justice area has focussed on exploring the implications of the rehabilitative basis for delinquency jurisdiction for mental health services in the juvenile justice system. Some mental health professionals have shown great enthusiasm for contributing to the juvenile justice system. For example, Sobel (1979) asserts that "psychology has infinite potential for productive inputs that would improve the condition of youths in the court system". Others suggest that mental health professionals should play a larger part in addressing the problems of juvenile offenders in part because the juvenile court seems to lack professionalism and effectiveness in doing so on its own (Rich, 1982). More balanced comments (Saxe, 1988; Mulvey, 1989) note that mental health systems tend to have their own problems with effectiveness, stemming from bureaucratization and subsequent failures of flexibility and responsiveness. They caution against casual and non-specific use of mental health evaluation and treatment by the juvenile justice system.

Others are more critical of suggested interactions of juvenile justice and mental health. From a youth advocacy perspective, Soler (1987) reminds us of ongoing institutional abuses of children in the name of treatment. He does not conclude that treatment is a failed endeavor in the juvenile justice system, but asserts that juveniles being treated need considerable protection from abuse. Melton (1989) offers a severe critique of the fundamental paternalistic assumptions of the juvenile court and of its supposed affiliation with treatment, noting that this affiliation seems so routinely to fail that it should simply be disposed of in favor of a due process juvenile court that would be even more demanding procedurally than the criminal court. Connell (1980) suggests that as the juvenile justice system becomes more focussed on due process protections and less rehabilitation oriented, the mental health system will step in and deal more with juvenile offenders on an informal paternalistic basis, with a net reduction in procedural protections for juvenile offenders. Some recent concerns about inappropriate hospitalization of adolescents (Kerr, 1991) suggest that this may be a legitimate concern.

On the other hand, courts are increasingly presented with requests to resolve complex social problems related to health care, social services, and family problems. In the future, courts may increasingly be called upon to resolve societal problems related to poverty, health care, social services, drug abuse and family matters. This trend is evident in the mandates of legislatures and

pronouncements of commissions (National Center for State Courts, 1991). Legislators have sought greater use of involuntary civil commitment to outpatient facilities instead of inpatient hospitals, for example, expanding the role of courts beyond adjudication and disposition. These roles may now include patient monitoring, supervision, revocation of outpatient status, and other duties previously assumed by the health and social service systems. In the future, many courts will need to develop closer cooperation and coordination with these systems. The drug abuse crisis, widespread movement of mental patients from large public institutions to community-based mental health facilities (deinstitutionalization), increased public visibility of mentally ill homeless persons, and various economic factors have put pressures on state courts in the areas of involuntary civil commitment, guardianship, and other court-ordered mental health and drug treatment care.

In response to such pressures, the legal system may establish further civil or administrative jurisdiction in cases involving mental health needs of juvenile offenders. Such civil jurisdiction would likely focus on regulation of treatment practice and entitlement, attending to such issues as the right to treatment, appropriate consent for treatment, insurance coverage for treatment, and even civil liability of professionals for failure to treat according to a proper standard.

A fundamental source of confusion about what constitutes appropriate legal processing as well as placement for mentally disordered juvenile offenders results from a lingering sense that juvenile offenders are *either* sick or bad, and thus are clearly appropriate to the functions of *either* the mental health or the juvenile justice systems. Hartstone and Cocozza (1984) point out that states tend to identify youth as either delinquent or mentally ill, thus limiting treatment for delinquents and punishment for the mentally ill. They argue that it may be reasonable to deal in this way with the few youth who are so mentally ill that their mental illness is totally responsible for their offending behavior, but that most delinquent offenders with emotional disturbance are indeed responsible for their actions. As a result, they require a dual approach, including both treatment for the emotional disturbance as well as more basic socializing sanctions. Similarly, Barnum (1987a) offers an analysis of socialization - the development of a youth's "responsibility" in various areas - that minimizes the significance of mental illness in the juvenile justice system from an explicit forensic point of view. He argues that the disturbances in emotional development that most juvenile offenders have make *both* justice interventions and a variety of mental health treatments appropriate to their care.

A careful understanding of the function of the juvenile justice system makes clear that its appropriate role is to provide a structured forum, according to law, for responding to a multitude of failures in individual development, family functioning, and in school and other agency functioning, almost always in a manner that involves the concurrent application of sanctions, supervision, education, and a variety of treatments. Nonetheless, it is still common to encounter arguments about the system that are more simplistic, and couched in "either-or" terms. Either juvenile delinquents are sick or they are bad; they are like children or they are like adults; they are responsible for their acts or they are not; they deserve either treatment or punishment.

These either-or arguments reflect fundamental conflicts in our values and beliefs about children and responsibility. When children fail to develop responsibility in appropriate ways at appropriate rates, unavoidable and legitimate questions include: "Whose fault is it?" "Should he be punished?" "How can he be helped, if at all?" The most stark conflict is between those who would see children as sick and impaired victims of such failures and as deserving of whatever help we may have to offer, and others who would see them as untamed perpetrators deserving of containment and punishment. One

result of this fundamental conflict is that there is inevitable tension between systems whose fundamental assumptions are of patienthood and need for help and treatment, and others whose fundamental assumptions are of "badness" and a need for containment and correction.

This tension shows up in difficulties between mental health systems and the juvenile justice system when there are disagreements about the nature and functional significance of psychopathology in a youth. Unlike the criminal justice system, however, the juvenile justice system continues to maintain a rehabilitative tradition, with an expectation that its involvement with a youth will include elements both of correction and of treatment. This expectation creates a routine need for the system to deal with treatment and rehabilitation issues that go beyond the narrowest limits of serious mental disorder in offenders, contributing to occasions for conflict between institutions and to the need for communication and cooperation.

MENTAL HEALTH EVALUATION ISSUES FOR JUVENILE OFFENDERS

From a practical point of view, the first step in addressing the question of appropriate placement for a mentally disordered juvenile offender comes in assessing the offender's mental health condition. Assessment of mental health issues for offenders generally and for juvenile offenders specifically has two basic purposes: The first is to address specific legal issues that may arise in various situations; this is the *forensic* evaluation agenda. The second is to address the clinical needs of the offender at any stage of proceedings, from intake to dismissal or discharge; this is the clinical, or *amenability to treatment* agenda. In some situations, such as the juvenile transfer or waiver case, or in some disposition cases, these two agendas overlap (Sacks, 1992).

Forensic Evaluations

The forensic agenda involves evaluation of the individual for the sake of the institution. The evaluator's primary function is to assist the juvenile court in the adjudication, disposition and management of the case. The evaluation may also benefit the individual, but the primary purpose is to answer questions about the state of the individual that the institution needs answered in order to carry on its work with this individual or with others. The forensic mental health evaluation of competencies (to stand trial, to consent to treatment, to testify, etc.) satisfies legal institutions' requirements that individuals meet a certain standard of capacity in order to take part in the activities of these institutions. The evaluation of need for civil commitment or continuation of commitment, or of dangerousness to self or others in other contexts such as bail or other preventive detention, meets the institutions' responsibility to protect the individual and others from harm (O'Leary, 1989). Broad evaluations regarding disposition (Appelbaum, 1991; Halleck, 1984) not only determine an individual's mental health needs, but also satisfy the court about the individual's legal appropriateness for certain sentencing alternatives.

A variety of situations in the juvenile justice system call for explicit forensic evaluation. These include: 1) situations requiring assessment of dangerousness, such as in considering detention alternatives, or in response to behavioral crisis in any institutional setting; 2) the juvenile trial process itself, regarding such issues as competence to stand trial and criminal responsibility; 3) the juvenile transfer or waiver hearing; and 4) dispositional planning.

Emergency assessment of dangerousness in situations involving potential suicide or violence to others is a familiar use of mental health expertise, even though dangerous behavior may not necessarily be a manifestation of mental disturbance. Violent behavior, whether to others or to the self, stems from many different sources (Cornell, 1990), many of which would fall outside the realm of what most mental health professionals would consider mental illness. Even so, mental health professionals may become as familiar as anyone with the actuarial variables which tend to be most powerful in making these predictions Monahan (1977). They may then use clinical skills in applying them to individual cases to ensure that the specific characteristics of the individual case under evaluation indeed match the variables in the actuarial model, and especially to determine if there are specific features of psychological functioning that might change the actuarial prediction.

Some systems of juvenile justice and mental health expend considerable resources on forensic mental health evaluation of such issues as competence to stand trial and criminal responsibility (Grisso, 1987; Weissman, 1983). Such efforts frequently seek more to provide circuitous routes to providing mental health treatment than to answer significant and relevant legal questions (Melton, 1987).

Forensic mental health evaluation may have an important role to play in the determination of whether a case will be heard in the juvenile setting or transferred (waived) to the adult criminal court. (Barnum, 1987c; Benedek, 1985; Quinn, 1988). As in other situations, mental health evaluation is likely to be more significant when there is some indication of psychological disturbance, when the legal criteria involved require consideration of the defendant's likely amenability to treatment, and where the law and the facts of the case do not point to a predetermined conclusion. Consultation in such cases reflects consideration of specific psychological disturbances and of social and emotional development; attention to the relationship between these disturbances, the offense in question, and the likelihood of future offenses with or without treatment; the availability of specific programs of treatment to address the defendant's difficulties (Sarri, 1985) and the degree to which the personal characteristics of the defendant match well with those programs (Weingard, 1987; Murphy, 1987; Grisso, 1988); the likely time course of treatment; and the expected results of treatment.

Mental health evaluation for dispositional purposes in juvenile justice may include attention to all four traditional areas of concern (incapacitation, deterrence, retribution, and rehabilitation) (Appelbaum, 1991), or, in a more paternalistic traditional juvenile justice orientation, it may address only the public safety and individual development issues of incapacitation, deterrence, and rehabilitation.

Amenability to Treatment Evaluations

Like forensic examinations, the amenability to treatment evaluation agenda meets institutional needs, but it tends to be more client focused. It addresses the question as to whether the individual is likely to respond to mental health treatment. This includes assessment of diagnosis, and also features of the person's individual situation that might have an impact on his or her capacity to engage successfully in treatment, including such concrete elements as insurance status and geographical access to care (Rogers & Webster, 1989), and more subtle ones such as matching patients with appropriate therapists or programs (Grisso, 1988; Weingard, 1987). If this evaluation concludes that mental health care of a particular type in a particular setting is likely to be of benefit, this may contribute to undertaking institutional attempts to provide it; this in turn may be attractive and helpful to the individual, or represent unpleasant intrusion and restrictions, or even (sequentially) both. If the

evaluation concludes that treatment is not likely to be useful, this may be disappointing to the individual and to institutions involved, or it may be a relief to all concerned, depending on the legal circumstances and various other institutional functions and interests at stake.

Amenability to Treatment and Need for Treatment

Assessing an individual's likely response to treatment (amenability) is not the same as assessing his or her *need* for treatment. The latter includes addressing the question of whether the treatment is actually likely to help. But beyond this prediction, it adds value and policy considerations about such matters as the severity and the importance of a condition, especially (in this context) the contribution of a condition of mental disturbance to offensive behavior. A surgical example makes the point best. Cosmetic surgery to change the appearance of a person's nose is likely to be successful, so that there would be a high estimate of amenability to treatment for this procedure. Surgical removal of a lung cancer is less likely to be successful. However, as long as there is any possibility of success, this is a treatment for which there may be a greater need, because of its critical importance to the patient's life.

There is no perfect analogy in psychiatry, but professionals make similar judgements all the time in which the relative importance of a disorder is considered together with an estimate of the likely success of treatment in reaching a determination of the need for treatment. States may be willing to pay a great deal for special programs for very seriously disturbed offenders which do not in fact have a high rate of success, because of the severity of the behavioral disturbance involved, whereas they may be averse to paying less for less intensive treatment of far more minor problems in emotional adjustment, for which treatment may be likely to be far more successful. These questions of prioritizing apportionment of treatment resources are especially challenging ones (Rogers & Webster, 1989), and require input beyond pure mental health expertise.

Conducting Amenability to Treatment Evaluations.

Because dealing with juvenile offenders always involves addressing issues from justice, educational, and family perspectives, in addition to issues of prognosis for mental health treatment, programs providing amenability to treatment evaluations for the juvenile justice system always have some trouble coping with the conflicting expectations and demands of the different institutions involved (Lewis et al., 1973a & b; Halpern et al., 1981; Chamberlain, 1975; White, 1976; Nurnberg, 1976). In light of these conflicts, the actual conduct of an evaluation for amenability to treatment needs to take into account the differing perspectives and institutional agendas (Barnum, 1986). Just as forensic evaluations need to have a sound clinical basis, and will often make contributions to treatment planning, so also must amenability to treatment evaluations rest on a sound basis of understanding legal and institutional requirements, goals, and capacities. To be useful, an amenability to treatment evaluation needs to avoid limiting itself to general treatment prognostication. It needs to offer explicit treatment recommendations that are consistent with the goals of the institutions for which they are performed, and grounded in the real capacities of those institutions to provide the sort of care and treatment which is being recommended.

MODELS OF SERVICE DELIVERY AND ORGANIZATIONAL INTERACTION

Mentally disordered juvenile offenders present multifaceted problems that require the organizations responsible for them — families, juvenile courts, juvenile detention, probation, and

corrections agencies, social service or child welfare agencies, mental health agencies, and local and state educational authorities — to interact with one another in providing mental health evaluation and treatment for youth. Flexibility and adaptiveness in these interactions appears to improve program effectiveness (Schorr, 1988). However, cross systems gaps and fragmentation of services are often the rule (Saxe et al., 1988). This section provides examples of arrangements for providing evaluation and specialized treatment services, including both community based and residential treatment, as well as aftercare services.

Agencies deal with one another along a number of organizational boundaries and about a number of recurring issues of common interest. They all need to deal with funding issues, to sort out among themselves who will be responsible for paying for what services. They may need to deal with one another around issues of access to services or programs, or regarding custody of or authority over a youth. How these agencies interact with one another depends on many factors, including their primary institutional missions, and the extent to which their missions may overlap with one another.

In his discussion of human service agencies' efforts to develop broad systems of care for mentally disordered youth, Friedman (1989) characterizes agency interactions as marked by a basic *system of care* pattern, by a pattern of *multi-agency* collaboration, or by a focus on providing individualized care. The following analysis characterizes agencies' interactions in dealing with mentally disordered juvenile offenders similarly. Three common patterns of interacting are discussed: *agency-centered, collaborative,* or *child-centered.* A fourth potential pattern, *family-centered*, which shows signs of becoming potentially significant as well, is also presented. No state or locality has agencies interacting with one another by only one of these patterns, but in different areas one pattern or another tends to predominate.

Agency-Centered Interaction

It is probably most common for agencies to deal routinely with one another in ways that aim to foster the integrity of the agency itself. Services are provided within the agency itself, under its own control, with no need for the disruption and uncertainty that tends to come with crossing boundaries into other institutions. These services tend to be structured as discrete programs, with well-defined eligibility provisions and consistent service characteristics.

Agency-centered organization of services is commonly criticized for its tendency towards bureaucratization, inflexibility, and lack of responsiveness to the specific needs of individual children and families. However, it is important to recognize that individual agencies may be capable of establishing a broad range of specific service programs within their own boundaries, providing thereby for the service needs of most of the youth who are assigned to the agency's responsibility.

Massachusetts' current arrangements for serving mentally disordered juvenile offenders provide a good example of interaction that is predominantly agency-centered and that offers a broad range of clinical services to a broad range of offenders. Mental health evaluation services for juvenile offenders are provided initially either by court clinics or by the Department of Youth Services (DYS) through a vendor contract with an independent mental health agency. Court clinics are primarily funded by the Department of Mental Health, though some receive funding from the Juvenile Court Department of the Trial Court. Regardless of funding source, however, in the areas where they exist, juvenile court clinics' primary institutional affiliation is with a court, and their business is to provide consultation in the context of ongoing cases to aid the court in its management of those cases. Where juvenile court

clinics do not exist, court-ordered evaluations are conducted by the DYS vendor. Additional mental health evaluation may be provided by the DYS vendor agency for youth committed to DYS, by other agencies or independent consultants on contract to the Department of Social Services (DSS) if DSS is responsible for the case, occasionally by the Department of Mental Health (DMH) (if the case appears to show the severity of explicit mental illness systems that would lead to DMH involvement), and sometimes by independent clinics or mental health professionals at the direct request of families. Occasionally, DYS will contract with individual independent mental health professionals to conduct evaluations in cases that have high public visibility and serious charges. Loughran (1985) describes the development of an interagency agreement between DMH and DYS, which calls for DMH to provide evaluation and consultation to DYS detention and treatment facilities similar to that provided by the New York State Mobile Mental Health Teams (described below), but in fact this consultation tends only to be screening for emergency admission to hospitals (Forbes, 1992). DYS obtains more detailed consultation services, including ongoing clinical evaluation of cases, from its contract with the same vendor that provides court-ordered evaluations in lieu of court clinics.

Inpatient evaluations are provided by DMH facilities or by private hospitals by agreement with DMH, with Medicaid funding. These tend to be reserved for emergency situations, though courts occasionally order explicit forensic evaluation on an inpatient basis. DSS has intensive, staff-secure residential evaluation centers, primarily used for containment and evaluation of status offenders. If a youth is committed to DYS on a serious charge, he is referred to a formal DYS classification process that includes psychological evaluation by a different vendor.

Mental health treatment services for youth in DYS are provided mostly within the DYS residential settings, as part of the overall treatment program. If treatment services beyond the capacity of the program itself are required, DYS will pursue them in the community from local agencies or independent providers, without other agency involvement. These are usually funded by Medicaid, though in unusual circumstances DYS will pay the bill directly for a non-Medicaid covered service. One small DYS program, the Butler Center, offers more intensive mental health services and is designed to serve committed youth with significant problems of mood, perception, and impulse control, who might otherwise be referred to the Department of Mental Health (Loughran, 1985).

The Department of Social Services also provides some specialized outpatient treatment for children and families through vendor contracts. It funds many residential treatment placements for status offenders and for children and adolescents it serves on a protective basis.

Extended inpatient mental health treatment is provided in Intensive Residential Treatment Programs (IRTP), small self-contained units administered by DMH but provided by independent vendors. These are jointly funded by DMH and Medicaid, have extended stays (a year or two), and require that a youth meet the legal standard of mental illness and dangerousness to be admitted. Though it is not uncommon for IRTP residents to have had juvenile justice involvement, it is now uncommon for DYS committed youth to be admitted to these programs. They are mental health department programs, and a youth generally becomes the responsibility of DMH when he is admitted.

DMH has also made a significant investment in out-patient case management services for mentally ill children and adolescents, and in community alternatives to hospital care, including respite care, day treatment, home based treatment, and residential treatment. However, these services are available only to clients who are eligible for them by reason of their demonstrating mental illness, and

not being involved in other agencies. If a youth is the responsibility of DSS or DYS, he is not eligible for case management services from DMH, as DSS or DYS caseworkers are responsible for providing these services. It is generally assumed that the responsible agency will provide needed residential or other treatment services as well.

In Massachusetts, agency-centered interaction appears to contribute to individual agencies developing multiple capacities to provide appropriate specialized care in different ways. Most noteworthy is that the youth corrections agency sees its responsibility for its clients as including the provision of at least some types of mental health care. As a result, youth receive appropriate diagnostic and treatment services in contexts that are familiar for the responsible agency and that do not require the activation of complex interagency agreements.

However, this sort of organization may work quite differently. For example, Myers (1992) notes that in Florida, most juvenile homicide perpetrators end up in youth corrections programs with very little treatment provided at all, despite the fact that many of them have significant mental health problems that have gone undetected. Hartstone and Cocozza (1984) note that New Mexico, like many other states, has a similarly wide separation between youth corrections and mental health services, limiting mental health treatment for all delinquents. Thus, agency-centered programming can only be expected to provide mental health services for youth to the extent that the agency sees these services as part of its responsibility.

Collaborative Interaction

When agencies come to recognize that they share responsibility for certain problems, and when they are capable of taking the initiative to approach one another to establish ways to work together in addressing these problems, they may develop a capacity for explicit collaboration. Such collaboration usually takes the form of explicit agreements, of greater or lesser scope, to address specific aspects of a shared responsibility. These agreements may focus on a narrow area of activity (such as Massachusetts DMH screening youth in DYS and DSS for emergency hospitalization), on the development of specific service programs, or on the development of an entire system of care.

An example of very extensive use of collaborative interaction is the *Ventura County* system, described by Jordan and Hernandez (1990). They describe implementation of a county-wide collaborative arrangement for mental health services for all youth for whom the public was responsible, including those in state hospitals, special education placements, abused and neglected children who were state dependents, and juvenile offenders. The agreements stemmed from a generic approach to planning public mental health service delivery, resting on five steps: 1) identification of a target population, defined in terms of the degree to which its members are, or are at risk of becoming, a state liability by virtue of specified difficulties (in this case mental health problems with functional impacts such as a potential need for out of home placement or justice system involvement); 2) defining goals of intervention, and measurable objectives; 3) collaboration among agencies responsible for various aspects of overall services for the target population, with an expectation of pooling resources and developing joint programs to provide individualized services; 4) development of specific service programs, with consistent standards of care across the entire system; and 5) development of careful evaluation measures, attending to both clinical and systems outcomes as well as to costs.

Their report describes a vast interlocking network of service agreements involving close collaboration by agencies providing services to one another in one another's programs. It claims significant resulting improvements in efficiency in service delivery in Ventura County including decreasing interagency conflicts, clarifying responsibility, and reducing redundant services. The study further suggests that provision of mental health treatment services to youth within the county youth corrections center both reduced delinquency recidivism in that center, and was also concurrent with an increase in the court's utilization of the center. Diagnostic characterization of this group was not detailed, but suggested high prevalence of affective disorder and of substance abuse. The authors do not offer detailed hypotheses about the increased utilization of the center after the development of the services; one obvious possibility is that the court was more enthusiastic about committing youth to the program for longer periods, even on lesser offenses, when commitment led to their being treated.

An example of limited collaboration is the *New York State Mobile Mental Health Teams* (Fagan, 1991). In this program, staff of the state Office of Mental Health (OMH) travel on a regular basis to juvenile correctional facilities operated by the state Division for Youth (DFY), providing diagnostic assessment, treatment planning, case monitoring, crisis intervention, training and consultation to DFY staff, and interagency planning and advocacy. Their regular scheduled placement within the offices of the DFY programs enables these teams to establish the sort of legitimacy within DFY that the Massachusetts DYS vendor consultation program enjoys, even though these teams are funded by the Office of Mental Health.

Other less extensive collaboration efforts have not been so successful. Cocozza et al. (1981) describe the utilization of a specialized mental health program for seriously disturbed violent youth in *New York*. This program involved careful collaboration between the New York mental health and youth corrections agencies to ensure that only the seriously disturbed youth appropriate for this program would be admitted. The report notes that these careful screening and strict admission criteria resulted in a rate of utilization that was far lower than had been anticipated, as 60% of the youth referred to this program were found inappropriate for admission, based on criteria of mental illness and violence. They indicate that many of those admitted, even with strict criteria, failed to complete the program, but that those who did complete the program had better overall results than youth involved in alternative treatment. This program has since been discontinued.

Another failed effort at collaboration was the development of the *Massachusetts Regional Adolescent Programs* (Bederow & Reamer, 1981; Loughran, 1985). These specialized inpatient treatment programs were established by the Department of Mental Health to serve a population of severely disturbed, highly assaultive adolescents, 50% of whom were to be Department of Youth Servies committed youth. Though the programs were the responsibility of DMH, they represented a major effort at interagency collaboration in that they were expected to serve DYS youth as well, and had elaborate referral and admission approval procedures involving multiple agencies. Loughran characterized these programs as failures even before they had all become operational, in part because they were much more expensive than other programs of DYS secure treatment, and in part because the Department of Mental Health seemed uncommitted to making them work. They ultimately were closed as a result of a withdrawal of funding from the legislature after an investigation suggested the presence of substandard care.

Child-Centered Interaction

A newer approach to agency collaboration in serving troubled youth involves an explicit commitment to complete flexibility in arranging services for a child. This approach aims to provide arrangements for care that are driven entirely by the needs of the individual child, rather than by any preconceived institutional requirements or capacities. Burchard and Clarke (1990) characterize this "individualized care" as an approach to mental health services that allows for increased flexibility of both programming and expenditure, based on the principle of providing what the child needs when and where he or she needs it. This approach tends to focus more on the social ecology of a youth's behavior problems than does a more traditional approach to individual psychiatric diagnosis and treatment. In assessment and planning, it includes characterization of the child's individual functioning in various spheres, and also characterizes the rest of the family, the community context of the family (neighborhood, school, church, work, friends, extended family), and the availability and functioning of the relevant service systems.

Probably the best known examples of child-centered agency interaction are the Willie M. program in North Carolina (Fagan, 1991), the Alaska Youth Initiative, and Project Wraparound in Vermont (Burchard & Clarke, 1990). These programs begin with an assumption of interagency collaboration, and establish this collaboration with multiagency teams to support service provision for individual youths. They go beyond the collaborative model, however, in that the agencies do not collaborate in providing a specific *program* that may or may not be appropriate to an individual youth. Instead, they collaborate in approving purchases of *services* to support the care of each youth, as the services are needed. This arrangement is intended to allow more rapid and flexible provision of care, with a tendency towards needing less restrictive placements.

While such flexible child-centered programming has considerable intuitive appeal, evaluation information is just beginning to become available. An important issue in applying this sort of interagency approach to juvenile offenders is how agencies and courts interact with youth and families in balancing a youth's individual treatment needs with other goals of the justice system such as community safety, deterrence, and retribution.

In discussing interactions between mental health and juvenile justice in North Carolina, Behar (1992) noted that there remains a small group of youth who are eligible for community-based mental health services under the Willie M. decree but who remain in training schools, either because appropriate programming is not available in their geographical regions, or because they are perceived as presenting too great a risk to the community. Although the Department of Mental Health then offers mental health services to these youth in the training schools, these services are seen as not fully adequate to the youths' needs. For juvenile offenders who are placed in the community, collaboration of mental health and juvenile justice agencies is structured on an individualized basis, and generally appears to be helpful in fostering effective mental health care.

Family-Centered Interaction

A further extension of child-centered interaction among agencies is interaction that focusses on fostering the integrity of the family as a whole unit (Friesen & Koroloff, 1990). Though child-centered arrangements certainly focus on supporting families, a truly family-centered process would set the goal of family support as primary, shifting the goal of service away from helping the individual child. Although protecting and supporting families in caring for children clearly has an important role in delinquency prevention and treatment (Wilson, 1987), there are potential problems with focussing on

the family at the expense of the child. These include the potential for exacerbating discord and emotional disturbance for all family members in situations where the parents do not in fact want a child at home. Mahoney (1981) characterizes this problem as moving from "storing kids in institutions to storing them in families."

Funding

The major issue in all interaction among agencies is funding for services. Who will pay the bill for specialized services for a youth whose problems go far beyond the boundaries of any single agency? The development of flexible services and the proliferation of private service providers who may be contracting with multiple agencies make these issues increasingly complex (Duchnowski & Friedman, 1990; Mordock, 1990). As states turn to increasing reliance on Medicaid and Medicare funding for services for mentally disordered offenders, the rules and policies regarding reimbursement for mental health services will be major determinants of service organization and access for mentally ill children (Dougherty, 1988; Beachler, 1990).

An important question affecting public funding options for services for mentally disordered offenders is to what extent Federal health care financing regulations allow juvenile offenders to be covered by Medicaid. Health Care Financing Administration regulations (Code of Federal Regulations v. 42) state that no individuals in corrections institutions are eligible for Medicaid, and most states have traditionally taken this prohibition to mean that Medicaid is not available as a funding source for mental health services for juvenile offenders. However, state youth agencies are increasingly exploring the possibilities of pursuing Medicaid reimbursement for mental health services for offenders, based on exceptions to this regulation. Apparent exceptions include youth who are placed in licensed child care institutions with under 25 residents, youth placed in primarily medical or psychiatric institutions, and youth who have not been "determined to be delinquent."

Shostak (1991) offers a detailed description of the approach that the Massachusetts Departments of Youth Services and Public Welfare (Medicaid) have taken to financing health care services for youth in DYS care. The Department of Public Welfare has agreed to issue Medicaid cards to all youth committed to the Department of Youth Services, and to pay for health care (including eligible mental health services) from the state Medicaid program. For those youth who meet eligibility requirements for federal financial participation (such as financial criteria and placement in appropriate settings, e.g. home or group care), the state Medicaid program seeks federal Medicaid reimbursement. Since most DYS youth come from low-income households and are placed in various community settings, the number of youth who are eligible for federal financial participation is significant. However, the most important aspect of this program is that the state has agreed to fund health care services for DYS youth from the Medicaid program, even when the youth are *not* eligible for federal financial participation. This agreement stems from the recognition that the state can purchase these services more cheaply through Medicaid, at Medicaid rates, than it could through DYS, with DYS or individual youth functioning as independent consumers and paying the higher rates of the private market. This arrangement relied for its implementation on the participation of a level of government higher than either DYS or Medicaid, since it involved a shift in the cost burden for health care from DYS to Medicaid. It is a good example of how inter-agency collaboration can lead to an overall increase in breadth of services for mentally disordered offenders, with a reduction in costs for the state as a whole.

The growing recognition of the potential for cost savings in funding mental health services for offenders through Medicaid, with or without federal reimbursement, will likely increase the

participation of state Medicaid programs in supporting these services. Although this development offers benefits in terms of cost-savings and consistency of care, it also may increase the vulnerability of these services to the vagaries of federal reimbursement policy and to external management of care.

IDEAL SYSTEMS OF CARE

It is difficult enough to articulate goals for institutions as diverse, varying, and broad in scope as the juvenile justice system and the child mental health system, though doing so is fundamental to improvements in the performance of these institutions (Keilitz & Roesch, 1992). It is even more difficult to articulate goals for the *interactions* between these institutions. Attempts with a group of interested professionals to articulate goals for interactions between the mental health and justice systems generally (Hafemeister, 1991; Casey et al., 1992) yielded a very broad and sometimes conflicting array of possible goals for these interactions, including such general statements as improving communication, attending to the needs of individual clients, and fostering efficiency and accountability in systems interactions.

As suggested earlier, the juvenile justice system and the child mental health system are different institutions with different institutional goals. It is not reasonable to set goals for their interaction that would include the elimination of difference or conflict. Instead, we would urge that in interacting with one another, these institutions pursue the goals of being clear regarding the separate functions and purposes of the individual institutions, and being rational, efficient, and accountable in the pursuit of services and support from one another. Conflicts are inevitable between the justice, fairness, and public protection goals of the justice system (National Center for State Courts, 1990) on the one hand, and the individual care-giving goals of the mental health system on the other. Interactions should aim to develop fair and reliable means of resolving such conflicts, in accordance with law and explicit public policy.

To make the meaning of these proposed goals more explicit, some specific recommendations regarding ideal systems of care are offered.

Evaluation

An ideal system of interaction between mental health and juvenile justice would be *efficient* regarding the use of mental health assessment services. That is, it would incur the costs of mental health assessment (in terms of money, time spent, intrusiveness, and possible increases in ambiguity) only in proportion to the presence of indications that there will be a reasonable return on the investments involved. The nature of this potential return, and thus the determination of its likelihood, depends on the *purpose* of the assessment.

In *forensic* evaluation situations, rational use of mental health evaluation in the juvenile justice system would strictly limit mental health evaluations of specific forensic issues to legal matters meeting clearly articulated threshold criteria for raising the questions, and in which answers to the questions would be relevant to the ultimate outcome of the case (Mulvey, 1989). For example, it would not ask for criminal responsibility examinations of juvenile defendants in situations where the consequences of a finding of lack of criminal responsibility are no different from a finding of delinquency (Weissman, 1983), and where other outcomes (such as transfer to criminal court) are not at issue. It would seek

evaluation only when there was some rational initial basis for believing that the outcome of the evaluation would be positive.

Rational use of mental health expertise in making *emergency predictions of dangerousness* would involve a clear delineation of potential dangerous behaviors about which an agency is concerned and feels an obligation to predict and prevent. It requires implementation of a screening process to discover individuals involved in the institution who are at higher than random risk for those behaviors. This screening makes use of actuarial models, based on group membership data, as well as on available historical information about individuals and clearly observable current characteristics and behaviors. Individuals found to be at high risk are referred for individual clinical evaluation, prioritized according to the degree to which the individual shows characteristics of mental disturbance contributing to the risk in question, and according to the level of apparent risk and the social or legal significance of the specific behavior that is the object of concern.

Many (e.g. Monahan, 1977; Stone, 1984) have pointed out that accuracy of clinicians' predictions in these areas is not very high, especially in that they tend to include so many false positive predictions. On the other hand, Grisso and Appelbaum (1992) explain that high levels of accuracy in predicting dangerous behavior are not necessary for it to be worthwhile for clinicians to be involved in this activity. It is necessary only that they provide honest estimates of the likelihood of danger, and that courts or agencies then determine what level of increased likelihood over that of the general population deserves a protective response.

An ideal system of *amenability to treatment evaluation* discriminates among individual offenders with regard to the appropriateness of mental health services. It attends to the complex issues of defining mental disorder and mental health services, understanding the functional significance of specific mental disorders, and differentiating between amenability to treatment and need for treatment.

Selection of cases for evaluation should rest on clear definitions of *what areas of mental disturbance* the system aims to discover and treat. If justice institutions make these definitions, they will likely be made less on diagnostic grounds and more on functional significance grounds, using as indicators for evaluation such factors as severity or nature of offense. For example, regulations of the Massachusetts Department of Youth Services require certain committed offenders to go through a classification process, involving considerable clinical evaluation addressing amenability to treatment (Loughran, 1986). The major indicator of the need for classification is seriousness of offense.

If a mental health agency defines the limits of disturbance that evaluation aims to discover and assess, the definitions are likely to be more clinical, focussing on specific diagnoses or symptoms. For example, the Massachusetts Department of Mental Health sets explicit criteria of chronic or severe mental illness as the basis for entitlement to mental health services from the state. Thus evaluations that it offers or sponsors, even to juvenile offenders in DYS custody, focus on discovering those conditions, and less on issues regarding offense.

An ideally interactive evaluation system would focus its efforts on mental health problems that are *functionally significant* with regard to contributing to offensive behavior. Especially to the extent that mental health care in this context is seen as a justice function (i.e. offered for the purpose of offender rehabilitation, incapacitation or deterrence), targeting it to problems that are clearly related to offenses would be appropriate. In this view, entitlement to mental health care for problems that did

not contribute to offensive behavior would not be so great. Such treatment would serve a pure mental health function, and would not need to rely on interaction between the mental health system and the juvenile justice system.

In performing amenability to treatment evaluations, an ideal system would differentiate between *amenability to treatment and need for treatment.* It would articulate disturbances and their functional significance, and characterize treatment approaches quite specifically. It would then offer estimates of the likelihood of treatment success, its expected time course, and its results in terms of specific symptoms or behavior change, so that customers, including justice professionals, offenders, families, and the public, would know the functional significance of the treatment. Finally, it would be explicit regarding evaluating the need for treatment, prioritizing treatment efforts based on explicit algorithms involving such variables as functional significance, likelihood of success, cost, and desires of the offender and other interested parties.

If the disorder contributes to, or is likely to contribute to, seriously offensive behavior with major adverse consequences, especially for the public, it is likely to be judged more in need of treatment than another mental health problem with less serious consequences. Examples of this reasoning include paying considerable clinical evaluation attention to evaluating amenability for disorders underlying sexual offenses, because of the likelihood that they will recur and cause harm to large numbers of citizens (Bengis, 1986), and paying less attention to the less dramatic symptoms of depression and low self-esteem that may be very common among juvenile offenders.

In general, an ideal system of interaction would incur evaluation costs in a stepwise manner, only requiring more expensive or intrusive evaluations when screening devices indicated they were necessary. For example, it would not order detailed inpatient forensic examination of a defendant's capacities without some outpatient screening to determine whether such a course is necessary to answer the question, and likely to yield a positive result. It would attend to the legal stakes of situations in which forensic questions are posed, and be sure that the costs involved in answering them were not disproportionate to those stakes. On the other hand, it would not overlook the presence of major psychopathology with potential forensic relevance (Lewis et al., 1988).

Finally, to be truly efficient, a system of forensic mental health assessment would also have to be successful in answering the questions that were posed to it, with high quality evaluations that were culturally competent, clinically valid, and responsive to the questions, in order to justify the costs. It would not only avoid unnecessary evaluations, but it would recognize when evaluations were likely to yield significant results, and find a way to provide them.

Treatment

The ideal system would provide appropriate mental health services for all juvenile offenders who need them. It would provide continua of care along multiple dimensions, including such program characteristics as security, structure, intensity of supervision and monitoring, specific type of mental health treatment, and involvement of ancillary services. It would serve a full range of patients from the most mentally ill to the least, from the most violent to the least, from those with the most cognitive impairment to those with the least, and from those with the most need for basic socialization to those with the least. It would set explicit goals for treatment and provide services that were appropriate to those goals (Barnum, 1990b).

It would rely on the coercive powers of the juvenile justice system to support treatment only to the extent that treatment was aimed at solving problems that made substantial contributions to behavior that had been adjudicated offensive, and only in proportion to the seriousness of that behavior. It would provide access to treatment in the community, for offenders involved in diversion programs and probation, attending carefully to issues of liaison and supervision between justice and mental health professionals, and providing needing case management services. It would offer treatment within special circumstances, including detention centers, group homes, residential schools, secure treatment, and incarceration. It would offer access to hospitalization in circumstances where it was clearly established that only hospital care would be sufficient to provide for a youth's treatment needs.

The ideal system would have the capacity to identify younger children at risk for developing serious delinquency or mental disturbance, and to offer treatment aimed at preventing this development. It would be sensitive to family capacities and needs, providing flexible support and specific treatments to foster effective family functioning, but also being able to recognize when children and youth need protection and care beyond what their own families are capable of providing.

Organization

Casey et al. (1992) reviewed a variety of specific characterizations of organizational interactions that may apply to activities of the justice and mental health systems. They note that in general, ideal interaction would be characterized by effective communication, flexible collaboration, and careful attention to developing an empirical basis for informing decisions, including ongoing review and internal feedback about problems in interagency collaboration. They acknowledge that it is not clear what structures of interagency collaboration will likely work best under various circumstances. Bederow and Reamer (1981) suggest that an ideal approach to specialized programming for mentally disordered juvenile offenders might be separate programing for youth corrections populations and for mental health populations, where resources allow for multiple programs. If it is necessary to base programming in only one agency, they recommend that it be in mental health, since access to a mental health program is likely to be easier than access to a corrections program.

Interagency Collaboration

Our limited review of interorganizational arrangements indicates that collaborative approaches may offer significant gains in reducing costs and increasing flexibility, but that these gains may be offset by problems of interagency conflict over issues such as access and standards of care. Separate agency programming offers potential benefits in terms of agency control, accountability, and consistency of programming. It also offers the prospect of services tailored more specifically to "appropriate" populations, though it is important to be cautious about the potential for bias in differentiating between populations that are appropriate to mental health as opposed to correctional programming. The capacities of child- and family-centered arrangements to respond rapidly to the needs of individuals rather than of institutions is appealing, but it is not clear to what extent these arrangements can withstand the special institutional conflicts inherent in providing services for serious juvenile offenders.

Private vs. Public Providers

Providing services through contracts with private agencies offers many advantages over the government providing services directly. These advantages include greater flexibility in starting new programs, as well as in ending programs that don't work. Private agency contracts offer government managers the advantages of circumventing cumbersome civil service and public employee union requirements. These advantages can lead to improved flexibility in staffing programs as well as reduced

costs in some circumstances. Private agency contracts may also increase the potential for obtaining third party reimbursement for mental health services, partially shifting costs from state and local governments to the federal government or the private sector. Potential disadvantages of contracting with private vendors include the likelihood that accountability for services will be further removed from the government, and that as a result services will be poorly managed or provided at a low standard. Of course, it is common enough for services provided directly by the government to have these problems as well.

Standards and Quality Assurance

Whatever model of interagency collaboration is established, it should include standards or guidelines for performance and quality assurance, including training and continuing education of mental health and justice systems officials who deal with juvenile offenders with mental disorders. As a means toward the integration of the forensic mental health system with the justice system, Keilitz (1989) suggests that forensic mental health professionals acquaint themselves with established standards for court performance. Such standards have been developed by the National Center for State Courts (1990).

Quality assurance should include provisions for training of mental health professionals in the special clinical needs of mentally disordered juvenile offenders (Duchnowski & Friedman, 1990) and in the complexities of forensic evaluation (Fein et al., 1991; Melton et al., 1985). Training should routinely include efforts at developing culturally competent evaluation and treatment skills. It should also include attention to issues of organizational adaptation, both regarding youth and families, and also regarding service providers. It should foster both skill in and commitment to providing clinical service in the public sector.

An ideal overall program of quality assurance would include not only training and the establishment of clinical standards of care but would also establish mechanisms for internal organizational feedback regarding process problems, in order to foster continuous quality improvement. It would require ongoing evaluation of programs of clinical evaluation and treatment, including review of services and feedback to service providers regarding any issues that presented problems.

Transitioning Out of the Juvenile System

A neglected area of inquiry is what happens to mentally disordered juvenile offenders when they become too old to be considered juveniles (Koroloff, 1990; Loughran, 1985). Some states have the capacity to extend juvenile jurisdiction, which enables them to continue services with some consistency. However, this can lead to difficult problems owing to continuing juvenile jurisdiction over individuals who are unequivocally adult. In some situations mentally disordered juvenile offenders will enter the adult mental health system when they leave the juvenile justice system, but this transition may require them to adjust to marked differences in programming, and may not include the capacity for the sort of specialized programming that they may continue to need.

In summary, an ideal system of organizational interaction would enable recognition of different types of offenders and mental health needs, and provide appropriate services for them without interruption by interagency conflict. Agencies would develop mechanisms for sharing responsibility that would be informal enough to allow for flexibility and easy communication, and formal enough to allow for internal review, accountability, and quality improvement. The ideal system would

acknowledge the existence of conflicting needs of justice institutions and mental health institutions, and would establish means of resolving these conflicts that would be clear, mutually respectful, and reliable.

Research Needs

It is easy to agree that there is a great need for information to shed light on how systems might improve their capacities to interact successfully in responding to the needs of mentally disordered juvenile offenders. A few specific areas of study seem especially important, and reasonably practical.

One of the most basic needs is for better information about the nature and extent of juvenile offenders' mental health problems, both for the system as a whole and in individual cases. It would be of great help in addressing this problem if researchers could develop a simple screening device that could be used with all offenders at entry into the system, and at other points along the way as well, to identify the likely presence of mental health problems, and the need for more detailed clinical evaluation. Such a device should be simple and easy to administer, not requiring professional involvement, and should focus on symptoms, behavior, and functional capacities rather than diagnosis. It should include attention to problems of substance abuse and disturbed cognitive, emotional, and social functioning, as well as to explicit problems of severe mental illness. The development of such a device could then contribute to more detailed epidemiological study using more thorough structured diagnostic instruments.

Neither the justice system nor the mental health system--both of which have long-standing programs for the development and reporting of "case" statistics (e.g., number of arrests, volume and composition of civil, criminal, and juvenile court cases; average daily jail census; admissions to inpatient hospitals by selected diagnoses)--possess a meaningful statistical portrait of the volume and composition of juvenile court cases in the United States in which claims of mental disorder are made. Without such information, questions fundamental to reform and improvements of mental health and justice systems interactions are difficult to answer. For example, how many mentally disordered juveniles are subjected to involuntary civil or criminal commitment annually in the United States? Do state court caseloads and compositions correlate with population? How do caseload levels, adjusted for the population, compare across different states? What social, economic, legal and systemic factors affect the rates of filing of cases? Although such questions are at the core of effective policy, planning, and improvement of mental health and justice systems interactions, the lack of empirical knowledge about the volume and composition of juvenile cases involving claims of mental disorder have precluded addressing them effectively.

A second area involves problems of "appropriateness" in individual case processing, and what these problems may tell us about the functioning of a system overall. All programs providing services in this area are troubled by "inappropriate admissions." These cases have the potential to tell us a great deal about where interaction between systems is breaking down. What characterizes the clinical histories, presentations, and course of these youth? In what specific ways do they appear "inappropriate" and to whom? By what process failures were they allowed into whatever program in which they appear to be inappropriate? From where did they come, and by what sort of preventable mistake (if any)? What further problems in legal process and in treatment result from their inappropriate admission?

To what extent is the notion of appropriateness an illusion? What differences are there between youths in mental health programs and those in juvenile justice programs? Studying these differences

in an agency-centered system with multiple programs (such as the Massachusetts Department of Mental Health IRTP's and the Department of Youth Services Butler Center), using reliable epidemiological diagnostic instruments, and comparing demographic and personal history factors, would help to answer these questions and provide direction as to the real clinical need for, as well as the fairness of, differential placement.

A third area where more systematic research is clearly needed is in the relationship between organizational models and effective treatments. What are the strengths and weaknesses of the agency-centered and collaborative interaction models for providing services to these youth? Can effective elements of collaborative interaction be identified and transferred to other locations? What do child- and family-centered service models have to offer to mentally disordered juvenile offenders? Can justice needs of community safety and due process be met adequately by programs organized around these principles? Do they provide genuine gains in terms of either cost savings or treatment effectiveness or both? Or do they short-change youth by keeping them out of residential programs offering more broad-based services? Does explicit involvement of such programming with a justice institution augment effectiveness or undermine it?

What is involved in developing a system's capacity to offer greater flexibility and individualization in service planning? Is it possible to develop these capacities without disrupting agencies' capacities to provide services and programs with which they are familiar and have a record of effectiveness? The study by Olson et al (1991) of the attempts of the state of Washington to increase its capacity for individualized service within an overall agency-based framework is an example of research in this area that may help planners to learn what to expect in pursing models of individualized care.

Finally, a fundamental area for systems research is that of the availability and impact of various funding mechanisms for mental health services. There appears to be enormous variation from place to place in who pays for these services, under what circumstances, and by what mechanisms. It is certain that these mechanisms have a very substantial impact on what services are indeed available and to whom, but what this impact may be has not been the subject of systematic research. The role of health insurance coverage (especially Medicaid but also other insurers) in determining access to mental health care for juvenile offenders appears to be critically important in some circumstances, but has not been carefully studied. Questions include the following. Are incarcerated juvenile offenders indeed eligible for Medicaid coverage? Who has the capacity to authorize the use of Medicaid or other insurance benefits for mental health evaluation of an offender, and with what threshold of clinical or forensic concerns? What is the role of managed care organizations in determining access to care? Do families have the right to "reserve" their mental health benefits for services which they have chosen for their children, or must they be expended on services which may have been ordered by a court or agency?

Some Recommendations for Improving Practice

No system of interactions can meet any of these ideals in real life. Even so, some practical recommendations for improving ordinary practice may be worth pursuing.

Screening

Although the ideal system would have available a screening device for mental health problems that had a research basis to ensure validity, reliability, and cultural competence, even a simple, ad hoc

means of screening is better than none. Simply establishing the issue of a youth's mental health history as part of the agenda for intake into the juvenile justice system may help to identify youth with mental health needs that might otherwise go unnoticed.

Such screening has been urged in other forensic mental health contexts. For example, in the area of involuntary civil commitment and guardianship, the National Center for State Courts (1986) and the American Bar Association (1989, 1991) have encouraged the designation or establishment, within each locale, of an organizational structure for receiving and screening potential cases. The purpose of such a screening agency is to provide an organizational and administrative structure for equitable and uniform decisionmaking about treatment and services in the least restrictive setting at the earliest point in time. Although initial contact with the screening agent or agency may be an inquiry specific to the particular legal question (e.g., commitment), the aim of the screening is to facilitate getting help for the individual, i.e., the most appropriate treatment, care or social services consistent with the individual's needs.

Collaboration

Anyone working in an agency setting offering opportunities for interaction with other agencies can look for chances to develop relationships with others across agency boundaries that can become a basis for improvement in interagency collaboration. These improvements do not need to be on a large scale to be significant. Even "small wins" in interaction contribute to overall system improvements. Similarly, all efforts, even limited ones, at articulating a system's resources, goals, and constraints contribute to clearer and more effective functioning. Small individual attempts to develop communication across agencies, even focussing on individual cases, can grow into relationships in which regular review of agency interactions becomes possible and even familiar.

A logical step toward improving collaboration would be to pay more attention to the structures, organizations and administration of mental health programs providing services to the justice system. Such attention is likely to stimulate research in areas where little research exists today with results that are likely to be of great interest. Relatively simple descriptive studies, for example, could establish reliable estimates of the number of mental health forensic units as well as their location within the judicial system. It is highly doubtful that each of the 18,000 courts in the United States has its own forensic mental health program, but the total number of courts stands as the outside estimate of the number of such programs. Descriptive studies could ascertain the structures, organizations, and various administrative mechanisms of the forensic mental health programs and from this information develop tentative typologies and frames of references.

Communication

In any interactions involving pursuit of clinical care, it is always helpful to be as clear and complete as possible in communicating the goals for a proposed intervention and the routes for reaching them. If, for example, it appears that hospitalization is called for, it helps to understand the various legal steps that can be taken to get a patient into the hospital, and especially how different moves will result in different types of hospital commitments, in different types of units, with different types of clinical and forensic interventions and outcomes. It is essential in this process to provide all the clinical history available, along with the specific questions for evaluation, or other specific goals for containment or treatment. As in any interaction involving obtaining clinical services, it is very helpful to insist on getting feedback as part of the initial contract for hospitalization. This helps to ensure that

the presenting concerns are being addressed, and that appropriate concrete plans are made for follow-up care after the patient is discharged.

Treatment Planning

In general, an explicit treatment plan should be articulated for any clinical services for juvenile offenders. This plan should specify who is to be providing what services to the patient and family, both in terms of clinical treatments, and also in terms of whatever other casework support, educational, or rehab services may be called for. It should specify what means will be used to evaluate the progress of the youth in response to clinical intervention, and what responses from the various players will be involved if progress is good, and if it is not. It should also make clear what continuing legal obligations the patient and family may be under, if any, regarding treatment, probation, liability for protective services and removal, and so forth, and who the players in these activities are as well. Absent explicit violation of such conditions, it should be understood that the youth and family are empowered by this plan and are the prime players in its execution.

Case Management

Regardless of what formal or informal arrangements may be in place for interagency collaboration in the execution of treatment planning, it seems clear that a key ingredient in successful access to care is explicit case management. Programs providing dedicated case management for mental health services to individuals involved with the justice system show that this specialized service, provided with small caseloads (e.g. less than 15 cases), can make a substantial difference in fostering effectiveness of mental health services for justice involved people.

Where these specialized programs do not exist, however, there may still be opportunities for professionals involved with young offenders and their families to craft networks of relationships that have some of the characteristics of good case management. Probation officers, social workers, therapists, consultants, advocates, and other professionals can all work together to identify services and to establish relationships with one another and with youths and families that will support effective involvement with treatment.

SUMMARY

The problems of mentally disordered juvenile offenders are complex and multifaceted, and so are institutional responses to them. They do not fit neatly into diagnostic categories or into ordinary programming for either juvenile offenders or mentally disordered children. They engender conflict among those who deal with them, because of the difficulties they present in understanding their needs, and because of the variety of demands they place upon public resources.

Professionals who deal with these youth need to have a capacity for flexibility, and for understanding that their own way of understanding the youth's problems will never be sufficient to provide a basis for a complete response to the youth's needs. They need to be willing to learn from and to respect the perspectives of others who may also be involved in public responses to the youth, on grounds quite different from their own. Institutions that provide public responses to these youth, whether in the justice system, the mental health, social service, or educational systems, or in the private realms of family and community, need to foster communication and respect across their own boundaries, to find ways to cooperate in responding to youth in areas where they can agree, and to learn to disagree when they must, in ways that do not destroy their capacity to work together to help.

REFERENCES

American Bar Association. Guardianship: An Agenda for Reform. Washington, DC: American Bar Association, 1989.

American Bar Association. Court-related Needs of the Elderly and Persons with Disabilities: A Blueprint for the Future. Washington, DC: American Bar Association, 1991.

Appelbaum, K.L. Dispositional Evaluation. Presented at the Annual Conference of the Massachusetts Division of Forensic Mental Health, Auburn, MA. June 20, 1991.

Barnum, R, Integrating multiple perspectives in forensic child psychiatry consultation. Journal of the American Academy of Child Psychiatry, 25, 718-723, 1986.

Barnum, R. The development of responsibility: Implications for juvenile justice. In F. Hartmann (ed.) From Children to Citizens: The Role of the Juvenile Court. New York, NY: Springer-Verlag, 1987a.

Barnum, R. Biomedical problems and juvenile delinquency: Issues in diagnosis and treatment. In Loury, G. and Wilson, J. (eds.) From Children to Citizens: Families, Schools, and Delinquency Prevention. New York: Springer-Verlag, 1987b.

Barnum, R. Clinical evaluation of juvenile delinquents facing transfer to adult court. Journal of the American Academy of Children and Adolescent Psychiatry, 26, 922-925, 1987c.

Barnum, R., Famularo, R., Bunshaft, D., Fenton, T., & Bolduc, S. Clinical evaluation of juvenile delinquents: Who gets court referred? Bulletin of the American Academy of Psychiatry and the Law, 17, 335-344, 1989.

Barnum, R. Managing risk and confidentiality in clinical encounters with children and families. In J. Beck (ed.) Confidentiality and the Duty to Protect: Foreseeable Harm in the Practice of Psychiatry. Washington, DC: American Psychiatric Press, 1990a.

Barnum, R. Understanding mental health treatment for juvenile offenders. Perspectives (Journal of the American Probation and Parole Association), 14 (2), 11-15, 1990b.

Beachler, M. The mental health services program for youth. Journal of Mental Health Administration, 17 (1), 115-121, 1990.

Bederow, L.S. & Reamer, F.G. Treating the Severely Disturbed Juvenile Offender: A Review of Issues and Programs. Chicago, IL: National Center for the Assessment of Alternatives to Juvenile Justice Processing, 1981.

Behar, L. Comments on Experiences in Dealing with Mentally Disordered Juvenile Offenders under the Willie M. Decree. Presented at the national work session Addressing the Mental Health Needs of Youth in the Juvenile Justice System, Seattle, WA, May 29, 1992.

Benedek, E.P. Waiver of juveniles to adult court. In D.H. Schetky & E.P. Benedek (eds.) Emerging Issues in Child Psychiatry and the Law. New York, NY: Brunner/Mazel, 1985.

Bengis, S. A Comprehensive Service Delivery and a Continuum of Care for Adolescent Sexual Offenders. Orwell, VT: Safer Society Press, 1986.

Burchard, J.D. & Clarke, R.T. The role of individualized care in a service delivery system for children and adolescents with severely maladjusted behavior. Journal of Mental Health Administration, 17 (1), 48-60, 1990.

Cady, D, Proposal for Psychological Screening and Evaluation Standards. Coconino County Juvenile Court, Flagstaff AZ, 1990.

Casey, P., Keilitz, I., & Hafemeister, T. Toward an agenda for reform of justice and mental health systems interactions. Law and Human Behavior, 16 (1) 107-128, 1992.

Chamberlain, C. & Awad, G. Psychiatric service to the Juvenile Court: A model. Canadian Psychiatric Association Journal, 20, 599-605, 1975.

Cocozza, J.J., Hartstone, E., & Braff, J. Mental health treatment of violent juveniles: An assessment of need. Crime and Delinquency, 17, 487-496, 1981.
Code of Federal Regulations, Volume 42, section 435, p. 1008-9.

Cohen, R., Harris, R., Gottlieb, S., & Best, A. States' use of transfer of custody as a requirement for providing services to emotionally disturbed children. Hospital and Community Psychiatry, 42 (5), 526-530, 1991.

Connell, P. Juvenile justice in the year 2005? Journal of Clinical Child Psychology, 9 (2) 113-116, 1980.

Cornell, D. Prior adjustment of violent juvenile offenders. Law and Human Behavior, 14 (6) 569-577, 1990.

Dougherty, D. Children's mental health problems and services: Current federal efforts and policy implications. American Psychologist, 43 (10), 808-812, 1988.

Duchnowski, A.J. & Friedman, R.M. Children's mental health: Challenges for the nineties. Journal of Mental Health Administration, 17 (1), 3-12, 1990.

Ewing, J. Mental health issues in incarcerated adolescent populations. In P. Sheehan (ed.) Health Care for Incarcerated Youth: Report from the 1991 Tri-Regional Workshops. Washington, DC: National Center for Education in Maternal and Child Health, 1991.

Fagan, J. Community-Based treatment for mentally disordered juvenile offenders. Journal of Clinical Psychology, 20 (1), 42-50, 1991.

Fein, R., Appelbaum, K.L., Barnum, R., Baxter, P., Grisso, T., & Leavitt, N. The designated forensic professional program: A state government-university partnership to improve forensic mental health services. Journal of Mental Health Administration, 18 (3), 223-230, 1991.

Forbes, J. Personal communication (Program manager, DYS), March, 1992.

Friedman, R.M. Strategies for conducting needs assessments based on system of care models. Second Annual Research Conference Proceedings on Children's Mental Health Services and Policy: Building a Research Base. Tampa: Research and Training Center for Children's Mental Health, Florida Mental Health Institute, 1989.

Friesen, B.J. & Koroloff, N.M. Family centered services: Implications for mental health administration and research. Journal of Mental Health Administration, 17 (1), 13-25, 1990.

Greenberg, F.E. The Prosecution of Minors Residing in Behavioral Treatment Facilities in Massachusetts. Unpublished draft prepared for the Children's Law Center of Massachusetts conference Prosecution of Emotionally Disturbed Children, Waltham, MA, April 24, 1992.

Griffin, P.A., Steadman, H.J., & Heilbrun, K. Designing conditional release systems for insanity acquitees. Journal of Mental Health Administration, 18 (3) 231-241, 1991.

Grisso, T., Miller, M.O., & Sales, B. Competency to stand trial in juvenile court. International Journal of Law and Psychiatry, 10 (1) 1-20, 1987.

Grisso, T. Improving Mental Health Evaluations to Juvenile Courts. Presentation at workshop Mental Health Services and the Juvenile Justice System, sponsored by the Institute for Court Management, Williamsburg, VA, April, 1988.

Grisso, T. & Appelbaum, P.S. Is it Ethical to Offer Predictions of Future Violence?. Law and Human Behavior, In Press.

Grisso, T., Tomkins, A., & Casey, P. Psychosocial concepts in juvenile law. Law and Human Behavior, 12 (4), 403-437, 1988.

Hafemeister, T.L. Goals to guide the interactions of the mental health and justice systems. Journal of Mental Health Administration, 18 (3), 178-197, 1991.

Halleck, S.L., Appelbaum, P., Rappeport, J., & Dix, G.E. Report of the Task Force on the Role of Psychiatry in the Sentencing Process. Washington, DC: American Psychiatric Association, 1984.

Halpern, W.I., Arkins, V., Mitchell, N., Freeling, N., & Healy, B. Continuity of mental health care to youth in the juvenile justice network. Hospital and Community Psychiatry, 32 (2), 114-7, 1981.

Hartstone, E. & Cocozza, J.J. Providing services to the mentally ill, violent juvenile offender. In R. Mathias et al. (eds.) An Anthology on Violent Juvenile Offenders. Newark, NJ: National Council on Crime and Delinquency, 1984.

Hartstone, E. Turnstile children: Falling between the cracks. Issues in Juvenile Delinquency. American Correction Association Monographs #10. College Park, MD, 1986.

Hutchinson, J. Challenging perceptions of youth: "Bad" or disturbed?. In P. Sheehan (ed.) Health Care for Incarcerated Youth: Report from the 1991 Tri-Regional Workshops. Washington, DC: National Center for Education in Maternal and Child Health, 1991.

Jordan, D.D. & Hernandez, M. The Ventura planning model: A proposal for mental health reform. Journal of Mental Health Administration, 17 (1), 26-47, 1990.

Kalogerakis, M.G. Handbook of Psychiatric Practice in the Juvenile Court. Washington, D.C.: American Psychiatric Association, 1992.

Kelley, T.M. Clinical assessment and the detention, disposition, and treatment of emotionally disturbed delinquent youths. Journal of Criminal Justice, 6, 315-327, 1978

Kerr, P. Mental hospital chains accused of much cheating on insurance. New York Times, November 24, p.1, 1991.

Keilitz, I. & Miller, S.L. Handicapped adolescents and young adults in the justice system. Exceptional Education Quarterly, 1 (2) 117-126, 1980.

Keilitz, I. Mental health services to the courts: A system isolated from judicial administration. In R. Rosner & R. Harmon (eds.) Critical Issues in Psychiatry and the Law: Mental Health Services to the Criminal Justice System, Volume 5, 1989a.

Keilitz, I. & Roesch, R. Improving justice and mental health systems interactions: In search of a new paradigm. Law and Human Behavior, 16 (1) 5-26, 1992.

Keilitz, I. An Interorganizational Analysis of Mental Health Expert Services Provided to Trial Courts. Williamsburg, VA: National Center for State Courts, 1989b.

Knoff, H.M. & Batsche, G.M. The place of the school in community mental health services for children: A necessary interdependence. Journal of Mental Health Administration, 17 (1), 122-130, 1990.

Koroloff, N.M. Moving out: Transition policies for youth with serious emotional disabilities. Journal of Mental Health Administration, 17 (1), 78-86, 1990.

Lewis, D.O., Balla, D.A., Sacks, H.L., & Jekel, J.F. Psychotic symptomatology in a juvenile court clinic population. Journal of the American Academy of Child Psychiatry, 12, 660-674, 1973a.

Lewis, D.O., Sacks, H.L., Balla, D., Lewis, M.B., & Heald, E.H. Introducing a child psychiatric service to a juvenile justice setting. Child Psychiatry and Human Development, 4 (2), 98-114, 1973b.

Lewis, D. & Balla, D. Delinquency and Psychopathology. New York, NY: Grune and Stratton, 1976.

Lewis, D., Balla, D., Shanok, S.S., & Snell, L. Delinquency, parental psychopathology, and parental criminality: Clinical and epidemiological findings. Journal of the American Academy of Child Psychiatry, 15, 665-678, 1976.

Lewis, D.O. & Shanok, S.S. Medical histories of psychiatrically referred delinquent children: An epidemiologic study. American Journal of Psychiatry, 136, 231-233, 1979.

Lewis, D.O., Balla, D., & Shanok, S.S. Some evidence of race bias in the diagnosis and treatment of the juvenile offender. American Journal of Orthopsychiatry, 49 (1), 53-61, 1979.

Lewis, D.O., Shanok, S.S., Cohen, R.J., Kligfeld, M., & Frisone, G. Race bias in the diagnosis and disposition of violent adolescents. American Journal of Psychiatry, 137, 1211-6, 1980.

Lewis, D.O., Shanok, S.S., & Pincus, J.H. A comparison of the neuropsychiatric status of female and male incarcerated delinquents: Some evidence of sex and race bias. Journal of the American Academy of Child Psychiatry, 21, 190-6, 1982.

Lewis, D.O., Pincus, J.H., Bard, B., et al. Neuropsychiatric, psychoeducational, and family characteristics of 14 juveniles condemned to death in the United States. American Journal of Psychiatry, 145, 584-9, 1988.

Lewis, D.O. From abuse to violence: Psychophysiological consequences of maltreatment. Journal of the American Academy of Child and Adolescent Psychiatry, 31, 383-391, 1992.

Loughran, E. The juvenile justice system and mental health: A juvenile justice administrator's perspective. Presented at the National Association of State Mental Health Program Directors Symposium, February 27, 1985, Washington, DC.

Loughran, E. Classification Policy Guidelines Governing Entrance into Secure Treatment Facilities. Boston, MA: Massachusetts Department of Youth Services, 1986.

Mahoney, A.R. Family participation for juvenile offenders in deinstitutionalization programs. Journal of Social Issues, 37 (3) 133-144, 1981.

McNiel, D.E., Hatcher, C., Zeiner, H., Wolfe, H.L., & Myers, R.S. Characteristics of persons referred by police to the psychiatric emergency room. Hospital and Community Psychiatry, 42 (4), 425-7, 1991.

Melton, G.B., Weithorn, L., & Slobogin, C. Community Mental Health Centers and the Courts: An Evaluation of Community-Based Forensic Services. Lincoln, NE: University of Nebraska Press, 1985.

Melton, G.B., Petrila, J., Poythress, N.G., & Slobogin, C. Psychological Evaluations for the Courts. New York: Guilford Press, 1987.

Melton, G.B. Taking Gault seriously: Toward a new juvenile court. Nebraska Law Review, 68, 146-181, 1989.

Melton, G.B. Promoting justice in child and family services. Presentation at the National Symposium on Justice and Mental Health Systems Interactions, sponsored by the National Center for State Courts and the State Justice Institute, Arlington, VA, November, 1990.

Monahan, J. The prediction of violent behavior in juveniles. In The Serious Juvenile Offender. Proceedings of a National Symposium, September 19 and 20, 1977, Minneapolis, MN. OJJDP, LEAA, US Dept of Justice Washington, DC: Government Printing Office, 148-160, 1978.

Mordock, J.B. Funding children's mental health services in an under-funded climate: Collaborative efforts. Journal of Mental Health Administration, 17 (1), 108-114, 1990.

Mulvey, E. Scenes from a marriage: How can juvenile justice and mental health go on together? Forensic Reports, 2, 9-24, 1989.

Murphy, E. An alternative approach to managing juvenile corrections. In F.X. Hartmann (ed.) From Children to Citizens: The Role of the Juvenile Court. New York, NY: Springer-Verlag, 1987.

Myers, W.C. What treatments do we have for children and adolescents who have killed? Bulletin of the American Academy of Psychiatry and the Law, 20 (1) 47-59, 1992.

National Center for State Courts. Guidelines for involuntary civil commitment. Mental and Physical Disability Law Reporter, 10 (5), 409-514, 1986.

National Center for State Courts. Trial Court Performance Standards. Williamsburg, VA: National Center for State Courts, 1990.

National Center for State Courts. Report on Trends in the State Courts. Williamsburg, VA: Unpublished manuscript, July 1991.

Nurnberg, H.G. Mental illness in a family court. Diseases of the Nervous System, 37, 521-523, 1976.

Ogloff, J.R.P., Tien, G., Roesch, T., & Eaves, D. A model for the provision of jail mental health services: An integrative, community-based approach. Journal of Mental Health Administration, 18 (3), 209-221, 1991.

O'Leary, W. Issues in custodial suicide. Psychiatric Quarterly, 60, 31-71, 1989.

Olson, D.G., Whitbeck, J., and Robinson, R. The Washington experience: Research on community efforts to provide individualized tailored care. In A. Algorin and R. Friedman (eds.) A System of Care for Children's Mental Health: Building a Research Base. Fourth Annual Research Conference Proceedings on Children's Mental Health Services and Policy. Tampa: Research and Training Center for Children's Mental Health, Florida Mental Health Institute, 1991.

Perlin, M. Fatal assumption: A critical evaluation of the role of counsel in mental health disability cases. Law and Human Behavior, 16 (1) 39-59, 1992.

Petrilla, J. Redefining mental health law: Thoughts on a new agenda. Law and Human Behavior, 16 (1) 89-106, 1992.

Quinn, K.M. Waiver of juveniles to adult court and the prediction of dangerousness. American Academy of Psychiatry and the Law Newsletter, 13 (3) 33-34, 1988.

Rich, P. The juvenile justice system and its treatment of the juvenile: An overview. Adolescence, 17 (65) 141-152, 1982.

Rogers, R. & Webster, C.D. Assessing treatability in mentally disordered offenders. Law and Human Behavior, 13 (1) 19-29, 1989.

Russell, D.H. From the Massachusetts Court Clinics, U.S.A.: II. Diagnosing offender patients. International Journal of Offender Therapy, 13, 147-152, 1969a.

Russell, D.H. From the Massachusetts Court Clinics, U.S.A.: I. A study of its administration and community aspects. International Journal of Offender Therapy, 13, 140-147, 1969b.

Rutter, M. & Giller, H. Juvenile Delinquency: Trends and Perspectives. New York, NY: Guilford Press, 1984.

Sacks, H. and Reader, W.D. Procedures in the juvenile court. In M.G. Kalogerakis (ed.) Handbook of Psychiatric Practice in the Juvenile Court. Washington, D.C.: American Psychiatric Association, 1992.

Sametz, L. The educators' role in the juvenile justice system. Adolescence, 16 (61) 101-109, 1981.

Sarri, R. Treatment alternatives in juvenile justice programs: A selected review. In D. Schetky & E. Benedek (eds.) Emerging Issues in Child Psychiatry and the Law. New York, NY: Brunner/Mazel, 1985.

Saxe, L., Cross, T., & Silverman, N. Children's mental health: The gap between what we know and what we do. American Psychologist, 43 (10), 800-807, 1988.

Schorr, L.B. Within Our Reach. New York: Anchor Press/Doubleday, 1988.

Shostak, G. Navigating benefits systems to ensure incarcerated youth's health care. In Sheahan, P. M. (ed.) Health Care of Incarcerated Youth: Report from the 1991 Tri-regional Workshops. Washington, D.C.: National Center for Education in Maternal and Child Health, pp. 112-119, 1991.

Sobel, S.B. Psychology and the juvenile justice system. American Psychologist, 34 (10) 1020-1023, 1979.

Soler, M. Horrors and Healers: New Directions for Child Advocacy. Address to American Psychological Association Division for child, youth, and family services, New York, NY, August 29, 1987.

Steadman, H.J. Boundary spanners: A key component for the effective interactions of the justice and mental health systems. Law and Human Behavior, 16 (1) 75-87, 1992.

Stone, A. Law, Psychiatry, and Morality. Washington, DC: American Psychiatric Press, 1984.

Szasz, T. The Myth of Mental Illness. New York, NY: Dell, 1961.

Wilson, J. Strategic opportunities for delinquency prevention. In G. Loury & J. Wilson (eds.) From Children to Citizens: Families, Schools, and Delinquency Prevention. New York, NY: Springer-Verlag, 1987.

Weingard, S. Classifying juvenile dispositions. In F. Hartman (ed.) From Children to Citizens, Vol. 2: The Role of the Juvenile Court. New York, NY: Springer-Verlag, 1987.

Weissman, J.C. Toward an integrated theory of delinquency responsibility. Denver Law Journal, 60, 485-518, 1983.

Westendorp, F., Brink, K.L., Roberson, M.K., & Ortiz, I.E. Variables which differentiate placement of adolescents into juvenile justice or mental health systems. Adolescence, 21 (81) 23-37, 1986.

Wexler, D. Essays in Therapeutic Jurisprudence. Durham, NC: Carolina Academic Press, 1991.

Wexler, D. Putting mental health into mental health law. Law and Human Behavior, 16 (1) 27-38, 1992.

White, S.L. Providing family-centered consultation to a juvenile court in Massachusetts. Hospital and Community Psychiatry, 27, 692-693, 1976.

Wilson, J.Q. and Herrnstein, R.J. Crime and Human Nature. New York: Simon and Schuster, 1985.

CHAPTER 4

LEGAL ISSUES AFFECTING MENTALLY DISORDERED YOUTH IN THE JUVENILE JUSTICE SYSTEM

Jennifer L. Woolard
Sharon L. Gross
Edward P. Mulvey
N. Dickon Reppucci

Youth who suffer from mental illness present a special challenge to the juvenile justice system. These youth are often difficult to recognize or categorize and even more difficult to treat. The complexity of the problems presented in these cases taxes the court's ability to meet its dual goals of providing effective due process safeguards and rehabilitation. This complexity brings the limitations and tensions of juvenile justice into bold view.

Clearly, youth with mental disorders who become involved in the juvenile justice system will not be afforded an opportunity for effective rehabilitation without an adequate system of identification and treatment. An infrastructure of legal procedures that promotes recognition of disorder, appropriate due process safeguards, and a more responsive approach is necessary. Presently, however, legal provisions in juvenile justice do little to ensure consistent consideration of mental illness as a factor at the different stages of decision-making regarding a case.

The purposes of this chapter are to examine critically: 1) how the existing legal framework of the juvenile court affects the identification, processing, and treatment of youth with mental illness and 2) how a juvenile's mental illness might be relevant at each step of juvenile justice involvement. The chapter begins with a discussion of the currently confused mission of juvenile court and the ambiguity surrounding the legal definition of mental illness. In the next four sections, the adequacy of case and statutory laws and other legal provisions for addressing mental health issues are reviewed from each of the major decision-making points encountered by juveniles from intake to placement and service provision. Because of the variations in processing and legal procedures that exist across states and jurisdictions, this discussion may not completely cover issues of concern in all communities. Regardless, this examination makes it clear that certain recommended legal changes and research are needed to move this system closer to its vision of providing both justice and rehabilitation for mentally ill juveniles.

THE CONFLICTED MISSION OF THE COURT

The lack of clarity regarding the relevance of mental illness to juvenile justice processing can be traced, at least partially, to the present state of confusion about the court's primary mission. Historically, the role of the juvenile court has been to spare children the harshness of the adult criminal justice system, instead promoting rehabilitation through individualized justice. The primacy of rehabilitation as a goal justified the more informal, non-adversarial nature of juvenile "civil" proceedings. In exchange for relinquishing due process and other constitutionally protected rights, minors were promised that the juvenile court would act in the minor's best interests as a parent substitute. As a result, during the first sixty years following their inception, juvenile courts were afforded almost unlimited discretion in making decisions concerning delinquent youth, with only the broad standard of "the best interests of the child" as a guideline. Although many states recognized that this guideline frequently entailed treatment that might require diversion from the juvenile justice system to alternative programs such as mental health services, legislatures and courts offered little guidance as to the exact nature of the treatment contemplated or its implementation.

The legal basis for the juvenile court has resided from its beginning in the parens patriae power of the state as legal guardian of the community and of those citizens who are not competent to care for themselves. In the 1960's, however, the Supreme Court recognized that the dual functions of protecting both the child and the community were often incompatible (Worrell, 1985). Kent[1], Gault[2], and several subsequent decisions emphasized that children's constitutional rights had been sacrificed in favor of the theoretically beneficial treatment that they often did not receive within the juvenile justice system. In response, the courts began to provide juveniles with many of the due process safeguards previously guaranteed to adult criminal defendants (e.g., notice of charges, the right to counsel, the right to confront and cross-examine witnesses, the privilege against self-incrimination, the application of the "reasonable doubt" standard of proof for adjudication)[3]. Notably, the Court declined to guarantee full adult rights to juveniles. The right to trial by jury[4] and the right to bail[5], for instance, were denied to juveniles. Thus, a new conception of legal processing, granting juveniles "limited rights", emerged, supplanting the former paternalistic system.

These developments have produced a court in conflict about its mission. On the one hand, it is rooted in the task of providing treatment through the application of innovative interventions in individual cases. Yet it also bears the responsibility of safeguarding the community and the individual liberties of the juveniles coming before it. Many commentators have begun to question the ability of any system to accommodate these often conflicting goals (Worrell, 1985; Mulvey, 1989). These concerns are particularly salient when children suffering from mental illness are considered.

---

[1] Kent v. U.S., 383 U.S. 541 (1966).

[2] In re Gault, 387 U.S. 1 (1967).

[3] In re Winship, 397 U.S. 358, (1970).

[4] McKeiver v. Pennsylvania, 403 U.S. 528 (1971).

[5] Schall v. Martin, 467 U.S. 253 (1984).

While rehabilitation and treatment are important to every juvenile coming into contact with the system, they are crucial to youth with mental disorders. These youth need both particular attention in planning for their rehabilitation needs and a refined system of legal safeguards for the protection of their civil liberties. In a system that performs each of these functions in a compromised fashion, juveniles with mental illness are the ones most likely to experience harmful consequences from juvenile justice involvement. Because their needs are so great with regard to both treatment and due process, these are the youths who will receive what Justice Fortas (in Kent) aptly decried the juvenile justice system for providing; that is, "the worst of two possible worlds."

DEFINING MENTAL ILLNESS UNDER JUVENILE LAW

Because juvenile proceedings have traditionally been structured as civil proceedings, in which rehabilitation planning was the central goal, rather than as criminal proceedings, the issue of the mental competence of the accused and its bearing on criminal responsibility has been largely overlooked by the judicial system. To some extent, state legislatures have attempted to recognize the need to afford special considerations to mentally ill juveniles, sometimes providing special classifications for children in need of treatment and/or mental health services. Nonetheless, few statutes set forth clear, concise, and informed guidelines for addressing the needs of this population.

Indeed, even in defining mental illness, the states have adopted diverse and often inconsistent terminology. As a rule, these definitions are set forth in the general mental health provisions rather than appearing as a special consideration in juvenile proceedings. Representative of these laws is the Alabama statute which classifies an individual as "mentally defective" when he or she "suffers from a mental disease or defect which renders him [or her] incapable of appraising the nature of his [or her] conduct."[6] Notably, the Alabama Code does not include a definition for "mental disease or defect." Other typical definitions of mental illness include:

> [a] disorder of thought or mood that substantially impairs judgment, behavior, capacity to recognize reality, or ability to cope with the normal demands of life.[7]
>
> ... an illness, disease, or condition, other than epilepsy, senility, alcoholism, or mental deficiency, that:
>
> > (A) substantially impairs a person's thought, perception of reality, emotional process or judgment; or
> >
> > (B) grossly impairs behavior as demonstrated by recent disturbed behavior.[8]

---

[6] Code of Alabama §13A-6-60.

[7] Alaska Statutes, §12.47.130 (1992).

[8] V.T.C.A., Health and Safety Code §571.003 (1992).

> ... any organic, mental, or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions.[9]

Unfortunately, the vast majority of the states provide only vague guidelines in making mental illness determinations. Perhaps best illustrative of this lack of precision is the Delaware statute which includes within its definition of the mentally ill "any idiot."[10]

Furthermore, states vary with regard to whether mental retardation and substance abuse are included within the definition of mental illness. A number of states specifically distinguish mental illness from mental retardation and substance abuse. For example, Arizona defines mental illness as a "substantial disorder of emotional processes, thought, cognition, or memory" which is not characterized as substance abuse.[11] Other states, such as Virginia, expressly include substance abuse within the definition of mental illness, contributing further to the inconsistencies between the states' procedures in dealing with juvenile offenders. The Arizona statute also excludes from mental illness "a personality disorder characterized by antisocial behavior patterns," invoking the question of whether the Arizona legislature actually intended to exclude individuals suffering from a personality disorder diagnosable under the American Psychiatric Association's Diagnostic and Statistical Manual - version IIIR (DSM-IIIR) from the ambit of the statute.

Some states have attempted to address the void in the law for juveniles suffering from a mental illness by creating a new adjudicatory category. For example, Oklahoma has labelled children alleged to be mentally ill as "children in need of treatment" or INT, thus distinguishing them from children alleged to be delinquent, deprived, or in need of supervision. The Oklahoma definition of "child in need of treatment" encompasses individuals with "demonstrable" mental illness who display danger to themselves or others.[12] Similarly, Virginia distinguishes a "child in need of services" as a "child whose behavior, conduct or conditions presents or results in a serious threat to the well-being and physical safety of the child."[13] For the court to acquire jurisdiction over such a child, it must be shown either that the conduct presents a clear and substantial danger to the child's life or health, or that there is a need for treatment or services and that court intervention is necessary to ensure their provision. Interestingly, the Virginia statute was the result of efforts to secure services in an individual case in which an adolescent with mental health problems did not qualify for involuntary commitment.

This lack of clarity regarding the definition of mental illness reflects both the theoretical and practical confusion about the overlap of mental illness and delinquency jurisdiction. Delinquency jurisdiction is invoked by a juvenile's actions, yet those same actions may often be seen as part of a larger constellation of mental health problems. There is no theoretical bright line indicating when the conceptualizations of mental illness are more or less appropriate than the law's rubric of delinquency.

---

[9] West's R.C.W.A. 71.05.020 (2).

[10] Delaware Code, Art. 1, §302.

[11] Arizona Statutes §8.242.01.

[12] Okla. Stat. tit. 10, §1101 (5) (Supp. 1990).

[13] Va. Code §16.1-228.

On a more practical note, there is also a question about the most appropriate methods for handling adolescents with such problems. Indeed, there is some debate as to whether the juvenile justice system has the resources and expertise to be dealing with mentally ill youth at all, or whether they should be prevented from entering the system and treated exclusively by the mental health system instead.[14]

The juvenile court is in a quandary about its capacity to individualize treatment in general, and cases in which mental illness is a factor raise this issue more dramatically. This confusion about what approach to take with juveniles with mental illness is not restricted to the issue of definition, however. As discussed below, it permeates each stage of the juvenile justice system.

INTAKE AND PRETRIAL PROCEEDINGS

Questions concerning mental capacity play a crucial role in determining the course of a juvenile's experience in the legal system even before formal proceedings are instituted. However, the extreme variability across local jurisdictions in how juveniles are processed upon being taken into police custody makes any general statement of the factors affecting prosecution or diversion to alternative programs impossible. There are few guidelines about criteria to be used in determining how to recognize or refer a child with mental illness.

The first assessment of the mental state of the child is inevitably made by the police. While the officer may defer to the courts, he or she must, nonetheless, make the initial decision of whether to arrest and where the child should be taken (e.g. home, temporary custody in an authorized secure or non-secure facility, detention center, or a psychiatric facility). Although research has consistently shown that only a minority of police contacts with juveniles result in arrest (Wadlington, Whitebread & Davis, 1983), and it can be assumed that the diversion decision is influenced by the presence of a mental disorder, no clear guidelines exist for this discretionary decision.

Before a juvenile is detained and questioned, officers must ascertain whether the child is capable of making a "knowing, intelligent and voluntary" waiver of Miranda[15] rights. Interestingly, despite the practical barriers to its implementation and the fact that the Supreme Court has not directly addressed the applicability of Miranda to juveniles, several states have held that Miranda applies to juveniles as well as adults. This means that children are afforded the privilege against self-incrimination and the right to counsel (Grisso and Conlin, 1984). The courts and legislatures, however, have enunciated only broad factors to be considered in determining the voluntariness of a confession, including age, prior police or court involvement, intelligence and mental age, educational level, maturity, and absence or presence of parents (Grisso, Tomkins, and Casey, 1988).

The assumption that the Miranda model will hold for juveniles ignores the differences between the adult and juvenile contexts. In the adult criminal context, the accused individual is viewed as an autonomous individual asserting his or her constitutional rights against the state. Such a model does

---

[14] Discussion at the Conference of the National Coalition for the Mentally Ill in the Criminal Justice System, May 1992, Seattle, Washington.

[15] Miranda v. Arizona, 384 U.S. 436 (1966).

not necessarily hold for juveniles. With juvenile cases, the social context of decisionmaking may exert considerable influence, especially in cases of adolescents with mental illness. For example, parents brought in ostensibly to "protect" the rights of juveniles, often induce confusion or counsel their children to waive their rights (Grisso, 1981; Grisso and Conlin, 1984). The realities of what occurs when a parent is involved in these deliberations thus casts doubt on whether there is true "voluntariness" present in the waiver of Miranda rights for a juvenile, especially for a mentally ill juvenile. No provisions for these possible dynamics presently exist in the law.

All cases involving juveniles are typically initiated by filing a petition through a special juvenile justice agency. In most states, the intake officer has discretion as to whether the petition should be filed in delinquency or some alternative disposition, such as "child in need of services." It is also usually within the intake officer's discretion to dispose of the action informally. The complaint can be kept on file and the child's family simply notified of the incident or referred to other social service agencies. An intake officer may refuse to file a petition if there is no probable cause; the filing would not serve the best interests of the child; or some agency other than the court could deal with the matter more effectively. At this juncture, the juvenile court judge may also be consulted on a more informal basis. Again, however, no clear guidelines exist for this determination.

When the child is noticeably suffering from some mental disturbance, the judge or agency representatives may urge the child or parents to institute commitment proceedings. The majority of the states provide that questions concerning the mental capacity of a minor may be raised by a variety of individuals, including persons who are not connected to the court, such as social service agency representatives and parents. For example, the Alabama statutes provide that a petition for the involuntary commitment of a child to custody of state Department of Mental Health and Mental Retardation (DMHMR) as mentally ill or retarded may be made by the state, any county or municipality, any other governmental agency, or "any person," including "a parent, legal guardian or other person standing in loco parentis."[16] In certain instances, if the parents are not willing to approve the proposed commitment, the court may issue orders compelling their cooperation. Conversely, court personnel may fail to advise parents who recognize that their child's problems extend beyond delinquency that this option is available to them. Realistically, though, if the court itself does not take this action, it is difficult for other frequently over-worked agencies to intervene, especially when the court makes no provision for their compensation.

Where the child has not been identified as mentally ill and diverted to alternative treatment before delinquency proceedings are instituted, he or she will follow a much different route to final disposition. The juvenile may have to be subjected to emergency detention for one to three days; a required judicial hearing will be held if extended detention is deemed warranted. Only Alabama, Nevada, and Rhode Island have not adopted decision standards to be applied by the juvenile courts in exercising their discretion regarding continued pretrial detention. The standards adopted by the majority of the remaining states comprise three categories: detention for the protection of the juvenile, detention if the juvenile is likely to flee the jurisdiction while charges are pending, and detention if the juvenile poses a danger to the community (Grisso, Tomkins and Casey, 1988). Continuing detention may also be deemed appropriate where adequate supervision is otherwise unavailable or the juvenile requests

[16] Code of Alabama §12-15-90 (1992).

protection. Some states direct the court to consider the nature of the alleged offense and the child's character, reputation, prior record, community ties, and mental condition in making a detention determination.

The practical effect of these general criteria is that juveniles may spend widely varying amounts of time in detention. The distribution of length of stay in detention tends to be bimodal (Mulvey & Saunders, 1982), with a large proportion of adolescents staying a short time and a smaller group staying for lengthy periods. Those who stay longer are usually adolescents with complicated placement needs, not necessarily those charged with more serious offenses. Mentally ill adolescents would thus seem exceptionally susceptible to extended detention stays once processed in this manner, unless adequate provisions for identification and review are established.

In sum, the identification of mentally ill juveniles can occur at a number of points in initial juvenile justice processing. This factor is a consideration in the waiver of Miranda rights, the diversion of a juvenile to the civil commitment system, and detention. In most cases, there is only the judgment and goodwill of the involved professionals available to ensure proper consideration of this factor.

WAIVER OF JURISDICTION AND ADJUDICATION

As stated earlier, delinquency proceedings are instituted with the filing of a petition and notice of charges. If there is evidence to suggest that a child is mentally ill (e.g., a history of psychiatric treatment at the time the petition is filed), screening by a mental health professional may be required by statute. Such a screening may result in the case being shifted to the civil commitment system. If there is no provision for screening or if the case, after screening, is determined still to be within the purview of the juvenile court, the case will be considered in an adjudicatory hearing (to determine guilt or innocence). Alternatively, the jurisdiction for the case could be waived to adult court (the case is "transferred"), and a hearing is held there for the determination of guilt.

There are two types of waiver from juvenile to criminal court. In some states, cases involving juveniles charged with particular crimes (e.g. rape, murder, arson), are waived automatically. Alternatively, a judicial transfer hearing can be required to determine whether a particular juvenile case meets the standards for transfer. Criteria for waiving to adult court include threshold criteria (age, seriousness of the act) and status criteria specific to the case (expected future dangerousness, amenability to treatment). Decision standards usually used in the decision regarding waiver include: 1) a juvenile's lack of amenability to treatment; and, 2) protection of the community (Barnum, 1990).

How mental illness should be considered in these waiver decisions is left vague in almost all state juvenile statutes. Some jurisdictions (e.g., District of Columbia) expressly provide that there is no transfer when the juvenile is deemed mentally ill. Other states do not specifically address the issue of mental illness and transfer. For the most part, the waiver decision is still an individualized determination made by the judge.

Court decisions, meanwhile, have differed markedly regarding the issue of mental illness and waiver. A 1978 decision In the Interest of Myra Burns[17] upheld a denial of transfer for a juvenile charged with armed robbery and murder, finding that, because of the benefits she could receive from mental health treatment available through the juvenile justice system, refusal to transfer served the juvenile's best interest while posing minimal threat to society. However, in a 1977 case, In the Interest of M.A. Ferris[18], the Kansas Supreme Court held that mental illness is but one of the factors to be considered in waiver determinations, and that the juvenile court is not required to retain jurisdiction because of alleged mental illness of a juvenile. Waiver in the case of mental illness was seen as acceptable because the juvenile has the ability to raise the insanity defense when tried as an adult. This ruling, however, fails to distinguish between mental illness and legal insanity; two terms with very different meanings. A juvenile could easily have a mental illness that could benefit from treatment, but still not qualify as legally insane at the time that the offense was committed.

It also must be noted that, with transfer to adult court, the question of the degree to which much mental illness mitigates culpability still remains. Once juveniles are moved up to the adult criminal system, they are held to the standards used for adults in judging the role that mental illness might have played in the commission of an offense. Currently there is no developmentally oriented legal framework for culpability that takes into account that the effects of mental illness on criminal activity might be different for adolescents than for adults. Whether it is reasonable to hold mentally ill juveniles to the same standards as adults regarding culpability is an open question.

Since waiver may effectively foreclose treatment options for juveniles, research needs to examine how and when the issue of transfer is raised and what the impact of mental illness is on the outcome of the hearing. The trend toward determinate sentencing and automatic waiver may preclude any practical consideration of amenability to treatment in deference to a concern with the protection of society (Feld, 1988; Braithwaite and Shore, 1981). It may be that the seriousness of the crime and the age of the defendant are the only factors that will really determine transfer, with the nature of the crime itself making the juvenile "not amenable." If so, juveniles with mental illnesses who could benefit from treatment but might not receive it in the adult system may be especially vulnerable to foreclosure from this option. The necessity for examining what role the consideration of mental illness does and should play in the waiver decision is imperative.

A specific question which may be raised at the outset of the adjudicatory phase is the issue of the juvenile's competence to participate. In the legal sense, competency does not refer specifically to the presence or absence of mental illness per se, but instead refers more to the juvenile's capacity for rational understanding. Since mental illness is not equivalent to lack of competence, children who are in need of some form of treatment may be found competent to participate in proceedings. The competency issue does not act as a screening device for mental illness.

---

[17] 385 N.E. 2d. 22 (1978).

[18] 563 P. 2d 1046 (1977).

Not all states explicitly address the competency issue for juveniles. If it is specifically noted, the adult standard set forth in Dusky[19] is usually used. Dusky indicates that, in order for a defendant to be considered competent to participate in proceedings, he or she must have the ability to consult with a lawyer with a reasonable degree of understanding, and to have a "rational as well as factual" understanding of the judicial proceedings. For example, the New York court in In the Matter of Jeffrey C.[20] held that juveniles are entitled to all formalities available to adult defendants in criminal proceedings when ability to stand trial is an issue. The court declared that there is a constitutional mandate that these safeguards be extended to juveniles based on the due process clause of the Fourteenth Amendment.

Competency hearings may be requested by the prosecution, the defense, or the judge. When a hearing is requested, the court must decide if there is enough evidence to warrant a hearing on this issue, and if there is, whether a mental health professional should conduct an evaluation to inform the court. A professional evaluation is almost always ordered. The court considers the results of the evaluation and other evidence to come to a decision regarding the juvenile's competency.

Most states do not provide guidelines on when and how a competency evaluation is to be used. Judges are given no explicit assistance on how to evaluate a mental health practitioner's report, or on what specific factors should be considered when making a competency determination. Grisso, Miller and Sales (1987) provide tentative guidelines as to when competency might be raised as an issue, one of which is history of mental illness. There is a clear dearth of information, however, about when and why competency evaluations are done, and what factors are salient for judges in those determinations. There is also little information on how evaluations are conducted and how competency is conceptualized by mental health practitioners.

The insanity defense raises a different issue than the capacity for rational understanding at the time of proceedings. The insanity defense is founded on the principle that, in determining criminal responsibility, the capacity of the accused to understand the nature of his or her acts and to exercise free will in acting must be considered. In light of the extensive line of cases holding that a denial of the insanity defense to an adult defendant violates his or her right to due process and fundamental fairness, the issue necessarily arises as to whether a denial of the defense to a juvenile does not deprive him or her of fair treatment under the juvenile justice system.

Given the series of Supreme Court opinions which extend to juveniles many of the due process guarantees afforded to adults, the foundation for the extension of the insanity defense to respondents within the juvenile justice system has been laid (Harrington and Keary, 1982). In a case, In re Winburn[21], the Supreme Court of Wisconsin became the first court to make the insanity defense available to juveniles, allowing a 16-year-old charged with the shooting death of his mother to assert the defense. While noting that the philosophy behind the juvenile laws of Wisconsin was rehabilitation and treatment, the Court recognized that enforced treatment equates to punishment and thus, retribution

---

[19] Dusky v. U.S., 362 U.S. 402 (1960).

[20] 366 N.Y.S. 2d 826 (1975).

[21] 145 N.W. 2d 158 (1966).

does play a role in the function of the juvenile system. Since Winburn, cases in California, Nevada, New Jersey, and Louisiana have resulted in rulings favorable to the applicability of the insanity defense to juvenile proceedings. This endorsement of the insanity defense has not been universal, however, with at least one court, in In re C.W.M.[22], holding that the rehabilitative mission of the court left no place for the insanity defense in juvenile proceedings. The exact role of mental illness in mitigating culpability through invocation of the insanity defense in the juvenile system is a murky area.

DISPOSITION

At disposition, the judge must make a decision regarding a treatment plan, once again balancing the protection of society versus rehabilitation of the youth. Ensuring that the most appropriate treatment is provided is assumed to occur from the judge's matching of the particulars of the case with dispositional options. In making this determination, judges are free to use almost any information available to reach their decisions.

When confronted with cases having unusual features or a history of mental health involvement, judges often turn to mental health professionals (i.e., psychiatrists, psychologists, social workers) and other agency personnel. These professionals contribute their opinions as to the juvenile's needs, character, and fit with particular treatment programs (Grisso, Tomkins and Casey, 1988). Most often, clinicians are called upon to make determinations regarding a juvenile's general amenability to treatment or likelihood of rehabilitation. Whether terms like "treatment" or "rehabilitation" mean the same thing to all mental health professionals, however, is questionable, and legal restrictions on the use of clinical expertise at disposition is minimal. Instead, statutes assume experts use the same terms uniformly in informing the court. That this may not be the case and the fact that there is limited validity of diagnostic formulations and predictions is seldom emphasized.

Of course, if there is inconsistency in the use of terms or wide variability in clinical judgment, this is particularly disturbing since the type of treatment which is deemed appropriate usually forms the framework against which the range of a youth's problems and future successes will be evaluated. Although psychiatric evaluations are common in many jurisdictions - especially for more serious offenses and where incarceration is likely - the expertise needed to make amenability decisions is all too often lacking in most locales. Moreover, even if the expertise exists, little systematic information is available regarding what factors are or should be used in assessing a juvenile's amenability to treatment.

There is also some evidence that these determinations of amenability to treatment may be influenced more by the existing service delivery system in a locale than would be desirable. In a field based study of mental health, court, and social service professionals across different levels of service availability in one state, Mulvey and Reppucci (1988) found that personnel in low resource locales saw more potential benefit from punishment than did personnel in higher resource locales. Also, mental health professionals in medium resource locales judged youths' likelihood of benefiting from treatment as higher than their counterparts in either high or low resource locales. These results clearly suggest

---

[22] 407 A.2d 617 (1979).

that the contextual factors of resource availability and agency setting may influence assessments of amenability. Thus, the traditional wisdom that mental health professionals' assessments may be a method to counteract the biases of judges may provide far less of a safeguard than believed.

The lack of theoretically valid clinical knowledge about amenability, the sparsity of expertise, and the potential contextual influences on clinical judgments have implications for policy and research regarding the dispositional process. Explicit recommendations to limit judicial discretion at disposition (e.g., Institute of Judicial Administration/American Bar Association Commission on Juvenile Justice Standards) appear warranted in light of these issues surrounding the dispositional process. Unfortunately, few locales have implemented these types of guidelines. Meanwhile, more research is needed to improve the validity of amenability determinations and dispositional judgments. At present, there is a dearth of empirical evidence about the optimal matching of juvenile offenders and treatment alternatives. What little research does exist on amenability has focused more on the process of decision-making rather than its content (e.g., linking outcomes and case characteristics). Yet, the amenability determination may be the critical area for mental health involvement, especially in cases with mentally ill juveniles, since the consequences at both transfer and disposition may differentiate those who receive treatment from those who receive punishment.

MONITORING OF PLACEMENT AND SERVICE PROVISION

Once the court has determined a treatment plan for a juvenile, the remaining issue concerns the court's role after this order has been entered. Historically, the court's role has been to prescribe particular services in the cases that come before it. However, since Gault and the concomitant recognition of the court's limited ability to deliver on its promise of treatment, the utility of the court in this role has been questioned. There has been considerable debate about whether the court should continue to prescribe interventions as an all- knowing parent substitute after disposition or whether the court should revert to a more administrative function, serving to ensure that other agencies are meeting prescribed standards of care (Mulvey, 1982; Feld, 1988).

The ultimate issue is the judiciary's ability to impact service delivery after disposition (Harris, 1989). For example, what recourse is available when a child's lawyer argues that the facility in which a juvenile is placed does not meet the juvenile's mental health needs? Should the court have the ability to revoke custody from that service provider and modify the treatment plan? In cases where the agency says that the service has not had an impact and requests another placement, should the court be in the position to determine whether the youth has "failed to adjust" or whether the agency has "failed" to provide adequate treatment? If the latter were determined, should the court be empowered to order the agency to provide certain types of interventions?

Most state statutes are vague, and case law is generally sparse and unclear about the extent of the court's monitoring and enforcement power. Some states require continued judicial review of juvenile court placements as a method for addressing this issue. For example, Arizona requires judicial review every 60 days after a child is committed. Whether such review can be done effectively, however, given the large case loads in most courts, is an open question. The level of review actually done by the courts and the ultimate value of this procedure requires further consideration and inquiry.

A case can be made that ongoing determination of treatment effectiveness is not a role that the court should assume. Such a posture by the court could ultimately have detrimental effects on both individual youth and the organization of the service network connected with the court. A court active in every phase of treatment planning and implementation could lead to "micromanagement" of treatment. Judges, rather than treatment providers, could be making determinations as to appropriate treatment efforts, and the qualifications of many judges in this regard may be questionable. In addition, heavy court involvement in evaluating the appropriateness of particular treatment approaches could reduce the range and diversity of services available. The organizational reality of service provision in most communities is that as long as the court does not have an expansive service system of its own, it has to maintain contractual relationships with service providers who might go elsewhere (e.g., child welfare agencies) for referrals. An active court pressing service providers for more accommodations and effort in troublesome cases could eventually find itself with a limited pool of agencies willing to work with it. Providers could simply go to an easier market.

This recognition of the court's undocumented record of ensuring adequate service provision and the potential risks of empowering the court to dictate treatment efforts creates a policy dilemma. The reasonable midground in this situation might be for the court to function in a more administrative role, ensuring that service organizations are working together and that minimally acceptable standards of treatment are met, but leaving the evaluation and modification of individual treatment up to the agencies which are providing or administering the treatment. By enforcing broad mandates for identified groups of juveniles (e.g., offenders with specific types of disorders) or for such outcomes as comprehensive care (as in Willie M. v. Hunt[23]), the court could operate to sketch out the general framework of a desired service system, rather than the specifics of intervention.

An important final note is that, regardless of the court mechanism used, the promotion of any system of more comprehensive, open-ended treatment planning presents the problem of possibly promoting "indefinite" treatment for selected groups of juveniles. In most states, juveniles can only be adjudicated in the juvenile court system until they are 18, but in some states they may be committed to treatment until they are 21. The length of treatment in some cases exceeds the sentence for the equivalent offense in criminal court (Gault entailed just such a situation). The usual criteria for continued placement are seriousness of offense and threat to the community rather than the youth's best interest.

Such provisions are of particular importance to the treatment of mentally ill juvenile offenders. These juveniles may be seen as appropriate for continued treatment when their antisocial acts (especially in the case of violent offenders) are presumed to be linked causally to their mental disorder. Given the tendency of both the public and treatment professionals to posit a link between mental disorder and community violence, mental illness might be considered de facto a sufficient condition to warrant extended intervention by the court system. Obviously, such a practice could only be seen as legitimate if the juvenile court were providing positive services for those youth and if the linkage between the disorder and the antisocial activity could be established. Ultimately, though, the joint involvement of the court and mental health professionals in more active treatment planning may produce a situation in which disordered youth will remain under the jurisdiction of the juvenile justice system for an extended period of time simply because of their mental condition.

---

[23] Willie M. v. Hunt, 657 F.2d 55 (1981).

SUMMARY AND RECOMMENDATIONS

Several legal and research issues regarding the interaction of mentally disordered youth with the juvenile justice system have been identified in this review. After examining the legal policies in this area, one is left with a picture of a system with little theoretical clarity or institutional infrastructure for systematically identifying and treating these youth. Part of this is attributable to the current state of flux surrounding the central mission of the post-Gault juvenile court with its increased emphasis on due process and appropriate retribution for crimes committed versus the centrality of rehabilitation and individualized justice. Part of it is also attributable, though, to the simple fact that the juvenile justice system has never been forced to address several overarching issues.

First, in our opinion, the right to treatment for these youth in the least restrictive, appropriate setting must be made explicit in case and statutory law. A review of the vagaries of legal policy in this area makes it clear that the lack of this right is the singular most substantial barrier to the provision of effective due process and treatment for mentally ill juvenile offenders. Because the due process rights of juveniles are not total and certain actions can be taken in the juvenile justice system in the name of the child's best interest, it is necessary to provide a right to treatment as a trade off for these limitations on individual liberty and family privacy.

Although the Supreme Court has not addressed the right to treatment issue, in recent years there has been a rise in the number of cases on the state level recognizing that right.[24] Most of these decisions have relied on constitutional grounds of procedural and substantive due process (Becker, 1980). Recognizing that inadequate mental health services violate the juveniles' right to treatment, several courts have ordered widespread institutional reforms and delineated minimal standards which must be met to satisfy the constitutional requirements (Costello and Jameson, 1987). These minimal standards have included individualized assessments by qualified mental health professionals for the development of treatment plans[25], ongoing access to a psychiatrist[26], and individual or group counseling[27]. In addition to these cases, numerous organizations involved with juvenile corrections have developed standards of medical and mental health care for detained juveniles. These groups include the Institute of Judicial Administration/American Bar Association Commission on Juvenile Justice Standards (IJA/ABA), the National Advisory Committee for Juvenile Justice and Delinquency Prevention Standards (NAC) and the American Correctional Associations Standards (ACA)[28]. Concerns for access and availability to quality services are raised in most of these standards.

---

[24] Gary W. v. State of Louisiana, 437 F. Supp. 1209; Gary H. v. Hegstrom, No. 77-1039-BU; Morgan v. Sproat, 432 F. Supp. 1130; Nelson v. Heyne, 355 F. Supp 451; Morales v. Turman, 383 F. Supp. 53; Inmates of Boys' Training School v. Affleck, 346 F. Supp. 1354; Martarella v. Kelley, 349 F. Supp. 575.

[25] Morales v. Turman, supra.

[26] Inmates of Boys' Training School v. Affleck, supra.

[27] Gary H. v. Hegstrom, supra.

[28] Costello and Jameson (1987) provide a detailed review of the various standards and how they relate to the previously noted case law on right to treatment.

Based on the above, a strong case can be made for the recognition of a constitutional right to treatment in the juvenile justice system. While recognition of this right does not guarantee that effective treatment plans will be developed and implemented, it provides the leverage to force service providers and courts to be accountable for failures to do so. Ideally, recognition of this right by the United States Supreme Court would offer the legal foundation for nationwide reform. Pending such recognition, however, state legislatures could work to incorporate a juvenile's right to treatment into state statutes. From this base, a state-by-state initiative to guarantee access to a minimally acceptable level of treatment could be launched. Alternatively, administrative regulations tied to federal and state funding of juvenile justice programs and facilities could specify that funding be conditional upon the provision of treatment meeting certain standards. Regardless of what route is taken, the need to establish such a right is clear if a reformed legal framework is to be constructed.

Second, the vagueness of statutory law regarding what special consideration should be given to mentally ill adolescents involved in the juvenile justice system must be eliminated, or, at the very least, vastly reduced. From the point of initial contact to placement, rules or guidelines for addressing the issue of mental illness in legal determinations are imprecise, ambiguous, and often tragically archaic. A clearer definition of the population constituting the "mentally ill" and how that classification may effect the proceedings is crucial in determining the fate of these youth in the system.

Third, several issues related to youth with mental disorders require additional research to inform the juvenile justice system about the effectiveness of its processing of these cases. One portion of the research should examine how mentally ill youth are identified upon their entry into the juvenile justice system. Regardless of the vagueness of statutes in specifying the population, the proper identification of those youth in need of mental health treatment is the preliminary step necessary to ensure that they receive care. Research on this issue may lead to the development of a more uniform screening device capable of identifying those youth most in need of mental health services.

Another major focus of a juvenile research agenda should address the issue of amenability. The determination of amenability to treatment and how mental illness affects that judgment will remain a central concern for juvenile justice processing. This determination is implicit in diversion decisions and explicit in waiver and disposition determinations. Despite this, little is known about the factors that presently do, or possibly should, go into this determination. Little research has been conducted about how to structure this judgment to maximize the effectiveness of a match between different types of adolescents and services. Mentally ill adolescents provide some of the greatest challenges to decisionmaking about amenability to treatment. Despite this, no special provisions exist for making these determinations with extra caution about their appropriateness.

In addition, the issue of service availability is one that broadly affects decision-making about processing and placement of mentally ill adolescents. As mentioned earlier, in several states and at a few points in processing, this factor is cited as a relevant consideration for making legal decisions. At other points, however, this factor operates as a subtle frame of reference against which many decisions about juvenile justice processing are made. An explicit consideration of the role of the service context in driving decisions, particularly those related to amenability, are questions that will ultimately have a great deal to do with the types of services received by mentally ill adolescents in the legal system.

Finally, another decision-making criteria that remains salient, but inadequately explored and structured, is the prediction of dangerousness. From pretrial detention to transfer hearings to disposition

treatment plans, the predicted dangerousness of the juvenile can override other considerations in determining outcome. Even though research indicates that mental health experts have a tendency to overpredict dangerousness (Webster & Menzies, 1987), the courts have deemed reliance on expert determinations of this issue acceptable[29].

The provision of treatment for potentially "dangerous" mentally ill juveniles becomes problematic, however, because the mental health system may not be equipped to handle, or may simply refuse to accept, dangerous, mentally ill juveniles in their treatment facilities. If that is the case, these juveniles may be forced to remain in juvenile correctional institutions when a mental health facility may actually be more appropriate. These children, then, find themselves caught between two systems which are unwilling or unable to provide needed services.

In the end, legal regulations and research findings can only set the stage for effective service provision. Such a task, however, is an extremely important one. An examination of the existing legal policies toward mentally ill adolescents in the juvenile justice system shows that there is considerable room for improvement and clarification. Until an appropriate foundation has been laid in state statutes and case law setting forth standards and definitions, it will be difficult to ensure a consistent and equitable service system.

---

[29] Barefoot v. Estelle, 463 U.S. 880 (1983); Schall v. Martin, supra.

REFERENCES

Barefoot v. Estelle, 463 U.S. 880 (1983).

Barnum, R. Self incrimination and denial in the juvenile transfer evaluation. Bulletin of the American Academy of Psychiatry and the Law, 18, 413-427, 1990.

Becker, R.J. The right to treatment for juvenile offenders, Loyola Law Review, 26, 364-388, 1980.

Braithwaite, L. and Shore, A. Treatment rhetoric versus waiver decisions. Journal of Criminal Law and Criminology, 72, 1867-1891, 1981.

Costello, J.C. and Jameson, E.J. Legal and ethical duties to incarcerated children. The Journal of Legal Medicine, 8, 191-261, 1987.

Dusky v. U.S., 362 U.S. 402 (1960).

Feld, B. The juvenile court meets the principle of offense: Punishment, treatment and the difference it makes. Boston University Law Review, 68, 821-838, 1988.

Gary H. v. Hegstrom, No. 77-1039-BU (1984).

Gary W. v. State of Louisiana, 437 F. Supp. 1209 (1976).

Grisso, T. Juveniles' waiver of rights: Legal and psychological competence. New York: Plenum, 1981.

Grisso, T. and Conlin, M. Procedural issues in the juvenile justice system. In N.D. Reppucci, L.A. Weithorn, E.P Mulvey and J. Monohan (eds.). Children, Mental Health and the Law. Beverly Hills: Sage (pp 171-194), 1984.

Grisso, T., Miller, M.O., and Sales, B. Competency to stand trial in juvenile court. International Journal of Law and Psychiatry, 10, 1-20, 1987.

Grisso, T., Tomkins, A., and Casey, P. Psychosocial concepts in juvenile law. Law and Human Behavior, 12, 403-437, 1988.

Harrington, M.M. and Keary, A.O. The insanity defense in juvenile delinquency proceedings. The Prosecutor, 17, 31-35, 1982.

Harris, L.J. Rethinking the relationship between juvenile courts and treatment agencies - An administrative law approach. Journal of Family Law, 28, 217-269, 1989.

In re C.W.M., 407 A. 2d 617 (1979).

In re Gault, 387 U.S. 1 (1967).

In re Winburn, 145 N.W. 2d 158 (1966).

In re Winship, 397 U.S. 358 (1970).

In the interest of M.A. Ferris, 563 P.2d 1046 (1977).

In the interest of Myra Burns, 385 N.E. 2d. 22 (1978).

In the matter of Jeffrey C., 366 N.Y.S. 2d. 826 (1975).

Inmates of Boys' Training School v. Affleck, 346 F. Supp 1354 (1972).

Kent v. U.S., 383 U.S. 541 (1966).

Lowenthal, J.S. Mental health - The minor's right to due process. Journal of Juvenile Law, 8, 117-126, 1984.

Martarella v. Kelley, 349 F. Supp. 575 (1972).

McKeiver v. Pennsylvania, 403 U.S. 528 (1971).

Miranda v. Arizona, 384 U.S. 436 (1966).

Morales v. Turman, 383 F. Supp. 53 (1974).

Morgan v. Sproat, 432 F. Supp. 1130 (1977).

Mulvey, E.P. Scenes from a marriage: How can juvenile justice and mental health go on together? Forensic Reports, 2, 9-24, 1989.

Mulvey, E.P. Family courts: The issue of reasonable goals. Law and Human Behavior, 6, 49-64, 1982.

Mulvey, E.P. and Reppucci, N.D. The context of clinical judgment: The effect of resource availability on judgments of amenability to treatment in juvenile offenders. American Journal of Community Psychology. 16, 525-545, 1988.

Mulvey, E.P. & Saunders, J.T. Juvenile detention criteria: State of the art and guidelines for change. Criminal Justice Abstracts, 14, 261-289, 1982.

Nelson v. Heyne, 355 F. Supp. 451 (1974).

Schall v. Martin, 467 U.S. 253 (1984).

Thompson, E.L. Children in need of mental health treatment: A judge's view of revised public law and new private law proceedings. Tulsa Law Journal, 26, 347-404, 1991.

Wadlington, W., Whitebread, C.H. & Davis, S. Children in the Legal System. Mineola, N.Y.: Foundation Press, 1983.

Webster, C.D. & Menzies, R.J. The clinical prediction of dangerousness. In D. Weisstub (ed.), Law and Mental Health. International Perspectives. Volume 3. New York: Pergamon, pp.158-208, 1987.

Willie M. v. Hunt, 657 F.2d 55 (1981).

Worrell, C. Pretrial detention of juveniles: Denial of equal protection masked by the parens patriae doctrine. Yale Law Review, 95, 174, 1985.

CHAPTER 5

TREATMENT IN THE JUVENILE JUSTICE SYSTEM: DIRECTIONS FOR POLICY AND PRACTICE

Gary B. Melton
Pauline M. Pagliocca

In considering the treatment needs of youth in the juvenile justice system, policy makers and service providers should be aware of two general points. First, because the populations vary little across youth service systems, the design of effective programs for emotionally disturbed youth in the juvenile justice system is a task that in principle differs little from child mental health planning in general. Although some specific forms of treatment (e.g., confrontational group therapies such as Positive Peer Culture and Guided Group Interaction) have been adopted almost exclusively in the juvenile justice system, there is no reason to believe that effective treatment in the juvenile justice system differs appreciably from that in the mental health system. The treatment needs of youth do not become magically transformed when they walk through the courthouse door. If the specialized services in the juvenile justice system could be demonstrated to work in that context, they probably also would be effective if provided under the auspices of the mental health system.

This point becomes even clearer when one considers the privatization of juvenile justice (see e.g., Lerman, 1980, 1982; Schwartz, 1989, chap. 7; Strasburg, 1978). Increasingly, the services that youth receive through the juvenile justice system are the same as if they walked through the door of the mental health center, residential treatment center, or psychiatric hospital. Indeed, they often do walk through that door as a disposition in the juvenile justice system, especially if they are White (Cohen et al., 1990; Cohn, 1963; Farrington, 1987; Lewis, Shanok, Cohen, Kligfeld, & Frisone, 1980).

Second, the services now typically available 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. The needs of emotionally disturbed youth in the juvenile justice system seldom match the traditional service options of office-based counseling (whether administered by a probation officer in a court service unit or a therapist in a community mental health center) and residential treatment (whether in a training school in the juvenile justice system, a residential treatment center in the child welfare system, a psychiatric hospital in the mental health system, or a residential school in the special education system[1]).

Examination of these two premises is a good starting place for consideration of how treatment for emotionally disturbed delinquent and status offending youth ought to be done, if the goal is a decrease in behavioral and emotional problems. As we shall see, though, planning of treatment services

---

[1]Of course, one program can simultaneously assume this myriad of identities, with the identity in any particular case being dependent primarily on the source of payment.

in the juvenile justice system is complicated by the fact that rehabilitation is not the only legitimate goal of the system and perhaps not even the primary goal. Design and implementation of treatment services in the juvenile justice system must accommodate those additional purposes.

WHAT'S DIFFERENT ABOUT JUVENILE JUSTICE?

Are the Kids Different?

South Carolina Studies

To return to the first premise, "(seriously) emotionally disturbed (mentally ill)" youth in the juvenile justice system are not very different from delinquent and status offending youth in general. At the same time, they are not very different from emotionally disturbed youth in other public-sector service systems (e.g., mental health; child welfare).

This point was demonstrated in a series of studies undertaken for the South Carolina Department of Mental Health (DMH).[2] Because the various state agencies serving children and families shared the belief that seriously emotionally disturbed (SED) youth in the Department of Youth Services (DYS) were the cause of many bureaucratic nightmares, the first author was asked to assist in defining the population of concern and designing community-based services to meet their needs. Although studies in other states (discussed later in this chapter) suggested that investment of time and resources in the population definition bordered on frivolous, agency administrators were sufficiently adamant that an epidemiological effort was necessary to identify SED/DYS clients before moving to the design of services.

As it turned out, the effort was worthwhile, not only because it persuaded local administrators that the service system's problems were not the product of uniquely emotionally disturbed clients but also because it uncovered some fortuitous findings (discussed later) that proved useful in service system reform. The initial belief was confirmed, though: SED/DYS clients looked much like DYS clients in general and community mental health (CMHC) clients in general.

Three studies were conducted in Greenville County, the largest county in South Carolina. First, DYS clients referred to community mental health centers (CMHCs) were compared with those in the general DYS population. Most youth in both groups had been found not innocent of minor crimes. The DYS/CMHC group did appear to have especially troubled and impoverished family backgrounds and to have entered the juvenile justice system at an early age. That group may have been de facto child protection cases in which DYS workers hoped that CMHC would maintain monitoring and intervention, especially after the youth "aged out" of juvenile justice.

---

[2]This series of studies and a subsequent series of intervention studies are being reported in a forthcoming special issue of the Community Mental Health Journal (see also Henggeler et al., 1991; Henggeler, Melton, & Smith, in press; Henggeler et al., submitted for publication). Mark Zrull collaborated with the first author on the prevalence studies, and Scott Henggeler has played the lead role in the subsequent intervention research. Linda Smith has been an active collaborator in all of our work, and Jerome Hanley was the project director on the Child and Adolescent Service System Program (CASSP) grant from the National Institute of Mental Health that supported the studies.

Second, CMHC clients who were also DYS clients were compared with the general CMHC population. The demographic characteristics, history of trauma, and family background of the two groups were virtually identical. About one-fourth of the children in both samples were reported by their parents to be failing at least one subject. Parents' reports of their children's behavior showed that characteristics associated with conduct disorders or oppositional disorders were common in both samples (e.g., disobedient at home--CMHC/DYS, 56.7%, CMHC-only, 52.6%; impulsive or acts without thinking, CMHC/DYS, 40.0%, CMHC-only, 41.4%; gets in many fights, CMHC/DYS, 13.3%, CMHC-only, 19.0%). The biggest difference between the two groups--probably reflecting the high rate of institutionalization within DYS--was that the majority of CMHC/DYS youth (61.3%) had a history of out-of-home placement, but a substantial percentage of CMHC-only youth (24.6%) also had such a history.

Third, all legal system and CMHC staff in the county who worked with juvenile offenders were surveyed. Using a questionnaire designed by Grisso, Tomkins, and Casey (1988) to assess decision making in juvenile courts, they were asked to describe their most recent case of an SED/DYS client. Except for some judges, the sample of professionals included the entire population of mental health and legal system personnel in juvenile justice in the county. The research team surveyed CMHC and state-hospital clinicians, DYS probation officers, youth-division police officers, the solicitor who prosecutes juvenile cases, and the family court judges.

Those youth identified as SED/DYS clients were typically reported to be:

- male
- behind in school
- involved in property or status offenses
- living in a chaotic family
- lacking classic mental health symptoms (e.g., self- destructive behavior)
- displaying traits commonly associated with conduct disorders (e.g., association with delinquent peers, lack of sense of conscience, poor insight into personal problems, poor school attendance).

Thus, although some differences appeared between the clients identified as both delinquent and in need of mental health services and their peers in DYS and CMHCs, the more striking message cutting across the studies was how similar the groups were. This point was especially clear when workers were asked to identify an SED/DYS client in their caseload.

Other Evidence

One might argue that these findings were specific to the county studied. Although the relative frequency of use of the juvenile court in South Carolina is unusually high, the literature is replete with supportive evidence for the largely overlapping populations in the children's service systems (Cohen et al., 1990; Lerman, 1992; Lewis et al., 1980; Stroul & Goldman, 1990; Weithorn, 1988). As Otto, Greenstein, Johnson, and Friedman (this volume) show, most youth in the juvenile justice system, especially its deep end, have diagnosable mental health conditions, and many have a history of mental health treatment.

Indeed, it is difficult to imagine a youth whose behavior is sufficiently objectionable to remain in the juvenile justice system who would not meet the DSM-IIIR (American Psychiatric Association,

1987) criteria for conduct disorder.[3] Any three of the following list of behaviors is enough to obtain the diagnosis: stealing, running away, lying, arson, truancy, breaking and entering, cruelty to animals, rape, fighting, fighting with a weapon, and armed robbery or extortion. Accordingly, a thief who sometimes lies and initiates fights would fit the criteria. When one considers the possibility of other behavior disturbances (e.g., oppositional disorders), it seems even more likely that most delinquents would fit a diagnosable condition.

Taking the point a step further, it is difficult to imagine that such a youth would not be classified as seriously emotionally disturbed. The National Institute of Mental Health criteria for classification as SED require only a diagnosable condition (e.g., conduct disorder), involvement in two or more service systems (e.g., education and juvenile justice), and evidence of persistent problems. Because the latter two criteria are generally satisfied by involvement in the juvenile justice system itself, the fact that most delinquent and status offending youth could be diagnosed as having a mental disorder means that virtually all youth who are more than transient clients of the juvenile justice system are SED. In short, the definitional criteria for conduct disorder and SED are such that the identification of emotionally disturbed youth in juvenile justice is virtually a search for a tautology!

Of course, the fact that most youth in the juvenile justice system are SED does not, by itself, establish that most youth in the mental health system are like them. The evidence is clear, though, that most youth in the public mental health system--like the samples in South Carolina--do not have classical mental health syndromes and, if they do, the reason for their referral typically is their coextensive behavior disorder (Lerman, 1982; Melton & Hargrove, in press; Miller & Kenney, 1966; Schwartz, Jackson-Beeck, & Anderson, 1984; Warren & Guttridge, 1984; Weithorn, 1988).

In their chapter, Otto et al. (this volume) note that mental disorders in youth in the juvenile justice system--and, they could have added, the mental health system--often are accompanied by substance abuse and serious learning problems (see Osgood & Wilson, 1991, for detailed discussion of covariation among adolescent problems). Although Otto et al. (this volume) focus on delinquents' personal characteristics, they could have added an additional array of social problems: poverty (Brathwaite, 1981; Elliott & Ageton, 1980; Farrington, 1986; West & Farrington, 1973); neighborhood disintegration (Aber, Mitchell, Garfinkel, Allen, & Seidman, in preparation; Maccoby, Johnson, & Church, 1968; Simcha-Fagan & Schwartz, 1986; Wilson & Herrnstein, 1985); family dysfunction (DiLalla, Mitchell, Arthur, & Pagliocca, 1988; Farrington, 1986; Loeber & Dishion, 1983; Rutter & Giller, 1984; Snyder & Patterson, 1987; West & Farrington, 1973; Wilson & Herrnstein, 1985); deviant peers (Elliott, Huizinga, & Ageton, 1985; Glueck & Glueck, 1950; Hirschi, 1969; Jackson, 1989; Rutter & Giller, 1984); present or soon-to-be unemployment (Elder, Liker, & Cross, 1983; Hirschi, 1969; Patterson, 1982). That list could be replicated for adolescent clients of the public mental health system (see Melton & Hargrove, in press, for a review).

---

[3] The criterion of remaining in the juvenile justice system is emphasized because illegal behavior is sufficiently common among adolescents (Erickson & Empey, 1963; Farrington, 1973, 1987; Gold & Petronio, 1980; Strasburg, 1978) that a one-time appearance in juvenile court is often a near-random event (i.e., many other youth, if caught, might have appeared on the charge, but the index youth does not have a pattern of impulsive, antisocial behavior) that in the majority of cases is not repeated (West & Farrington, 1973).

Is the Purpose Different?

Accordingly, in regard to treatment needs per se, there is little that is special about mental health services for youth in the juvenile justice system (compared with public child mental health service design more generally). Because the differences between youth in juvenile justice and mental health are minimal, the primary distinction that does exist is simply one of context. Mental health planners in juvenile justice must consider the values and goals present in the settings in which services might be delivered. Juvenile codes still almost uniformly retain a primary express purpose of rehabilitation. Therefore, the task for planners is, at one level, identical in the mental health and juvenile justice systems. To accomplish the goals of both systems, planners must seek to increase the availability and accessibility of services that will address the complex needs of SED youth and their families and increase their "fit" into the broader community.

Nonetheless, courts also often have a statutory charge--and, when not, nearly always have a political mandate--to consider community interests in safety and even retribution when making decisions about intake, detention, transfer, and disposition within the juvenile justice system. Mulvey (1984) concretized this point by describing the variability of the implicit meaning of amenability to treatment in various legal contexts:

> Each different proceeding presents potentially different factors weighing on the amenability judgment, and no single decision equation applies to all hearings where amenability is at issue. In the transfer decision, for example, the consideration of amenability is explicit (usually defined by statute), and must be documented by the judge's written decision. Also, the consequences of a judgment of nonamenability in this hearing is that the juvenile is processed through the adult system. For transfer, the question for the clinical profession is, thus, usually one of whether the youth is treatable at all. In contrast, the diversion and disposition decisions present a much more implicit amenability question, often framed by its interaction with several unstated but influential variables (e.g., concern for public safety and court philosophy). Clinical information in these situations is deemed valuable for matching a juvenile with an appropriate service. The point is that, while pervasive, the amenability determination and the clinical question related to it are far from uniform. Different court proceedings frame the decision differently. (p. 201)

Thus, purpose and context are defined not only by the particular system -- i.e., mental health or juvenile justice -- but also by the specific clinical question or legal decision at stake.

To some extent, these concerns are now outside the juvenile justice system, because ever-widening provisions for transfer--sometimes automatic transfer--of juvenile defendants to criminal courts have removed from juvenile court jurisdiction those youth about whom the community is most concerned with punishment and incapacitation. Even among those offenders whom the community regards as deserving of the relative solicitude of the juvenile justice system, though, there is sufficient variability of offense seriousness and chronicity that treatment goals may come into conflict with other systemic goals. Therefore, even if a given model of service can be demonstrated to be effective, it may be rejected by juvenile justice authorities who, even if not overtly, wish to give greater consideration to incapacitation and retribution as goals. For example, even if residential treatment is likely to be ineffective and a community-based program may have a reasonable chance of success, authorities may be willing to consider only out-of-home alternatives, because they believe that the seriousness of the offense demands a punitive or incapacitative response.

Moreover, a strong argument can be made that the ultimate purpose of the justice system is or should be the promotion of justice. Even an effective treatment system that interferes with, or is used to substitute for, fair resolution of respondents' cases fails in the end. Mental health professionals' first obligation in juvenile courts should be to ensure that those with whom they work believe that they are being heard, meaningfully represented, and treated with dignity and respect (see Melton, 1989a).

A related consideration is that the juvenile justice system is in many ways ill-suited to the delivery of treatment. When treatment is the primary purpose being pursued, juvenile justice probably ought to be the service alternative of last resort. Care must be taken to ensure that mental health goals do not interfere with due process, by placing juveniles in restrictive correctional facilities for the purpose of receiving mental health or educational services not easily available (or affordable) in non-correctional settings. Ironically, most often, such needed services are not provided adequately in juvenile justice programs either, negating the likelihood of achieving even treatment goals. Also related to the right to due process, care must be taken to ensure that the juvenile justice option is not used as a means of discrimination against ethnic-minority clients who, in principle, might be as easily treated in other, less restrictive systems.[4]

PRINCIPLES OF EFFECTIVE TREATMENT

Therefore, although psychosocial characteristics and treatment needs of emotionally disturbed youth differ little across service systems, context and purpose color the acceptability of particular treatment approaches. Despite contextual differences, however, optimal models of treatment in child mental health show striking similarity to those in juvenile justice. In that connection, the principles of mental health care proposed by Stroul and Friedman (1986) will be compared with the recent formulation of juvenile justice principles advanced by Barton, Streit, and Schwartz (1991). Both sets of tenets outline optimal system-level service models, rather than components of specific programs or interventions for individual clients. Both stress the needs of individual children and families in service development and the importance of community settings in decision making and service delivery.

Mental Health

In developing its mental health principles, the Child and Adolescent Service System Program (CASSP) proposed a "system of care," including not only an array of service components but also mechanisms for coordination and integration of service delivery. "A system of care is a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of severely emotionally disturbed children and adolescents" (Stroul & Friedman, 1986, p. 3). In support of such a system, the CASSP model offers the following ten guiding principles:

1. Emotionally disturbed children should have access to a comprehensive array of services that address the physical, emotional, social and educational needs.

---

[4]For findings addressing the relationship between racial stereotyping and recommendations for harsh punishment in the criminal and juvenile justice systems, see Bodenhausen & Wyer, 1985, and Pagliocca, 1992.

2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child, and guided by an individualized service plan.
3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.
5. Emotionally disturbed children should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.
6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Emotionally disturbed children should be ensured smooth transitions to the adult service system as they reach maturity.
9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.
10. Emotionally disturbed children should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics, and services should be sensitive and responsive to cultural differences and special needs. (Stroul & Friedman, 1986, p. 17)

Juvenile Justice

While recognizing the unique roles of the juvenile justice system in protecting the public and restricting the freedom of juvenile offenders, Barton et al. (1991) have proposed a model for developing and revamping youth corrections. The following "system characteristics" of their "blueprint" show considerable overlap with the CASSP principles:

1. Coordination -- at the system level, through interagency structures and agreements; at the case level, through the assignment of case managers who ensure that clients receive individualized services, as prescribed.
2. Rational decision making -- based on case-specific information, addressing the appropriate levels of restrictiveness on placement and supervision and the treatment needs of individual clients.
3. Array of services -- a range of options to meet client needs across the juvenile justice system, from probation to incarceration. Services include: basic supervision and supports; special treatments for substance abuse, mental health problems, sexual deviance, and medical problems; a variety of alternative living arrangements; job training and placement; regular, alternative, and special education; character and social skills building; day treatment; family interventions; leisure time and recreational services; and aftercare. Services may be provided by the juvenile justice system or by other child-serving systems.

4. Flexible funds -- allocated based on client needs rather than categorical funding schemes. In other words, money must be allowed to follow the clients, rather than forcing clients to follow the money.
5. Advocacy -- ongoing legal advocacy to ensure fairness in dispositional decision making; and independent advocacy to ensure availability of appropriate treatment options.
6. Evaluation -- at the system level, to assess coordination and decision making; and at the case level, to assess quality of services and case outcomes. (Barton et al., 1991)

Even a casual review of the two sets of principles reveals that, despite apparent differences in context and purpose of the two systems, optimal models of intervention look much the same. It should come as no surprise that when child-serving systems focus on the needs of clients (rather than on the competing interests of the systems, themselves), successful approaches to intervention are relatively indistinguishable, whether offered behind the door labeled "mental health" or that labeled "juvenile justice."

THE JERICHO PRINCIPLE

Given that the treatment needs of SED youth vary little on the basis of the system in which they find themselves, what services ought to be provided? Seriously emotionally disturbed delinquent youth commonly not only have aroused the ire of the guardians of public order (not to mention neighbors, teachers, and parents), but they frequently have a host of other problems that are apt to be persistent across time and pervasive across situations. These include: low educational achievement, distorted perceptions of social interaction, impaired problem-solving skills, troubled and delinquent friends, conflictual family relationships, poverty, and deteriorating neighborhoods. Indeed, the list of personal problems often is even longer: substance abuse, vulnerability to accidental injury, a history of maltreatment, depression, learning disabilities, and so forth. Given such a picture, why should one expect that going to an office to talk for 50 minutes a week (if indeed one can expect such a level of attendance at therapy sessions) is going to make a significant difference in the adjustment of most emotionally disturbed youth in the juvenile justice system? Similarly, when youth are removed from their homes and communities for incarceration or residential treatment, why should one expect a lasting change in their adaptation to those families and communities, once they return?

Outcome research supports these common-sense inferences from knowledge about the correlates of delinquency. This body of knowledge may be framed in terms of the Jericho Principle (Melton, 1989b). Metaphorically, walls ought to come tumbling down between disciplines and, therefore, various sectors (e.g., mental health; child welfare) of the child and family service system. Those services that have the best track record with the "multiproblem" clients who remain in the juvenile justice system are highly integrated and individualized. Such service models combine educational, social, family, and psychological interventions into a single treatment (see Clements, 1988; Mulvey, Arthur, & Reppucci, 1990). As the Jericho Principle concludes:

> Given the multiplicity of problems that SED youth present, it is logical that intervention, to be successful, must provide an integrated approach in which the youth is taught social, academic, and vocational skills, maladaptive expectancies are altered,

> community settings are changed to provide a better "match" with the youth, and the family is made a focus of intervention, in regard to both its "reality-based" needs and its interpersonal problems. (Melton, 1989b, p. 17)

We also ought to destroy the metaphorical walls that mental health professionals and service system administrators often seek to erect. It is time to move beyond the obsession with diagnosis:

> Separation of child and adolescent clients into the diagnoses contained in the DSM edition of your choice is largely uninformative....Amid...multifaceted and serious problems and a commonality of troublesome, "conduct-disordered" behavior, little of practical consequence is to be gained by attempting to compartmentalize child mental health disorders....(Melton, 1989b, p. 12 and 17).

Differentiation of conduct disorder, personality disorder, and oppositional disorder, for example, makes no difference in planning of treatments of demonstrated efficacy, whether in juvenile justice or mental health. Rather, a highly individualized functional and ecological assessment is needed (see Melton, 1983a, chap. 3).

Regardless, as has already been discussed, differentiation of SED delinquent youth from other persistently delinquent youth is a futile, even silly exercise. We should recognize the obvious: youth who cannot adapt to the community's expectations and who live in troubled and sometimes troubling families and neighborhoods need help to overcome those problems. Moreover, the complexity and severity of the problems that they and their families face imply, as outcome research confirms, that neatly packaged interventions based on diagnostic categories have little chance of success.[5]

The Jericho Principle is not simply metaphorical, though. Demolition of metaphorical walls is a formidable task, whether the obstacles are bureaucratic (e.g., categorical funding), political (e.g., protection of separate "turf" for the various professions), or conceptual (e.g., reliance on diagnosis). Overcoming reductionist policy and thought is not enough, though. Not just how we think, but what we do must change.

To facilitate that change in the mode of service delivery, therapists must leave their offices and institutions. Literally, clinic and residential-treatment walls ought to come tumbling down. As half-facetiously (but only half-facetiously) suggested by the Jericho Principle:

> Child and family services would be substantially improved if agencies divested their real estate holdings. One need not make a very high conceptual leap from facts about the characteristics of troubled children and youth to reach the conclusion that buildings are impediments to effective service delivery. (Melton, 1989, p. 12)

The services that work best involve treatment in natural settings, with substantial family, school, and community components. Not only is generalization of treatment easier when real-life issues are addressed at the place and time when they arise, but the context that creates or maintains maladaptive

---

[5]Indeed, the statement could go further, because childhood diagnoses are irrelevant even to extant packaged treatments, with the possible exception of some uses of psychoactive medication.

behavior also can be a focus of change. Moreover, for youth and families with as many problems as most who are in the juvenile justice system, the only real chance for successful treatment is to go where they are.

In that regard, the studies in South Carolina showed, serendipitously, that although referrals by DYS to CMHCs were relatively rare (about 10% of the DYS caseload), half were "lost" (i.e., they never showed up at the clinic)--a figure that is consistent with findings from various juvenile diversion programs That they did not arrive may not have been so tragic, though. In only about 3% of the cases in which DYS clients did appear at CMHCs did clinicians judge treatment to have been terminated as a success![6]

THE SOUTH CAROLINA FAMILY AND NEIGHBORHOOD SERVICES (FANS) PROJECT

A striking contrast has been developed in a project that follows the Jericho Principle. Responding to the sense of crisis in regard to SED/DYS clients, the FANS Project sought to demonstrate that even the most serious juvenile offenders could be treated successfully if services were sufficiently intensive, individualized, and integrated, with attention to the wide array of domains in which serious offenders have severe problems.[7]

Multisystemic therapy (MST), a treatment approach developed by Scott Henggeler and Charles Borduin (Henggeler & Borduin, 1990), is based on family systems theories (e.g., Haley, 1976; Minuchin, 1974) and social ecology theory (Bronfenbrenner, 1979), but also considers the role of child development variables. Treatment, then, focuses on dysfunction in any of the affected systems--e.g., the individual, family, peers, school, neighborhood--as well as on relationships between and among the various systems. Although multiple systems may be involved, MST involves a single therapist for each client, providing brief (about four months) but intensive treatment. (In the FANS Project, each therapist carried four cases at a time.)

Integrating intervention strategies from structural family therapy, strategic family therapy, behavior therapy, and cognitive behavior therapy, MST applies the following general principles (Henggeler, 1991):

1. The primary purpose of assessment is to understand the "fit" between the identified problems and their broader systemic context;
2. Interventions should be present-focused and action-oriented, targeting specific and well-defined problems;

---

[6]Incidentally, by simply moving outpatient services to the middle school, the no-show rate among early adolescents was reduced sufficiently that the difference in revenues generated by a single therapist--who at the same time spent a much greater proportion of her time in prevention programs that were not reimbursable--went far toward paying for another therapist.

[7]Violent juvenile offenders may differ from nonviolent delinquents primarily in the severity of the problems that they experience; the range of problems is similarly broad (Henggeler, 1989, chap. 6).

3. Interventions should target sequences of behavior within and between multiple systems;
4. Interventions should be developmentally appropriate, matching the developmental needs of the youth;
5. Interventions should be designed to require daily or weekly effort (including homework) by family members;
6. Intervention efficacy should be evaluated continuously from multiple perspectives (e.g., youth, family members, teachers);
7. Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change;
8. Therapeutic contacts should emphasize the positive and should use systemic strengths as levers for change; and
9. Interventions should be designed to promote responsible behavior and decrease irresponsible behavior among family members.

These principles were applied in the FANS Project. The 84 youths in the sample averaged 3.5 previous arrests, with the majority having at least one arrest for a violent crime and three-fourths having been previously incarcerated. Three-fourths were male, and most were older juveniles (mean age = 15.2). All had been recommended for residential placement by DYS. Youth were randomly assigned either to the services that they would have received otherwise (Usual Services) or to multisystemic treatment (MST).

The results with this very "deep-end" sample were impressive. After more than a year of follow-up, the MST group had 42.7% fewer arrests than the Usual Services group (even though the MST group had been locked up substantially less), 64.2% fewer weeks of incarceration, 66.3% fewer self-reported delinquent incidents, and 78.6% fewer self-reported incidents of illegal drug use. Family cohesiveness was also better in the MST group, and peer aggression was reduced.

The savings in reduced delinquent activity are obvious. Moreover, MST is much less expensive than Usual Services ($2800 versus well over $20,000). Thus, a highly integrated treatment approach substantially reduces restrictiveness (relative to alternatives), increases efficacy, and reduces costs, even for treatment of the most serious juvenile offenders!

Even more impressive results have been obtained in a study of less serious, but chronic, juvenile offenders in Missouri (Borduin et al., in preparation). Youth were randomly assigned to individual psychotherapy or MST. After four years of follow-up, recidivism in the MST group was only 22%, but it was 72% for youth who received individual treatment and 87% for youth who refused any treatment. For youth who terminated treatment prematurely, the recidivism rate was 42% for MST and 72% for psychotherapy (the same rate as those who completed psychotherapy). MST also has been shown to be effective in treating juvenile sex offenders--the only controlled treatment study of which we are aware in regard to that population (Borduin, Henggeler, Blaske, & Stein, 1990).

COMMON FORMS OF INTERVENTION

As discussed above, the most commonly available forms of intervention for emotionally disturbed children, including those involved in the juvenile justice system, are outpatient psychotherapy and residential placement.

Individual and Family Psychotherapy

Although approaches to individual and family psychotherapies may differ somewhat, available outcome studies do not show substantial differences in generalizable effects of treatments of various orientations (Casey & Berman, 1985). Moreover, Casey and Berman's (1985) metaanalysis of child psychotherapy studies revealed that while treatment may be effective for relatively circumscribed problems (e.g., phobias, anxiety, disorders, psychosomatic disorders), this is not the case for broader problems of social maladjustment, such as those exhibited by youthful offenders. Most often, psychotherapy is provided on a once-a-week basis in a therapist's office and offers limited opportunity to address clients' "real life" problems in their "real life" settings. Rarely do therapists venture into the community to function as part (or coordinator) of a larger, integrated system of necessary services. After an exhaustive review of research on juvenile delinquency, Rutter and Giller (1984) concluded that "[c]ounselling and psychotherapy are of no value as a means of preventing delinquency, and as a mode of treating offenders it is likely that they are useful only in a minority of cases" (p. 318). (For extensive reviews of psychotherapy outcome with children, see Casey & Berman, 1985; Kazdin, 1990; Kuperminc & Cohen, in press; and Melton & Hargrove, in press.)

Residential Placement

Residential treatment, whether offered in group homes, psychiatric hospitals, or more security-focused training schools, does not appear to be any more effective in producing long-term improvement in delinquents' social adjustment. Indeed, the literature is replete with accounts of residential treatment efforts that failed to show generalized behavioral change after clients returned to the community (e.g., Allerhand, Weber, & Haug, 1966; Blumstein & Cohen, 1987; Braukmann et al., 1985; Cavior & Schmidt, 1978; Jesness, 1971; Kirigin, Braukmann, Atwater, & Wolf, 1982; Taylor & Alpert, 1973). (For extensive reviews of research on residential treatment for juvenile offenders, see Mulvey et al., 1990; Quay, 1987a; and Rutter and Giller, 1984.)

The discouraging findings of residential treatment should not be surprising, however, considering that, even though operating 24 hours a day, such settings face formidable obstacles to integration of affective, educational, and social services, even if all are apparently available. First, that a facility runs round the clock does not mean that services are well conceptualized or even that treatment is provided. Second, the residential character of a program disrupts a child's attachments and makes work with families difficult. Third, the more that a setting is divorced from "real life" in the community, the less likely it is to ensure that a child masters skills necessary for coping with the demands of everyday life. Fourth, removal of a child from the community minimizes the possibility that supports will be built in that community to which the child may return or that the conditions that maintained the child's deviant behavior will be remediated. These features of residential treatment are clearly in conflict with the proposed models of juvenile justice (Barton et al., 1991) and mental health (Stroul & Friedman, 1986), described above.

WHAT TREATMENTS WORK?[8]

Before describing specific programs and reform efforts, we will outline general conclusions drawn from the outcome literature about principles to guide therapeutic programs for behavior disordered youth. As may be expected, these are consistent with the models for system reform, already discussed. The programs that will then be described will serve as selected examples of the application of these principles.

Perhaps the most fundamental rule is that programs must integrate affective, cognitive, and social interventions. Findings in regard to the characteristics of successful programs and the predictors of maintenance of behavior change among graduates of those programs indicate that a skills orientation is critical (e.g., Hobbs, 1982). Because school is the locus of many of the demands placed on children and youth, it is not surprising that those who are unable to cope with the academic and social requirements of school show poor general adjustment.

At the same time, programs must be truly community-based; that is, for behavior change to be sustained, efforts must be made to alter the setting as well as the child, and to find a "best fit" between the child and his or her environment. Although some programs that focus more or less exclusively on the child, without attention to the family and the community, show impressive in-program gains, those gains rarely are maintained over the long term.

To ensure that a child's program is fully integrated and that his or her interests are protected in the community, a strong case advocacy component is critical. Clinical child advocacy (Melton, 1983a) provides consistent theoretically-based advocacy for children, with the aims of increasing the responsiveness of the community and fostering children's own participation in the community. It is noteworthy that such an approach has been central to some of the most successful programs for behavior disordered youth. Such programs (e.g., the FANS Project, described above; the vocationally oriented psychotherapy project, described below) have incorporated a procedure in which the child has an adult who assists in mastering problems of everyday living, through direct efforts to change the community, as well as to increase the child's skills in adapting to the demands of school, workplace, and other community settings. That therapist-advocate is available outside the office and beyond an hour a week. Community-based services are especially amenable to such an approach.

Clinical advocacy is important not only because of its significance in ensuring a broad ecological intervention. It also is critical to protection of child clients' rights. Although such concerns obviously have profound ethical implications, they also are important in increasing the efficacy of treatment. Programs should show respect for the privacy and dignity of child and adolescent clients and provide opportunities for their involvement in treatment planning. Direct participation by children and adolescents in planning medical, psychological, and educational interventions results in greater involvement and achievement, a stronger sense of personal efficacy, and fewer premature terminations (see, e.g., Adelman, Kaser-Boyd, & Taylor, 1984; Adelman, Lusk, Alvarez, & Acosta, 1985; Brigham, 1979; Holmes & Urie, 1975; Lewis, 1983; Lewis & Lewis, 1983; Melton, 1981, 1983b; Taylor & Adelman, 1986; Taylor, Adelman, & Kaser-Boyd, 1985a, 1985b).

---

[8]Portions of this section are also discussed in Melton and Hargrove (in press).

Alternative Treatments

Before describing specific programs that operationalize the systemic principles presented thus far, a brief mention of individual service components that are frequently cited in proposals for a "continuum of care" is in order.[9] Generally, these components may be considered "alternative" or non-traditional forms of service, that is, alternative to the more commonly available outpatient psychotherapy and residential placement. Non-traditional children's services include: partial hospitalization and day treatment (see, for review, Baenan, Parris-Stephens, & Glenwick, 1986; Zimet & Farley, 1985); intensive home-based services (see, e.g., AuClaire & Schwartz, 1986; Kinney, Madsen, Fleming, & Haapala, 1977); respite care and other crisis intervention services (see, e.g., Subramanian, 1985; Upshur, 1983); and therapeutic foster care (see, e.g., Hawkins & Breiling, (1989); Trout & Meadowcroft, 1989; Update, 1986).

Clearly, many other core and supplementary services--such as school-based intervention, self-help groups, therapeutic recreational programs, and transportation--could be included. However, the significance does not lie in any ability to develop an exhaustive list of alternative interventions, but rather, in the creativity and flexibility required to develop a service plan tailored to the multiple and unique needs of individual children.

Vocationally Oriented Psychotherapy[10]

Although most research on psychotherapy has failed to support it as an effective intervention with youth in the juvenile justice system, those studies that have demonstrated substantial and persistent gains in social adjustment generally have focused on treatment programs that have gone well beyond what usually is labeled "psychotherapy." Probably the most frequently cited example is Massimo and Shore's "vocationally oriented psychotherapy" (1963, 1967), which was administered to conduct disordered late adolescents.

Although called "psychotherapy" and often included in metaanalyses of psychotherapy outcome studies, the term really is a misnomer when applied to Massimo and Shore's work. The therapy initially focused on expectations and attitudes related to work and, after the youth found a job, switched to job performance and problems encountered on the job. Thus, the "talking" part of the therapy centered on skill building and reality concerns. Perhaps most importantly, the therapy did not stop there. The therapist was available 24 hours a day, often as many as 10 times in a week, and functioned as advocate as much as counselor:

> Motility and action were emphasized. The therapist had no central office, and made frequent field trips when necessary. In essence, the therapist entered all areas of the adolescent's life. Job finding, court appearances, pleasure trips, driving lessons when appropriate, locating and obtaining a car, arranging for a dentist appointment, going for glasses, shopping for clothes with a first pay check, opening a bank account and other activities require this maximum commitment (Massimo & Shore, 1963, p. 636).

---

[9]For a more in-depth discussion of these components, see Burns and Friedman (1990), Melton and Hargrove (in press), and Stroul and Friedman (1986).

[10]Portions of this section are also discussed in Melton and Hargrove (in press).

The Massimo-Shore study is virtually unique in showing marked differences in adjustment between experimental and control groups 15 years after treatment ended (Shore & Massimo, 1966, 1969, 1973, 1979). Follow-up assessment showed that the group receiving the vocationally oriented treatment were functioning well in terms of employment, schooling, legal involvement, and marital status. Control group members, on the other hand, were still experiencing severe difficulties in legal, vocational, and personal adjustment.

Although the Massimo and Shore project was limited in size (ten experimental and ten control youths), the long-term positive outcomes provide strong support for the integration of services within a single, community-based treatment program.

OTHER REFORM EFFORTS

Data from reform efforts based in the juvenile justice system itself present a mixed message. It is clear that many more youth are being locked up than need to be for the purpose either of treatment or community safety. Even in a largely deinstitutionalized system, such as the Massachusetts Department of Youth Services (DYS), the core group of youth who have brief periods of incarceration may be larger than some had originally thought (see Lerman's 1992 review). Unlike many other state juvenile corrections systems, DYS operates or contracts with a wide range of service options. At one end of the system are the secure treatment facilities, each housing up to 15 adolescents for an average of ten months. At the other end of the system are community-based programs, such as "outreach and tracking," that supervise committed youth living at home or in other mainstreamed community settings. A variety of alternative programs exist along the continuum in between, e.g., foster care, community group homes, residential special education facilities.[11]

An unusual feature of the Massachusetts system, related to "hidden" rates of incarceration, is that DYS, rather than individual county or local authorities, operates a state-wide juvenile detention system. Therefore, the Department has an easier access to detention than many other states might have. Lerman (1992) calls attention to this feature, stressing DYS' use of "intermittent and relatively short periods of secure confinement" (p. 87) for committed youth who reside in non-secure settings and violate their "grant of conditional liberty" (comparable to rules of probation or parole). Such violations do not necessarily involve committing chargeable offenses; instead, they may consist of repeatedly breaking the rules in a residential setting or failing to maintain curfew or attend school on a regular basis. As such, detention serves as punishment or an attempt to control escalating deviant behavior. Whatever the purpose, this episodic use of incarceration has remained largely unexamined (with Lerman, 1992, being a rare exception) in the many accounts of DYS' radical move to deinstitutionalization. Even Lerman (1992), however, describes Massachusetts as a model application of Barton et al.'s (1991) "blueprint" for an effective system of juvenile justice.

---

[11]In the Massachusetts system, being "committed" does not automatically mean that a youth is sent to a correctional facility, as it does in many other states. Instead, committed youth live in a variety of settings, including their own homes. DYS retains authority, however, until the youth is officially discharged from the system.

Given the mixed goals of the juvenile justice system and the fact that significant levels of incarceration may persist in "deinstitutionalized" systems, there is a critical need for integration of mental health services into diverse settings in juvenile justice. Even in a "just-deserts" system, humane care demands that offenders in need of treatment receive it. Experience with programs such as the Teaching-Family Model (Phillips, Phillips, Fixsen, & Wolfe, 1974) and the Robert F. Kennedy Center's former token economy program (Cohen & Filipczak, 1971), both well-known behaviorally oriented treatment programs, establishes that juvenile offenders can be treated with dignity in a safe, even if sometimes punitive environment. No illusions should exist, however, that such programs do effective treatment (meaning generalizable, post-treatment behavior change), even though they are able to demonstrate within-program behavior change (see, e.g., Braukmann et al., 1985; Kirigin et al., 1982).

Both the CASSP (Stroul & Friedman, 1986) and juvenile justice (Barton et al., 1991) model principles suggest that better aftercare may improve the dismal post-release record that has accrued thus far even from "good" residential programs. The role of "teacher-counselor liaison specialists," as used in Project Re-Ed (Hobbs, 1982), illustrates the potential for aftercare through early planning for a child's return to the community (or "ecosystem") following residential placement. During and after treatment (up to 18 months), liaisons work to mobilize community resources--such as parents, extended family, schools, neighborhoods, and community services--necessary to sustain a child's progress beyond that attained while in residential care.

Hobbs (1982) argues that the liaison role, although filling some of the same functions as case managers, differs in some crucial respects. Most especially,

> ...an important strategy in liaison work is to teach the liaison function to one or more adults who are important in the life of a child, and to the adolescent when old enough and competent, so that the ecosystem can function effectively and meet new crises without external assistance....the liaison concept may be an idea immune from the professional tendency to keep knowledge arcane; if not openly shared (so that others can take over the liaison function), the idea destroys itself (Hobbs, 1982, pp. 214-215).

These examples illustrate efforts to develop innovative strategies within the usual confines of the juvenile justice system. Even with their mixed results, they highlight the need for the integration and coordination of services within and across child-serving systems.

PROMISING INTEGRATED SERVICE MODELS

The models to be described, and the FANS Project discussed above, are presented, not as therapeutic schemes for wholesale adoption, but as examples of programs that employ many of the treatment strategies supported by outcome research and the model system principles proposed by the CASSP initiative (Stroul & Friedman, 1986) and the Blueprint for Youth Corrections (Barton et al., 1991).

Individualized Care ("Wraparound" Services)[12]

A general approach to service coordination and delivery that has attracted considerable attention and support is that of "individualized care" (Friedman, 1988), or what is sometimes referred to as "wraparound" services (Behar, 1985) The term "individualized" is often used in recommending innovative programs for behaviorally disordered children and youth. Most often, however, the activities represented by the term are limited to development of new programs to fill gaps in the overall treatment system or, even more likely, to efforts to "fit" individual clients into some combination of available programs. In both cases, the emphasis is usually on programs. Individual child-serving systems generally fund a host of programs into which they funnel their own clients, with little accounting for client needs not met by existing options. In an effort to distinguish such a "component" system from an "individualized" system, Burchard & Clarke (1990) stated

> Individualized care involves a total commitment to serve the child and his or her family on an individualized basis. From the point of intervention all resources are available to follow the child and family until services are no longer needed. While many programs in a component system of care individualize their services, individualized care is the total system of care for the children and families who receive it (p. 50).

Individualized care represents an operationalization of the CASSP principles at a system level, but with additional emphasis on the roles of funding and service coordination. Six basic principles (Burchard & Clarke, 1990) serve as the foundation for individualized/wraparound care:

1. Unconditional care. Unlike component programs, whose responsibilities might end because of a client's age, legal status, diagnosis, or unacceptable behavior, individualized care makes a commitment to provide services until they are no longer needed. Clients cannot be "kicked out" of the system; instead, service plans (and accompanying funding) are redesigned to meet developing and changing needs. Responsibility for overseeing and guaranteeing service provision is assigned to an individual in a case manager, or similar, position.

2. Least restrictive care. According to Sewell (in press) "[r]estrictiveness can be thought to exist along several dimensions: physical, programmatic, chemical, geographic and social." In that regard, services are provided in as "mainstreamed" a fashion and setting as possible. Two exceptions (not unique to wraparound services) to the least-restrictive rule apply: a) when the child presents a danger to him/herself or others; and b) when all less restrictive alternatives have been tried and proven ineffective.

To guard against punitive or capricious changes in placement or programming (even to less restrictive alternatives), all decisions are made by an interdisciplinary team (described below). Moves to less restrictive settings, rather than depending on a standard amount of time or a client's "completing the program," are based on demonstrated improvements in adjustment. "With individualized care the child's program would be made increasingly less restrictive over a shorter period of time, guided by an active reintegration plan" (Burchard & Clarke, 1990, p. 50).

---

[12]The authors would like to thank Robert Sewell for his review and commentary on this section.

3. Child and family-centered care. This may be considered the core principle, the one from which the terms "individualized" and "wraparound" derive, and the one which best serves to distinguish this system from more traditional component programs. Service plans are developed based on the assessed needs of individual clients and families. Needed interventions that do not already exist must be developed.

Individualized care is not restricted in terms of time or place of delivery or admissions criteria. Likewise, services do not end simply because a particular component is completed; instead, treatment plans are designed to address long-term but changing needs. Service providers are hired because of their ability to meet a specific child's needs, rather than on the basis of general professional credentials.

4. Flexible care. A key to maintaining a wraparound system for any individual client is the ability to provide services when they are needed, especially in times of crisis. In order to prevent more restrictive placement, it is essential that the system be capable of providing immediate intervention that can be increased or decreased as needed. Flexible care is a necessary backup and support if the principle of unconditional care is to be realized.

5. Flexible funding. Even when separate systems collaborate in developing creative solutions for coordinated service delivery, budget limitations and other bureaucratic barriers to spending and pooling funds often thwart their efforts. In a wraparound system of services, flexible funding is seen as the "linchpin;" "it is essential that money is attached to the child for the purchase of services and not to a program for the delivery of services" (Burchard & Clark, 1990, p. 51). This is what is meant by funding "following the child." Flexibility in spending becomes crucial in times of crisis when immediate and unorthodox interventions may be needed to sustain existing services, placement, and supports.

6. Interagency care. An individualized service plan is developed, monitored, and modified by a youth-specific interdisciplinary team, including the youth, parent(s), and representatives of relevant agencies. Such an approach fosters collaboration, communication, and accountability in developing and implementing the agreed-upon services.

The Alaska Youth Initiative (AYI)

One application of the individualized care model is the Alaska Youth Initiative (AYI), originally developed to support the return of Alaska's children and youth from out-of-state placements, and later expanded to prevent such placements in the future. Several accounts of the development and history of AYI exist (See e.g., Burchard, Burchard, Sewell, & VanDenBerg, in press; Lerman, 1992; Sewell, in press; Sewell & Whitbeck, 1992) and that will not be retraced in detail here. Instead, the "principal features" of what has developed from an "initiative" into an established system of care will be presented. As indicated by Sewell (in press) initially "[v]ery little was understood of what later became known as 'individualized,' or so-called 'wrap-around' care. Virtually all of that remained to be elaborated...." Thus, rather than serving as the building blocks of AYI, these ten features reflect the learning and evolution that inevitably occur in the real life application and implementation of any set of model principles.[13]

---

[13]In this instance, the CASSP "guiding principles" (Stroul & Friedman, 1986) and the "basic principles of individualized care" (Burchard & Clarke, 1990).

Principal Features of AYI Individualized Care

1. Building and maintaining normative life-styles. Consistent with its original intention of returning Alaskan youth from out-of-state placements, AYI has maintained a commitment to serving clients in their home communities and away from others with severely maladaptive behavior--that is, in as mainstreamed a fashion as possible. In that regard, all services should be developmentally, culturally, and ethnically appropriate.

AYI also recognizes that to approach the care of youth who have multiple and severe problems in social adaptation with a "cure orientation" would be naive. Instead, the project stresses the need for ongoing supports for clients' long-term and changing needs and strengths.[14]

2. Ensuring that services are client-centered. Terms such as "client-centered" and "child-centered" have become popular in the treatment literature in mental health, social service, and juvenile justice. Usually, the terms refer to a process of "fitting" the client into some combination of existing programs; as such, this process is actually program-centered, rather than client-centered. Unfortunately, as AYI found, "[c]omponent services tend to have extremely limited flexibility regarding the (a) types of services delivered; (b) types of staffing patterns available; (c) locations of service delivery; (d) ongoing modifications of service plans; and (e) case-specific commitments of additional resource" (Sewell, in press) --all features which work against the implementation of a child-centered scheme.

As the shortcomings of a component service system were discovered[15], AYI turned more to the needs of individual clients to guide the development of Individualized Service Plans constructed by local interdisciplinary planning groups (Core Service Teams). Each team is youth-specific; that is, membership is also individualized, determined by the needs of individual clients. As those needs are identified, appropriate services are developed, adapted, or purchased as-is, on a case-by-case basis.

---

[14]It is interesting that in evaluating the research literature on delinquency intervention (not specific to children identified as having any emotional disturbance) Mulvey et al. (1990) reached a similar conclusion.

> ... the necessity to...plan for service provision as an ongoing, rather than "one shot," enterprise. In working with youths who appear to have an identifiable propensity for antisocial behavior, interventions should be conceptualized as a series of possible treatments for a problem that is likely to appear again in a different form as new issues and challenges arise. ... Management, regular support, and routine care, rather than a dose of a treatment, would be the guiding activities. Such a strategy would mean providing care on an ongoing basis ... and replacing our present strategy of trying to "fix" the problem each time it reaches crisis proportions. (Mulvey et al., 1990, p. 33)

[15]Interestingly, the prototype for the planning of AYI was a community-based component service system, Kaleidoscope, in Illinois. That system utilized a "continuum of care" approach that included: home-based supportive services; therapeutic foster care; vocational services; group homes; and case management.

3. Providing unconditional care. This is a hallmark of AYI. Commitment and responsibility for care extend beyond individual providers and programs. The emphasis is on the service plan adapting to the changing needs of the client, rather than the client being seen as "failing the program," and thus, terminated from service. Youth cannot be excluded or expelled from AYI because of extreme behavior or multiple needs. Instead, discharge is to be based on a client no longer needing services. (Of course, this has sometimes meant multiple modifications in treatment planning and service delivery in order to honor this commitment of unconditional care.)

4. Planning for the long term. With AYI's initial commitment to serving clients with the most severe needs, planners have learned that meeting those needs requires long-term attention. "Planning for chronicity mean[s] focusing on 'wrapping' residential and daily structure supports around the youth so as to build sustainable life-styles with sustaining relationships" (Sewell, in press). For AYI, this lesson has translated into (a) a focus on support strategies, rather than "cure strategies," (b) careful planning of contingent interventions for the episodic crises that are now routinely anticipated, and (c) detailed planning for transitions from one phase or setting of treatment to another.

5. Working toward lesser restrictive alternatives. Consistent with the current practice of most therapeutic service systems, AYI adopted the goal of providing treatment in the "least restrictive environment." Working toward this goal, however, required overcoming the belief that the most intensive services can be provided only in the most restrictive settings. Indeed, initially AYI frequently used highly restrictive placements in returning Alaskan youth to the state. Currently, AYI practices generally exclude placement in residential facilities and group homes, but do allow for the use of short-term inpatient hospitalization and both short- and long-term therapeutic foster care. When decisions to place a youth in such restrictive settings are made, however, plans also begin for his or her eventual return to the community, with the same coordinator retaining responsibility for overseeing continuity of services, regardless of changes in placement.

AYI has learned (as likely have many other programs) that "least restrictive" does not have a single definition. Instead, what constitutes the least restrictive alternative for a given client is an empirical question whose answer depends not only on the individual client, but on the personnel and resources available to support that client, as well. One important issue in assessing the level of restrictiveness is the common preoccupation with the physical setting, with little attention paid to the specific modality and duration of the treatment. For example, it should not be presumed that placement in a long-term community-based group home that relies upon the routine use of psychotropic medication and physical restraints is less restrictive than emergency psychiatric hospitalization simply because of the physical setting (see Hoffman & Foust (1977) for further discussion).

6. Achieving provider competencies. Although rarely addressed explicitly in descriptions of optimal models of care, the roles and competencies of individual service providers are critical to the success of any intervention, and perhaps most especially to those based on a "wraparound" concept. In a system such as AYI, not only are service plans individualized, but the roles, schedules, and activities of workers are also highly individualized, requiring careful selection and matching of personnel to specific youth. To support such efforts, an emphasis must be placed on the role of "human resource development" on a broad, rather than only a case-specific, basis. Interestingly, AYI has found personnel experienced in the developmental disabilities field to be particularly effective in

working with severely behaviorally disordered children. Perhaps this reflects their emphasis on skill building and an orientation (consistent with the experience of AYI) toward gradual independence and long-term support, rather than one-time cure-oriented interventions.

7. Maintaining consensus among key decision makers. Early in AYI's development, the importance of interagency collaboration--at both the system and case levels--became apparent. In developing Individualized Service Plans, the role of the local coordinator became crucial in overcoming the "usual" barriers to innovative planning: e.g., thinking in terms of available services, rather than individual client needs; remaining "stuck" in routine responses, even in the face of complex client and family problems; focusing on blame for past program failures; and bickering about programmatic and fiscal responsibility. Coordinators learned that such problems are not resolved through involvement with any specific case, but instead, require working with key decision makers on a repeated and long-term basis.

8. Funding services with flexible budgets. In returning a youth from out-of-state placement, an effort was made to allocate a comparable amount of funding to develop his or her array of community-based services. In developing ISPs, existing component services were used whenever possible; but when no relevant services existed, money had to be made available to develop and fund unique pieces of the total plan. As might be expected, moving from categorical to flexible funding incurred multiple intra- and inter-agency complications and objections. Over time, AYI developed a strategy for determining the costs of the overall program, as well as the unique components of each youth's plan. Other ways of covering costs--e.g., services of other systems, health insurance, Medicaid, etc.--are utilized before those available to AYI.

9. Installing a gatekeeper function. As with many of the features of AYI, the gatekeeper function, which has become critical in adhering to the principle of unconditional care, is one that has evolved over time. A state-level Interdepartmental Team (IDT)[16] serves as the body that controls youth admission to and discharge from AYI, so that the task of finding a youth eligible for AYI is separated from that of arranging and delivering services. "This case review process provide[s] a relatively independent authority which [can] make substantive decisions regarding a youth's service alternatives and welfare apart from the immediate pressures and limitations of local service capacity" (Sewell, in press).

10. Developing measurable accountability. Accountability is a necessary but complicated function of any service delivery system. For AYI, it is particularly challenging because of the frequently changing needs and concomitantly, the individual service plans, of each client. Local coordinators must monitor individual client behavior and progress, the performance of multiple service providers, as well as the individualized budgets developed to deliver each Service Plan.

---

[16]The IDT is composed of one mid-level manager from each of the following state agencies: Department of Education - Division of Special Education; Department of Health and Social Services - Division of Family and Youth Services; and Department of Health and Social Services - Division of Mental Health and Developmental Disabilities. (Each member has the power to authorize the spending of departmental funds.) State-level administration also now includes a non-voting State Individualized Services Coordinator and a project assistant.

To support its accountability function, AYI developed a novel approach to routine checking on the performance of clients and service vendors. Through a system of "Proactive Client Tracking," paraprofessionals made weekly telephone calls to identified key informants who had frequent contact with each client. Written summaries of informants' feedback were submitted to local coordinators and interdepartmental team members to inform service and budget modifications. (This strategy is no longer used routinely by AYI.)

A unique feature of the Alaska Youth Initiative is that much has been written to document its development and functioning.[17] Program leaders have been candid about problems encountered and lessons learned. "Maintaining an open, self-critical, and non-defensive stance towards service delivery issues is an important organizational ingredient possessed by AYI..." (Lerman, 1992, pp. 55-56). AYI appears to have allowed a mixture of reality, common sense, and program outcome to influence and guide an evolving system. The lessons learned are probably not unique; administrators in other settings have probably confronted many of the same implementation issues and learned many of the same lessons. What is unique, however, is AYI's ability to change itself, in response to the lessons learned. Such an attitude can be instructive as other jurisdictions undertake the complex task of implementing model systems of service delivery for children and adolescents with seriously maladjusted behavior.

If the Alaska Youth Initiative is to serve as a model for other states, it is because of its ability to achieve its initial goals of returning children from out-of-state placements, preventing further placements, and developing alternative interventions within its own boundaries. In that regard, it may be considered a successful demonstration project. Although components of the program are still in operation, its future as an institutionalized system of care remains unclear (see Sewell, in press).

SOME CAVEATS

The general thrust of this review has been clear. Insofar as treatment is the goal, juvenile justice authorities--like child mental health planners in other contexts--should maximize integrated, highly individualized, home- and neighborhood-based services.

Several cautions should be added to this general thesis, however. First, the replicability of flexible, integrated service models is not well established. Because such interventions are not easily "packaged," this point is one of special concern. Research that we have begun in several South Carolina communities to measure replicability will begin to answer this question.

Second, because they involve multiple components and require intensive staff time, maintenance of program integrity is a particular issue in complex and flexible service models like multisystemic therapy and individualized care (Davidson, Redner, Amdur, & Mitchell, 1990; Sechrest & Redner, 1979; Sechrest & Rosenblatt, 1987). When a state attempts to implement such an approach on a large scale with severely emotionally disturbed youth in the juvenile justice system, care must be taken to ensure that individualization and intensity are not lost as program scale increases.

---

[17]A series of documents, Answers from AYI, is available from Daniel Wigman, Division of Mental Health and Developmental Disabilities, Department of Health and Social Services, P.O. Box H, Juneau, Alaska 99811-0604.

Third, because (a) the juvenile court is better suited to doing justice than administering treatment and (b) a substantial proportion of juvenile offenders fail to recidivate even if nothing is done, careful consideration must be given to net widening (Klein, 1979). The juvenile court should not be the centerpiece of the treatment system. Otherwise, youth will be drawn into a setting in which the goals are mixed and the method is unduly intrusive.

POLICY RECOMMENDATIONS

The level of change that is being proposed, while compatible not only with empirical data but also common sense, is sufficiently striking that it is difficult and perhaps even impossible to accomplish quickly. The problem with the existing treatment system is not simply one of poor diffusion of therapeutic technology; to a large extent, the problem is structural. Financing systems and personnel plans must be rearranged.[18] Juvenile courts and youth service programs must begin to establish treatment plans that are multifaceted and involve multiple parties when the agencies' institutional mission is oriented toward accountability for individual behavior.[19] Change must be synchronized across systems -- that is, multiple systems must change, all at the same time. Changing only one system at a time may result in transinstitutionalization--simply shifting children and adolescents from one system to another. In that regard, the movement based in the child welfare system toward "family preservation services" (programs intended to offer alternatives to foster care) offers a base, often including both legislation (Smith, 1991) and the support of private foundations (see Barthel, 1992), for cross-system initiatives (see Gittler, 1992, for a list of such initiatives).

To be successful, system reform must be based on planned experimentation and accomplished incrementally. It is unlikely that such change could be initiated on a state-wide level. Starting on a smaller scale--at a city or county level--is likely to receive wider acceptance and ultimately greater success. Major changes in service delivery are often more palatable if conducted as research or as "commissioned studies," especially if they are well-designed and include plans for assessing cost effectiveness. Once positive outcomes have been documented, then the planful addition of other communities or jurisdictions can begin.

Obviously, such a proposal presents a significant challenge to all child-serving systems. Difficulty of reform, however, does not excuse its absence. The U.N. Convention on the Rights of the Child (1989), to which most nations of the world (unfortunately, not yet including the United States)

---

[18]For example, we have observed the actual or threatened demise of various home-based programs and other intensive, flexible treatments because of conflict with agency or civil service rules about staff working hours. Therapists' lack of availability when families need help often is is derived less from unwillingness by staff to work on an "on-call" basis with unconventional hours than from the unwillingness of agencies to let them! If flexible services are to work, administrators must be prepared to relinquish some control and accountability. It's hard for therapists to punch time clocks when they are out of the office!

[19]In concert with service system reform, consideration should be given to experimentation in systems of dispute resolution that emphasize community responsibility for the integration of youth into the community and the reconciliation between offenders and victims (see Melton, 1992).

are parties, requires availability of a broad array of alternatives to institutionalization (art. 40, § 3). As the drafters of the Convention recognized, development of such alternatives is necessary to the fulfillment of more fundamental principle that every child in the juvenile justice system "be treated in a manner consistent with the child's sense of dignity and worth, which reinforces the child's respect for the human rights and fundamental freedoms of others and which takes into account the child's age and the desirability of promoting the child's re-integration and the child's assuming a constructive role in society" (art. 40, § 1).

REFERENCES

Aber, J. L., Mitchell, C. M., Garfinkel, R., Allen, L., & Seidman.
Indices of neighborhood impoverishment: Their associations with adolescent mental health, antisocial behavior, and school achievement, in preparation.

Adelman, H. S., Kaser-Boyd, N., & Taylor, L. Children's participation in consent for psychotherapy and their subsequent response to treatment. Journal of Clinical Child Psychology, 13, 170-178, 1984.

Adelman, H. S., Lusk, R., Alvarez, V., & Acosta, N. K. Competence of minors to understand, evaluate, and communicate about their psychoeducational problems. Professional Psychology: Research & Practice, 16, 426-434, 1985.

Allerhand, M. E., Weber, R. E., & Haug, M. Adaptation and Adaptability: The Bellefaire Followup Study. New York: Child Welfare League of America, 1966.

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorder (3rd ed. - revised). Washington, DC, 1987.

AuClaire, P., Schwartz, I. M. Overview: An evaluation of the effectiveness of intensive home-based services as an alternative to placement for adolescents and their families. Unpublished paper, University of Minnesota, Hubert H. Humphrey Institute of Public Affairs, 1986.

Baenan, R. S., Parris-Stephens, M. A., & Glenwick, D. S. Outcome in psychoeducational day school programs: A review. American Journal of Orthopsychiatry, 56, 263-270, 1986.

Barthel, J. For Children's Sake: The Promise of Family Preservation. New York: Edna McConnell Clark Foundation, 1992.

Barton, W. H., Streit, S. M., & Schwartz, I. M. A Blueprint for Youth Corrections. Ann Arbor, MI: University of Michigan, Center for the Study of Youth Policy, 1991.

Behar, L. Changing patterns of state responsibility: A case study of North Carolina. Journal of Clinical Child Psychology, 14, 188-195, 1985.

Blumstein, A., & Cohen, J. Characterizing criminal careers. Science, 237, 985-991, 1987.

Bodenhausen, G. V., & Wyer, Jr., R. S. Effects of stereotypes on decision making and information-processing strategies. Journal of Personality and Social Psychology, 48, 267-282, 1985.

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

Borduin, C. M., Mann, B. J., Cone, L., Henggeler, S. W., Fucci, B. R., Blaske, D. M., & Williams, R. A. Multisystemic treatment of adolescents referred for serious and repeated antisocial behavior., in preparation.

Brathwaite, J. The myth of social class and criminality reconsidered. American Sociological Review, 46, 36-57, 1981.

Braukmann, C. J., Bedlington, M. M., Belden, B. D., Braukman, P. D., Husted, J. J., Ramp, K. K., & Wolf, M. M. Effects of community-based group-home treatment programs on male juvenile offenders' use and abuse of drugs and alcohol. American Journal of Drug & Alcohol Abuse, 11, 249-278, 1985.

Brigham, T. A. Some effects of choice on academic performance. In L. C. Perlmuter & R. A. Monty (Eds.), Choice and control (pp. 131-141). Hillsdale, NJ: Erlbaum, 1979.

Bronfenbrenner, U. The Ecology of Human Development. Cambridge, MA: Harvard University Press, 1979.

Burchard, J., Burchard, S., Sewell, R., & VanDenBerg, J. One Kid at a Time -- The Alaska Youth Initiative: A Demonstration of Individualized Services. Washington, DC: Georgetown University, in press.

Burchard, J. D., & Clarke, R. T. The role of individualized care in a service delivery syystem for children and adolescents with severely maladjusted behavior. Journal of Mental Health Administration, 17, 48-60, 1990.

Burns, B. J., & Friedman, R. M. Examining the research base for child mental health services and policy. Journal of Mental Health Administration, 17, 87-98, 1990.

Casey, R. J., & Berman, J. S. The outcome of psychotherapy with children. Psychological Bulletin, 98, 388-400, 1985.

Cavior, H. E., & Schmidt, A. S. Test of the effectiveness of a differential treatment strategy at the Robert F. Kennedy Center. Criminal Justice & Behavior, 5, 131-139, 1978.

Clements, C. B. Delinquency prevention and treatment: A community-centered perspective. Criminal Justice & Behavior, 15, 286-305, 1988.

Cohen, H. L., & Filipczak, J. A New Learning Environment: A Case for Learning. San Francisco: Jossey-Bass, 1971.

Cohen, R., Parmelee, D. X., Irwin, L., Weisz, J. R., Howard, P., Purcell, P., & Best, A. M. Characteristics of children and adolescents in a psychiatric hospital and a corrections facility. Journal of the American Academy of Child and Adolescent Psychiatry, 29, 909-913, 1990.

Cohn, Y. Criteria for the probation officer's recommendations to the juvenile court judge. Crime & Delinquency, July, 262-275, 1963.

Davidson, W. S., Redner, R., Amdur, R. L., & Mitchell, C. M. Alternative Treatments for Troubled Youth: The Case of Diversion from the Justice System. New York: Plenum Press, 1990.

DiLalla, L. F., Mitchell, C. M., Arthur, M., & Pagliocca, P. M. Aggression and delinquency: Family and environmental factors. Journal of Youth and Adolescence, 17, 233-246, 1988.

Elder, G. H., Liker, J. K., & Cross, C. E. Parent-child behavior in the Great Depression: Life course and intergenerational influences. In P. Baltes & O. Brim (Eds.), Life Span Development and Behavior (Vol. 6, pp. 109-158) New York: Academic Press, 1983.

Elliott, D. S., & Ageton, S. S. Reconciling race and class differences in self-reported and official estimates of delinquency. American Sociological Review, 45, 95-110, 1980.

Elliott, D. S., Huizinga, D., & Ageton, S. S. Explaining Delinquency and Drug Use. Beverly Hills, CA: Sage, 1985.

Erickson, M. L., & Empey, L. T. Court records, undetected delinquency and decision-making. Journal of Criminal Law, Criminology, & Police Science, 54, 456-469, 1963.

Farrington, D. P. Self-reports of deviant behaviour: Productive and stable? Journal of Criminal Law & Criminolgy, 64, 99-110, 1973.

Farrington, D. P. Stepping stones to adult criminal careers. In D. Olweus, J. Block, & M. R. Yarrow (Eds.), Development of Antisocial and Prosocial Behavior (pp. 359-384). New York: Academic Press, 1986.

Farrington, D. P. Epidemiology. In H. C. Quay (Ed.), Handbook of jvenile dlinquency (pp. 33-61). New York: Wiley, 1987.

Friedman, R. Program update: Individualizing services. Update: Improving Services for Emotionally Disturbed Children, 3(2), 10-12, 19. Tampa: Florida Mental Health Institute, University of South Florida, 1988.

Glueck, S., & Glueck, E. Unraveling Juvenile Delinquency. Cambridge, MA: Harvard University Press, 1950.

Gold, M., & Petronio, R. J. Delinquent behavior in adolescence. In J. Adelson (Ed.), Handbook of Adolescent Psychology. New York: Wiley, 1980.

Grisso, T., Tomkins, A., & Casey, P. Psychosocial concepts in juvenile law. Law & Human Behavior, 12, 403-437, 1988.

Haley, J. Problem Solving Therapy. San Francisco: Jossey-Bass, 1976.

Hawkins, R. P. & Breiling, J. (Eds.). Foster Family-based Treatment and Special Foster Care: Implementation, Evaluation, and Dissemination. New York: Child Welfare League of America, 1989.

Henggeler, S. W. Delinquency in Adolescence. Newbury Park, CA: Sage, 1989.

Henggeler, S. W. Treating Conduct Problems in Children and Adolescents: An Overview of the Multisystemic Approach with Guidelines for Intervention Design and Implementation. Columbia, SC: South Carolina Department of Mental Health, 1991.

Henggeler, S. W., & Borduin, C. M. Family Therapy and Beyond: A Multisystemic Approach to Treating the Behavior Problems of Children and Adolescents. Pacific Grove, CA: Brooks/Cole, 1990.

Henggeler, S. W., Borduin, C. M., Melton, G. B., Mann, B. J., Smith, L. A., Hall, J. A., Cone, L., & Fucci, B. R. Effects of multisystemic therapy on drug use and abuse in serious juvenile offenders: A progress report from two outcome studies. Family Dynamics of Addiction Quarterly, 1, 40-51, 1991.

Henggeler, S. W., Melton, G. B., & Smith, L. A. Multisystemic treatment of serious juvenile offenders: An effective alternative to incarceration. Journal of Consulting and Clinical Psychology, in press.

Henggeler, S. W., Melton, G. B., Smith, L. A., Foster, S. L., Hanley, J. H., & Hutchinson, C. M. Assessing violent offending in serious juvenile offenders, in preparation.

Hirschi, T. Causes of Delinquency. Berkeley: University of California Press, 1969.

Hobbs, N. The Troubled and Troubling Child: Reeducation in Mental Health, Education, and Human Services Programs for Children and Youth. San Francisco: Jossey-Bass, 1982.

Hoffman, P. B., & Foust, L. L. Least restrictive treatment of the mentally ill: A doctrine in search of its senses. San Diego Law Review, 14, 1100-1154, 1977.

Holmes, D. S., & Urie, R. G. Effects of preparing children for psychotherapy. Journal of Consulting and Clinical Psychology, 43, 311-318, 1975.

Jackson, P. G. Theories and findings about youth gangs. Criminal Justice Abstracts, 21, 313-329 1989.

Jesness, C. F. The Preston Typology Study: An experiment with differential treatment in an institution. Journal of Research in Crime & Delinquency, 8, 38-52, 1971.

Kazdin, A. E. Psychotherapy for children and adolescents. Annual Review of Psychology, 41, 21-54, 1990.

Kinney, J. W., Madsen, B., Fleming, T., & Haapala, D. A. Homebuilders: Keeping families together. Journal of Consulting and Clinical Psychology, 39, 905-911, 1977.

Kirigin, K. A., Braukmann, C. J., Atwater, J. D., & Wolf, M. M. An evaluation of teaching-family (Achievement Place) group homes for juvenile offenders. Journal of Applied Behavior Analysis 15, 1-16, 1982.

Klein, M. Deinstitutionalization and diversion of juvenile offenders: A litany of impediments. In N. Morris and M. Tonry (Eds.), Crime and Justice: An Annual Review of Research (Vol. I, pp. 145-201). Chicago: University of Chicago Press, 1979.

Kuperminc, G., & Cohen, R. Building a research base for community services for children and families: What we know and what we need to learn. Community Mental Health Journal, in press.

Lerman, P. Trends and issues in the deinstitutionalization of youths in trouble. Crime and Delinquency, 26, 281-298, 1980.

Lerman, P. Deinstitutionalization and the Welfare State. New Brunswick, NJ: Rutgers University Pres, 1982.

Lerman, P. Child Protection and Out-of-home Care: System Reforms and Regulating Placements. Paper prepared for the U.S. Advisory Board on Child Abuse and Neglect of the U.S. Department of Health and Human Services, 1992.

Lewis, C. E. Decision making related to health: When could/should children act responsibly? In G. B. Melton, G. P. Koocher, & M. J. Saks, (Eds.), Children's Competence to Consent (pp. 75-91). New York: Plenum, 1983.

Lewis, C. E., & Lewis, M. A. Improving the health of children: Must the children be involved? Annual Review of Public Health, 4, 259-283, 1983.

Lewis, D. O., Shanok, S. S., Cohen, R. J., Kligfeld, M. & Frisone, G. Race bias in the diagnosis and disposition of violent adolescents. American Journal of Psychiatry, 137, 1211-1216, 1980.

Loeber, R., & Dishion, T. Early predictions of male delinquency: A review. Psychological Bulletin, 93, 68-99, 1983.

Maccoby, E. E., Johnson, J. P., & Church, R. M. Community integration and the social control of juvenile delinquency. In J.R. Stratton & R.M. Terry (Eds.), Prevention of delinquency: Problems and Programs (pp. 300-313). New York: Macmillan, 1968.

Massimo, J. L., & Shore, M. F. The effectiveness of a comprehensive vocationally oriented psychotherapeutic program for adolescent delinquent boys. American Journal of Orthopsychiatry, 33, 634-642, 1963.

Massimo, J. L., & Shore, M. F. Comprehensive vocationally oriented psychotherapy: A new treatment technique for lower-calss adolescent delinquent boys. Psychiatry, 30, 229-236, 1967.

Melton, G. B. Children's participation in treatment planning: Psychological and legal issues. Professional Psychology: Research & Practice, 12, 647-654, 1981.

Melton, G. B. Child Advocacy: Psychological Issues and Interventions. New York: Plenum Press, 1983a.

Melton, G. B. Decision making by children: Psychological risks and benefits. In G. B. Melton, G. P. Koocher, & M. J. Saks (Eds.), Children's Competence to Consent (pp. 21-40). New York: Plenum, 1983b.

Melton, G. B. Taking Gault seriously: Toward a new juvenile court. Nebraska Law Review, 68, 146-181, 1989a.

Melton, G. B. The Jericho principle: Lessons from epidemiological research. In L. S. Abramczyck (Ed.), Social Work Education for Working with Seriously Emotionally Disturbed Children and Adolescents (pp. 12-25). Columbia SC: National Association of Deans and Directors of Schools of Social Work, 1989b.

Melton, G. B. Foreign Innovations in Dispute Resolution in Matters Related to Juvenile Justice and Child Protection. Unpublished manuscript, Consortium on Children, Families, and the Law, Lincoln, NE. (Report to the Judicial Council of California, 2020 Vision Project, Committee on Family Relations), 1992.

Melton, G. B., & Hargrove, D. S. Planning Mental Health Services for Children and Youth. New York: Guilford, in press.

Miller, R. B., & Kenney, E. Adolescent delinquency and the myth of hospital treatment. Crime and Delinquency, 12, 38-48, 1966.

Minuchin, S. Families and Family Therapy. Cambridge, MA: Harvard University Press, 1974.

Mulvey, E. P. Judging amenability to treatment in juvenile offenders: Theory and practice. In N.D. Reppucci, L.A. Weithorn, E.P. Mulvey, & J. Monahan (Eds.), Children, Mental Health, and the Law (pp. 195-210). Beverly Hills: Sage, 1984.

Mulvey, E. P., Arthur, M. E., & Reppucci, N. D. Review of programs for the prevention and treatment of delinquency. Background paper for Adolescent Health, Vol. II. Washington, DC: Office of Technology Assessmnt, U. S. Congress, 1990.

Osgood, D. W., & Wilson, J. K. Covariation among health compromising behaviors in adolescence. A background paper for the Adolescent Health Project of the U.S. Congress, Office of Technoloogy Assessment. Springfield, VA: National Technical Information Service, 1991.

Otto, R. K., Greenstein, J. G., Johnson, M. K., & Friedman, R. M. (this volume). Prevalence of mental disorders in the juvenile justice system. In J. J. Cocozza (Ed.), Responding to Youth with Mental Disorders in the Juvenile Justice System, 1992.

Pagliocca, P. M. Multiple schemas of dangerousness in judgments about juveniles. (Doctoral dissertation, University of Virginia, 1991). Dissertation Abstracts International, 53B, 1615, 1992.

Patterson, G. R. Coercive Family Process. Eugene, OR: Castilia, 1982.

Phillips, E. L., Phillips, E. A., Fixsen, D. L., & Wolf, M. M. The Teaching-Family Handbook. Lawrence, KS: University of Kansas Printing Service, 1974.

Quay, H. C. Institutional treatment. In H.C. Quay (Ed.), Handbook of Juvenile Delinquency (pp. 118-138). New York: Wiley, 1987.

Rutter, M., & Giller, H. Juvenile Delinquency: Trends and Perspectives. New York: Guilford, 1984.

Schwartz, I. M. Injustice for Juveniles: Rethinking the Best Interests of the Child. Lexington, MA Lexington Books, 1989.

Schwartz, I. M., Jackson-Beeck, M., & Anderson, R. The "hidden" system of juvenile control. Crime and Delinquency, 30, 371-385, 1984.

Sechrest, L. B., & Redner, R. Strength and Integrity of Treatments in Evaluation Studies. Washington, DC: National Criminal Justice Reference Service, National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration, U.S. Department of Justice, 1979.

Sechrest, L., & Rosenblatt, A. Research methods. In H. C. Quay (Ed.), Handbook of Juvenile Delinquency (pp. 417-450). New York: Wiley, 1987.

Sewell, R. Effective indiviualized care: Initial experience and recommendation from the Alaska Youth Initiative. In J. Burchard, S. Burchard., R. Sewell, & J. VanDenBerg, One Kid at a Time -- The Alaska Youth Initiative: A Demonstration of Individualized Services. Washington, DC: Georgetown University Press, in press.

Sewell, R., & Whitbeck, J. Individualized "Wrap-around" Care: A Promising Services Approach for Youth who Experience Severe Emotional Disturbance and who have been Adjudicated Delinquent. Paper presented to Meeting of Community Action for the Mentally Ill Offender: "Addressing Mental Health Needs of Youth in the Juvenile Justice System in Washington State. May, 1982, 1992.

Shore, M. F., & Massimo, J. L. Comprehensive vocationally oriented psychotherapy for adolescent delinquent boys: A follow up study. American Journal of Orthopsychiatry,36, 609-615, 1966.

Shore, M., & Massimo, J. Five years later: A follow-up study of comprehensive vocationally oriented psychotherapy. American Journal of Orthopsychiatry,39, 769-773, 1969.

Shore, M., & Massimo, J. After ten years: A follow-up study of comprehensive vocationally oriented psychotherapy. American Journal of Orthopsychiatry, 43, 128-132, 1973.

Shore, M. F., & Massimo, J. L. Fifteen years after treatment: A follow-up study of comprehensive vocationally-oriented psychotherapy. American Journal of Orthopsychiatry, 49, 240-245, 1979.

Simcha-Fagan, O., & Schwartz, J. E. Neighborhood and delinquency: An assessment of contextual effects. Criminology, 24, 667-703, 1986.

Smith, S. L. Family Preservation Services: State Legislative Initiatives. Denver and Washington, DC: National Conference of State Legislatures, 1991.

Snyder, J., & Patterson, G. Family interaction and delinquent behavior. In H.C. Quay (Ed.), Handbook of Juvenile Delinquency (pp. 216-243). New York: Wiley, 1987.

Strasburg, P. A. Violent Delinquents: A Report to the Ford Foundation from the Vera Institute of Justice. New York: Sovereign, 1978.

Stroul, B. A., & Friedman, R. M. A System of Care for Severely Emotionally Disturbed Children and Youth. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center, 1986.

Stroul, B. A., & Goldman, S. K. Study of community-based services for children and adolescents who are severely emotionally disturbed. Journal of Mental Health Administration, 17, 61-77, 1990.

Subramanian, K. Reducing child abuse through respite center intervention. Child Welfare, 64, 501-509, 1985.

Taylor, L., & Adelman, H. S. Facilitating children's participation in decisions that affect them: From concept to practice. Journal of Clinical Child Psychology, 15, 346-351, 1986.

Taylor, L., Adelman, H. S., & Kaser-Boyd, N. Exploring minors' reluctance and dissatisfaction with psychotherapy. Professional Psychology: Research & Practice, 16, 418-425, 1985a.

Taylor, L., Adelman, H. S., & Kaser-Boyd, N. Minors' attitudes and competence toward participation in psychoeducational decisions. Professional Psychology: Research & Practice, 16, 226-235 1985b.

Taylor, D. A., & Alpert, S. W. Continuity and Support Following Residential Treatment. New York: Child Welfare League of America, 1973.

Update. 1986, 2, 8-10. Therapeutic foster care.

Trout, B., & Meadowcroft, P. (Eds.). Troubled Youth in Treatment Homes: A Handbook of Therapeutic Foster Care. New York: Child Welfare League of America, 1989.

U.N. Convention on the Rights of the Child, U.N. Doc. A/Res/44/25, 1989.

Upshur, C. C. Developing respite care: A support service for families with disabled members. Family Relations, 32, 13-20, 1983.

Warren, C. A. B., & Guttridge, P. Adolescent psychiatric hospitalization and social control. In L. Teplin (Ed.), Mental Health and Criminal Justice (pp. 119-137. Beverly Hills, CA: Sage, 1984.

Weithorn, L. A. Mental hospitalization of troublesome youth: An analysis of skyrocketing admission rates. Stanford Law Review, 40, 773-838, 1988.

West, D. J., & Farrington, D. P. Who Becomes Delinquent? London: Heinemann Educational, 1973.

Wilson, J. Q., & Herrnstein, R. J. Crime and Human Nature. New York: Simon & Schuster, 1985.

Zimet, S. G., & Farley, G. K. Day treatment for children in the United States. Journal of the American Academy of Child Psychiatry, 24, 732-738, 1985.

CHAPTER 6

ASSESSING THE MENTAL HEALTH NEEDS OF CHILDREN AND ADOLESCENTS OF COLOR IN THE JUVENILE JUSTICE SYSTEM: OVERCOMING INSTITUTIONALIZED PERCEPTIONS AND BARRIERS

Mareasa R. Isaacs

OVERVIEW

There are two simple and compelling facts about children of color and the mental health and juvenile justice systems that must be constantly evoked:

(1) Children and adolescents of color are overrepresented in the American juvenile justice system, given their proportions in the overall American population. This disproportionate representation is increasing, not decreasing.

(2) Children and adolescents of color are underserved and/or inappropriately served by the child mental health system. When services are received, they tend to be in the more restrictive settings within the mental health system, i.e. state psychiatric institutions and/or long-term residential treatment centers.

The research literature advances many different reasons for these facts and they will be reviewed in this chapter. However, there are many methodological flaws and theoretical misconceptions in the research that tend to provide inconsistent findings when causes for these phenomenon are explored. To a large extent, this results from the fact that the overrepresentation of children of color in juvenile justice and their underservice in the mental health system have not been of top priority to many researchers over the last decade. Few researchers have explored systematically the reasons or the consequences of such accepted practices.

These practices have dire and far reaching consequences and outcomes for youth of color, their families, and their communities. Mental health is essentially viewed as a "treatment" system, in the sense that those who seek its services are looked upon as having a problem that is in need of, and that can benefit from, a benevolent care approach. Certainly mental health has not always been viewed in this manner, but current viewpoints see those who seek treatment as "sick". Juvenile justice, on the other hand, although supposedly "rehabilitative" in philosophy is also a "punishment" system designed to protect the community from "bad" youth who create fear or compromise the safety of other citizens.

This chapter will examine the plight of youngsters of color, especially those with emotional disturbances, caught in the crossfires between two systems that are both failing them. It is true that the child welfare and education systems are also failing them, but those systems are not the focus of this particular review. However, it should be understood that the failures of education and child welfare are major forces that propel children into the secondary systems of mental health and juvenile justice. Many children are first identified by a school or social service agency as being at-risk or living within a family at-risk. However, due to the lack of an effective prevention network, these identifications do little to subsequently divert children and youth of color from the belly of the American juvenile justice system. Mental health and juvenile justice fail these children and adolescents in exactly the same way -- an inability to recognize, understand, or provide adequate assessment, diagnosis and treatment --- and for exactly the same reasons -- the lack of culturally appropriate and competent tools, staff, and programs.

This chapter will attempt to answer the following questions:

(1) What problems do children and adolescents of color encounter when interacting with the mental health system?
(2) Why are youth of color overrepresented in the juvenile justice system? What percentage of these youth are suffering from some level of emotional disturbance that would warrant mental health treatment and interventions? Are they receiving mental health services in the juvenile justice setting and, if so, what types of services are being offered?
(3) Why are both systems unable to accommodate or to meet the needs of children and adolescents of color?
(4) What approaches or models appear to be more effective in meeting the needs of children of color?
(5) What are the policy implications and research issues that result from this analysis?

Finally, before reviewing the relevant literature, there are certain caveats that must be stated:

- There is a noticeable lack of data on all of the major groups of color in the United States, i.e. African Americans, Asian Americans/Pacific Islanders, Latinos/Hispanics and Native Americans. When data does exist, it almost always pertains to African Americans and occasionally to Latinos/Hispanics. Seldom does data adequately reflect the Asian American or Native American populations. Therefore, most of the research, especially in juvenile justice, is focused primarily on African Americans.
- The confluence of race/ethnicity and socioeconomic status (SES) poses a critical problem for researchers in interpreting data and information concerning youngsters of color. Of course, there is a large correlation between these two variables when applied to many youth of color since they are also disproportionately poor. The literature tends to argue back and forth about whether race/ethnicity or SES is the predominant factor for the patterns described at the beginning of this chapter. Both play a major role and any change in either one of the variables would substantially change the impact of American institutions on children of color and their families.
- Information on the mental health of children and adolescents of color is poor. In those few studies that do exist, findings on children of color are often suspect due to the inadequacy of assessment and measurement instruments and diagnostic techniques, as

well as the imprecise nature of most mental health interventions that make outcomes difficult to determine.

- Most of the research on youth of color in mental health and juvenile justice is focused on comparison studies with majority youth and/or "deficit" models of interpretation. This research assumes that the white middle class should almost always be the "norm" for all groups within the country.

The fact that there is so little data or relevant research conducted on groups of color is a major problem in and of itself and certainly has clear implications for policies, program development, and future research activities.

MENTAL HEALTH AND CHILDREN OF COLOR

In The Status of Children's Mental Health, (Rog, 1990), it is noted that the mental health needs of children have been a concern of policy makers, professionals working with children, researchers, parents, and the general public since 1909. Today, that concern is growing because of the increasing number of children experiencing some type of emotional, behavioral, or developmental problem and numerous more who are considered at risk of emotional disturbance In 1986, an Office of Technology Assessment (OTA) study estimated that approximately 7.5 million American children were suffering from some type of emotional or psychological disorder. This estimate was based on an estimated prevalence rate of 12 percent for children under the age of 18. However, more recent studies have yielded estimates between 14 and 22 percent (Brandenburg, Friedman and Silver, 1990; Costello, 1989).

Further, these estimates do not include the number of children and adolescents thought to be at-risk for emotional disorders. In fact, the rate of mental health problems among certain at-risk groups is believed to be greater than the rate for the general population of children. Those presumed to be at greatest risk are those exposed to multiple risk factors. For example the authors of the OTA report (1986) noted:

> "Being poor and being a member of a minority group are environmental stressors that may pose risks to children's mental health... Although the relationships are correlational rather than causal, increasing evidence about the effects of psychosocial stress on both physical and mental health supports the view that poverty and minority status pose risks for mental health" (p. 50).

In her report, Rog (1990) reviewed factors found to be related to increased probability of mental disorders among children and adolescents. These included:

- parental disorders, including parents who are mentally ill or substance abusing;
- poverty, including homelessness;
- family disruptions, such as living in foster care and divorce;
- physical abuse or neglect or sexual abuse;
- poor prenatal care; and
- low birthweight.

There are also indications that domestic (spousal) abuse and chronic community violence are also factors that place children at greater risk of emotional disorders and developmental lags. Recent

data on children in our society illustrates that these factors are becoming more prevalent in the lives of our children and that more and more children are subjected to one or more of these factors that place them at-risk of emotional turmoil and developmental disruptions. The high rates of psychiatric hospitalization, homelessness, adolescent suicide, adolescent homicide, foster care placements, school dropout, teenage pregnancy, and juvenile arrests attest to, and are the results of, the critical condition of children and adolescents in our society.

Given the disproportionate presence of many of these factors in the lives of many children of color, it would be logical to assume that they experience a greater incidence of emotional disorders. However, there are few studies or sources that address the prevalence of emotional disturbances among children of color. For instance, there has been little research that has focused systematically on the psychological development of Native American children and adolescents, but some studies have estimated the prevalence of psychological disorders among them (LaFromboise and Low, 1989). A study conducted by Ablon, Metcalf and Miller, in 1967, estimates that 10-20 percent of Native American children needed psychiatric help. Wallace (1972) found that up to 25 percent of Indian children displayed psychological problems. In a more recent study of American Indian-Alaska Native youth health, Blum et. al (1992) found that Native American youth reported substantial stress and depression. In fact, six percent of the population displayed severe emotional distress. Further, 17 percent of the survey participants reported that they had attempted suicide at some point in their lives.

For Asian /Pacific Islander Americans, prevalence rates are also hard to obtain, primarily because this generic grouping includes many different ethnic populations. Studies that have attempted to separate them into their ethnic groups, i.e. Chinese, Filipino, Japanese, Cambodians, etc. have found that there are differential rates of mental and psychiatric problems among them (Meinhardt et al., 1986). However, these studies and surveys were not focused on children and adolescents. In general, Asian American children and adolescents are underrepresented in mental health services. An assumption is made, therefore, that low utilization rates imply a low incidence of mental health problems in Asian American communities which may not be true (Nagata, 1989).

There have also not been any systematic epidemiological studies of prevalence among Latino/Hispanic children and adolescents. As noted with the Asian American grouping, the generic grouping of Hispanic tends to mask the many different ethnic groups that are encompassed, including Cubans, Mexican Americans, Puerto Ricans, etc. However, the literature often suggests that the prevalence of psychological distress among the various Hispanic groups are at least as high as in the overall population and, in some instances, higher (Ramirez, 1989). Clinical data on Puerto Rican children and adolescents in New York tend to suggest that there is a wide range of psychiatric symptoms among them and in some categories of psychiatric symptomatology, there are higher percentages of emotional disturbance among Puerto Rican children than among majority children (Canino, Earley and Rogler, 1980). In a review by Ramirez (1989) of one clinical setting, Mexican American children received diagnoses similar to those of non-Mexican American children, but were slightly more likely to receive certain diagnoses such as conduct disorder and affective psychosis.

There is an assumption that African American children have high rates of psychological and behavioral disorders, although there are no large-scale epidemiological surveys of African American mental health problems (Gibbs, 1989). However, clinical and other studies have shown that rates of severe depression have ranged from 5 to 15 percent, with higher rates found among males and low-income African American adolescents. Psychiatric hospitalization rates of African American youth have

traditionally been two to three times the rates for majority youth (Myers, 1990). Although the prevalence of conduct disorders among African American adolescents is not known, it can be safely said that the group is seen as displaying a disproportionately high rate of conduct problems in group settings (Gibbs, 1989).

Thus, the prevalence of mental disorders and emotional disturbances among children of color has not been a subject for formal investigation by researchers. and this presents a major problem. The inadequacy of data leads to an inability to present cogent, verifiable facts. Rather, the mental health rates for these children are left to very different and noncompatible clinical studies and generalizations based on the preponderance of risk factors that play such a major place in their lives. Certainly, however, the literature does not suggest, except perhaps some Asian American children, that children of color suffer from fewer emotional disorders or that their incidence are very different from the majority child population. Yet, utilization patterns for mental health services are significantly different.

In general, many of the children suffering from mental health problems in our society do not receive the treatment that they need. In her study, Unclaimed Children, Knitzer (1982) addressed the failure of public mental health systems at the Federal, state and local levels to meet the needs of children and adolescents with severe emotional disturbances (SED). She documented that, of the three million such children and adolescents, two million were receiving inadequate and inappropriate care, if they were receiving any care at all. She also found that many of these children were not know to the formal mental health system, but had been identified and were receiving services through the auspices of other child-serving systems such as education, child welfare, and juvenile justice. She found that children of color were seriously underserved and most often referred to the juvenile justice or child welfare systems that had limited mental health services available. She also found that children of color, when served in the mental health system, were more likely to receive more severe diagnoses and be placed in the most restrictive settings.

In a more recent study of mental health utilization across four levels of care -- outpatient, partial hospitalization, residential treatment center, and inpatient -- Burns (1991) also found that the level of available mental health services were insufficient to meet the needs of children and adolescents. Burns found that more than half a million adolescents received mental health services in 1986, which translates into less than two percent of this age group being served. In addition to this finding, Burns also found that :

- The pattern of use for youth of color was at least proportionate to their representation in the population, ranging from 20 percent of inpatient users to 34 percent for partial hospitalization.
- One-third of adolescents of color were admitted to inpatient services without a recent history (past year) of outpatient treatment. This finding would seem to point either to an important failing in the provision of community-based services or to a large number of admissions for conditions with rapid onset. Most likely, intensive community services were not available as an alternative to hospitalization.
- Between 1975 and 1986 the number of youth of color who were admitted to state and county hospitals decreased.

Thus, Burns concluded that there is a need to improve the mental health system for adolescents, especially low income and youth of color who have limited access to treatment.

In addition to the lack of adequate information on prevalence and utilization patterns for children of color, there is also the problem of the imprecision of the diagnostic assessment tools and measures used. Assessment tools do not often take into account the various stresses that impact on and influence the psychological states of children of color. Nor do these assessment tools appear to be sensitive to differences in cultural values and practices. As noted earlier, these instruments are normed on the "white middle class" and as such, place all children of color at some level of disadvantage.

Studies have consistently shown that children of color receive more severe diagnoses or those that are believed to not be amenable to traditional treatment approaches. In fact, the most common diagnoses for adolescents are conduct disorders, attention deficit disorders (ADD) and depression. These diagnoses appear to lead to different treatment approaches and settings for children of color. An African American male child is far more likely to end up in the juvenile justice system with a diagnosis of conduct disorder while his majority counterpart receives treatment in the mental health system.

The conduct disorder diagnosis is one of great controversy in the field of mental health and one that illustrates the imprecise nature of mental health diagnoses and subsequent placement and treatment decisions. As noted earlier, children of color are more likely to receive a diagnosis of conduct disorder that places them in the juvenile justice system than are majority children and adolescents. Since conduct disorder is a diagnosis that is equally applied to psychiatric clients and juvenile justice youth, there have been extensive discussions of how to distinguish the psychiatric diagnosis from the juvenile justice usage. In the OTA (1986) report, the authors state that:

> "Children with conduct disorder exhibit a pattern of behavior that violates social norms, often harming others. Conduct disorders are often first defined as problems by the legal system. Despite some overlap, however, conduct disorder is not the same as 'juvenile delinquency'. Conduct disorder is a psychiatric term describing a longstanding pattern of misbehavior, whereas delinquency is a legal term applied to minors convicted of an offense...Many children incarcerated in juvenile justice facilities would not be diagnosed as having conduct disorder, primarily because their behavior does not comprise a pattern. The extent to which juvenile crime is associated with conduct-disordered adolescents is unknown" (pp. 40-41).

The continuing confusion and the inability to distinguish conduct disorders from pure "juvenile delinquency" have led many mental health professionals to regard it as a useless diagnosis, especially when applied to children of color. Hutchinson (1991), an African American psychiatrist and pediatrician who consults to a juvenile detention facility in the District of Columbia, sums up the prevailing attitude among minority mental health professionals when she states:

> "The most commonly diagnosed mental health problem in this population is conduct disorder. This is really just a euphemism for bad. Conduct disorder is a useless diagnosis. It reveals nothing about the characteristics of the person committing the act. It is a diagnosis that is superficial and narrow, and ignores underlying pathology" (p. 100).

A related issue is the co-occurrence of mental health problems and substance abuse among the juvenile delinquent population. Although this paper will not examine all of the ramifications of lack of substance abuse treatment and/or the relationship between mental health and substance abuse

agencies, suffice it to say that the research consistently shows a relationship between substance abuse and delinquent acts (Greenbaum et. al, 1991; Watts and Wright, 1990; McManus et. al, 1984). In fact, Watts and Wright (1990) found that the best predictors of violent delinquency were the frequent use of illegal drugs and alcohol in a population of high school males and adjudicated delinquents of Mexican American, African American and white descent. Use of these substances explained 59% of the variance in violent delinquency among blacks and 53% of the variance in violent delinquency among Mexican Americans.

Despite the strong correlations between mental illness and substance abuse and between these factors and juvenile delinquency, there are few programs or policies that address these concerns. The research is unclear as to the exact relationships and causal effects between these critical variables. It is uncertain, for example, whether substance abuse increases mental instability or whether mental instability leads to increased use of substances. The same lack of clarity is found in the research concerning substance abuse, mental illness and juvenile delinquency (Milin et. al, 1991). The high levels of co-occurrence between all three of these and the tendency for each problem to be treated or focused on in a separate intervention system, further complicates the diagnostic and treatment process.

Another major issue that significantly affects the ability of mental health systems to address the needs of children of color is mental health personnel training and attitudes. Braxton (1991) contends that the prevailing philosophy of the mental health system does not provide its professionals with the ability to adequately address the needs of youth of color, especially African American male children. Braxton postulates that these children produce major problems for the mental health system due to three major factors:

(1) The mental health system has failed to adequately treat any angry child or adult. This is particularly true if the person in question is non-white and male. It is as if black male anger cannot be tolerated, much less managed. This is primarily because anger is seen as bad and something that interferes with treatment. Consequently anyone coming into the system for treatment that is angry cannot be treated until they cease being angry. This is a profound contradiction since part of the reason they came for treatment is their anger.

(2) The task of the mental health system seems to be to facilitate the return to a state of mental/emotional health, those who came to it with problems. The disorder inside of a person invites two options for managing it. The system can attempt to either control the external situation, or to help the person put some order back into their internal situation, thereby regaining some control. ... Mental health professionals reinforce the clients need for external control rather than focusing on the development of their own internal controls. External controls require secure facilities, police and guards, and strong medication.

(3) "The mental health system's treatment paradigm is a <u>dependency one</u> - based on the assumption that the patient/client, who is seen as helpless, disabled, vulnerable, powerless, victimized, wounded, paralyzed, etc. needs the help of the <u>omnipotent</u>, powerful, all-knowing, wise, insightful, strong, able therapist or helping professional. The system is structured to protect the omnipotence of professionals and insure the dependency of the patient" (pp. 3-4).

Braxton, therefore, contends that the average mental health professional has not been trained to work in a model that will be effective with children of color, the majority of whom present with anger and frustration. He notes that mental health professionals are provided with "techniques as tools". The patient is then required to fit the technique. When they don't fit or there isn't a good match, we say the patient can't be worked with, rather than the technique or the user can't relate to the patient. The failure of treatment then becomes the patient's problem and the professional is off the hook". He suggests that mental health professionals need to be retrained or trained in a different way to adequately meet the needs of angry, hopeless, and disempowered children and families.

Friedman (1991) also argues for a major re-examination of the entire professional training and human resource development area. He states that:

> "Given the changes in the nature of the population of youngsters to be served, there is a pressing need to assure that professionals are well-trained to deal with issues such as physical and sexual abuse, separation and loss within the family, adoption, depression, aggression, substance abuse, and biological bases of behavior. There is also a need to insure that they have skill in working in many different ways with families, in providing services outside of traditional mental health settings, and in working with culturally diverse populations" (p.6).

It would appear that many of these problems would be sufficiently addressed or neutralized with the reforms currently taking place in child mental health. Since the advent of the Child and Adolescent Service System Program (CASSP) in 1983, state mental health programs have undergone fundamental changes in philosophy and organization of service delivery. According to the CASSP philosophy, the system must be community-based and family-focused. There must be services available in the least restrictive, most normative environment, starting with the child's home and moving progressively from there. Thus, CASSP and others have emphasized the need for increased in-home services (Stroul, 1988), crisis intervention services (Goldman, 1988) and family preservation services (Knitzer and Cole, 1989; Nelson, 1988; Whittaker et al., 1988). There must be a continuum of services available so that children can move and consistently receive the level and intensity of care demanded by their functional levels. There must also be an integration of services, both at the system's level and the individual client level. Thus, CASSP stresses the need for interagency, multiagency collaboration for the treatment of children and adolescents with severe emotional disturbances since they so often have multiple problems and multiple systems' involvement. There must also be management of these various resources for the individual client. Thus, case management is considered the glue that binds all the needs of the individual child and family together in a coordinated fashion. Finally, CASSP requires that the service system be culturally competent.

Despite this major effort, the majority of mental health funding for children still goes to inpatient units and residential treatment centers that are not community-based (Tuma, 1989). In communities of color, very few of the principles of CASSP have been realized and they continue to be communities which overrely on removal of children from their homes and placements in restrictive institutional settings.

CHILDREN OF COLOR AND THE JUVENILE JUSTICE SYSTEM

There has always been a relationship between mental health and juvenile justice. In fact, the initial child guidance movement grew out of concerns that juvenile court judges expressed regarding the need for "treatment and therapy" for children appearing before them. This uneasy "relationship " was created by the original belief that there was little distinction between criminals and the mentally ill. In colonial America, criminals and the mentally ill were all considered dangerous to society and locked away, primarily in jails and/or well-barred rooms.

Usually, however, the relationship is an inverse one, i.e. treatment or punishment assumes primacy, depending on the prevailing paradigm or political whim of the times. It is also an inverse one in the sense that as one system contracts, the other tends to expand. Thus, in the deinstitutionalization of mental hospitals for adults, there has been an increase in the prison population. In fact, Laurie Flynn, executive director of the National Alliance for the Mentally Ill (NAMI), sadly refers to the Los Angeles jail as the largest mental health facility in the country now. One can observe a similar phenomenon as child mental health systems move toward community-based services and away from institutions. There has been a substantial increase in the number of juveniles incarcerated in states between 1980 and 1989. According to the Kids Count Data Book (1992), 32 states (63%) report an increase in the number of children who are incarcerated in the juvenile justice system.

The current prevailing paradigm can best be characterized as "confused". On the one hand, there are those who believe that the mentally ill are "sick" and are deserving of treatment while "law and order" constituents believe that those who break laws are "bad" and deserving of punishment. This either/or approach, so characteristic of American policies does not easily handle ambiguity. Those who are "sick" often break laws and breach societal norms. These "sick" and "bad" persons pose the greatest dilemma for us as policy and decisionmakers. As noted earlier, the mental health profession is unable to offer clear, precise definitions or interventions for how to handle such persons; consequently, decisions are often based on individual perceptions, values and beliefs.

Given the lack of clear distinctions between bad and sick, decisionmakers have imposed their own criteria -- regretfully, the criteria appears to be based on skin color and/or ethnicity. Krisberg et al. (1987) state that "there is broad agreement in the literature that minority adolescents are overrepresented at all stages of the juvenile justice system as compared to their numbers in the general population" (p. 174). The authors note that there was an increase in incarcerations between 1979 and 1982. The incarceration rate for white males increased from 154.8 per 100,000 to 183.3 -- an increase of 18 percent. But the African American rate of increase was even more dramatic -- from 587.9 to 810.0 -- an increase of 38 percent. Latino/Hispanic males experienced a 36 percent increase in their incarceration rate. Both African American and Latino/Hispanic female incarceration rates increased by 29 percent as compared to 14 percent for majority females. The authors suggest that:

> "Race emerges as the single best predictor of arrest, incarceration, and release, even when the influence of other variables are controlled...This is not only true for Black youth, but also Hispanic youth, Native Americans and Japanese Americans" (pp. 174-175).

Data from Pennsylvania (Commonwealth of Pennsylvania, 1991) -- a somewhat progressive state when it comes to juvenile justice reform -- can be used as an example to graphically demonstrate the

differential treatment received in the juvenile justice system by children of color. According to the 1990 census, children of color comprise 12 percent of the population. Yet, children of color make up 51 percent of those coming into the juvenile justice system in 1990. African Americans represent 43 percent of the children of color in the juvenile justice system -- out of all proportion to their overall population percentage. The data from Pennsylvania is not atypical.

Public analysts and researchers have offered several explanations for the differential incarceration rate of children of color, especially African American males. These explanations include:

(1) **Changing demographic trends**
Some observers speculate that the growing numbers of incarcerated youth of color are the result of demographic trends in which the majority population contains a smaller proportion of children than do communities of color. However, Krisberg et al. (1987) find that "the data on incarceration rates refute the hypothesis that these demographic trends are the principal forces generating the growth in minority incarceration" (p. 187).

(2) **Youth of color are arrested for and commit more violent or serious crimes**
A review of FBI arrest data does not support the straightforward conclusion that rates of arrest for serious youth crime are the primary determinants of minority incarceration rates (Dembo, 1988; Krisberg et al., 1987). Further, in the National Youth Survey (NYS), a longitudinal study of delinquent behavior and alcohol and drug use among the American youth population, researchers consistently find no significant race differences in any of the violent or serious offense scales (Elliott et al., 1983). Even if there were significant race differences, serious offenses represent only 20 percent of the offenses committed by juveniles and would still not account for the large discrepancy in incarcerations of youth of color.

(3) **Youth of color are more "prone" to delinquent behavior and are therefore, more likely to be arrested**
Again, data from the NYS, which include self-reports of various delinquent behavior, find that there are no significant differences between the self-reports of whites and children of color for general delinquency, index offenses, felony assault and felony theft from 1976 to 1980. There is a slightly higher proportion of African American involvement in general delinquency in most years. Both African American and Latino/Hispanic youth report higher rates of involvement in Index offenses and in Felony Assaults. However, few of these differences are statistical significant (Huizinga and Elliott, 1986). Therefore, Huizinga and Elliott conclude that:

> "Overall these findings suggest that there are few if any substantial differences between the delinquency involvement of different racial groups. This finding is not unique. Other large scale self-report studies of delinquency have reached similar conclusions...As a result, it does not appear that differences in delinquent behavior can provide an explanation for the observed race differential in incarceration rates" (p. 13).

(4) **It is socioeconomic status (SES), not race/ethnicity, that accounts for the disproportionate rates of incarceration for minority youth**

There certainly appears to be some evidence, primarily from the NYS, to substantiate an SES difference in self-reported delinquency activity. Lower class youth reported greater involvement in serious offenses against persons than youngsters from working class or middle-class families. Further, researchers found a significant race-by-social class interaction indicating a relatively high participation of lower class children of color in serious offenses against persons (Dembo, 1988). Since race and SES are so highly correlated, it is difficult, if not impossible, to determine which variable has primacy. Also, many argue that it may not be the greater prevalence of crime in low-income areas as much as the greater presence of police in low-income communities (Cashmore and McLaughlin, 1991).

(5) **It is racism and discrimination that accounts for the disproportionate rates of incarceration of youth of color**

More and more, professionals of color and others are coming to the conclusion that it is racism and discrimination that best explains the overrepresentation of youth of color, especially African American males, in the juvenile justice system. Racism is increasingly recognized as less blatant or overt discrimination than a set of subtly intertwined rules, policies, and activities that produce constant "mini-assaults" against groups of color and maintains the power relation of white supremacy in all American institutions and customs. Hacker (1992) states that "something called racism obviously exists. As a complex of ideas and attitudes, which translate into action, it has taken a tragic toll on the lives of all Americans...It goes beyond prejudice and discrimination and even transcends bigotry, largely because it arises from outlooks and assumptions of which we are largely unaware" (pp. 19-20).

Until researchers present compelling evidence to the contrary, it is almost impossible not to conclude that race and ethnicity are the major determinants of the overrepresentation of youth of color in the juvenile justice system. This practice has tremendous impact on the lives of youth of color, their families, their communities and, ultimately, American society. In 1983, Morales, Ferguson and Munford noted that this subtle, institutional racism places children of color at "far greater risk than white children of being permanently emotionally scarred by their experiences with the juvenile justice system. Additionally, the impact of their arrests and court records will handicap them further in future employment...meager employment opportunities will further lock them into a life of continued poverty and also possibly criminality" (p. 516). Gibbs (1988) echoes many of these thoughts when she noted that:

> "Too much emphasis has been placed on 'blaming the victims' for their own victimization and for the consequences of over three centuries of discrimination, deprivation, and denial of equal opportunity. Double standards have been applied in a blatantly hypocritical attempt to attribute immoral and deviant motives to black youth for the same kinds of behaviors for which white youth are ignored, excused, tolerated, or exonerated...a generation of black youth is truly endangered" (pp. xxii, xxvii).

In line with these concerns, a recent study by Miller (1992) found that on an average day in 1991, 42 percent of the District of Columbia's African American male population, ages 18 through 35

had some level of involvement with the criminal justice system. He declares that "in a vain attempt to deal with a range of serious social problems through near-exclusive reliance on the criminal justice system, the vast criminal justice apparatus of Washington, D.C. has been engaged in a disastrous feeding frenzy... The call seems to be -- 'If you can't deal with the problem, arrest it'. In effect, the social safety net has been replaced by a dragnet" (p. 1).

The same logic seems to hold when dealing with youth of color. The response to their real social and emotional problems seems to be arrest and punishment rather than treatment. As indicated earlier, there are many that do not believe that "badness" and "sickness" can reside in the same individual. Consequently, by placing youth of color into detention, we continually fail in the more rehabilitative components of juvenile justice while further placing these youth at greater disadvantage in the larger society. It has now become a truism that children have mental health needs, regardless of the system door through which they come. Youth in substance abuse programs, those with serious illnesses and chronic conditions, those in our child welfare structures, and those in juvenile justice often display major symptoms of psychiatric and emotional distress.

Child professionals are also recognizing that children basically look alike across all the child-serving systems. However, the services received are determined by the door through which the child enters. In fact, most children enter the system numerous times and through numerous doors. Many of the children currently in the juvenile justice system have been known to special education, child welfare and mental health -- often in the same year. However, once a child, especially youth of color, enters the juvenile justice door, the less likely he or she is to receive therapeutic services and the more likely the possibility of being permanently branded. And yet, state surveys and researchers have consistently found a high percentage of emotional disturbance among the juvenile justice population -- often a range from 10 to 60 percent.

In her work with African American males in the juvenile justice system in the District of Columbia, Hutchinson described them as follows:

> "Psychiatric examinations revealed a wide range of signs and symptoms of mental health disorders. About one in five boys gave histories that were compatible with attention deficit disorder. Hyperactivity, inattention and impulsivity were common findings. Occasionally a young man had been treated with ritalin or placed in a special program to address these signs. This was the exception rather than the rule. Most were undiagnosed and untreated...Another common finding was hallucinations, both auditory and visual...self-mutilation...extreme anger and unusual levels of aggression... The most common finding, however, is depression and post-traumatic stress disorder (PTSD) is a frequently undiagnosed problem... Identification is necessary, however, for treatment to begin" (pp. 100-101).

This description is very similar to the ones that Lewis and her colleagues (Lewis et al., 1979; Lewis et al., 1980; Lewis and Shanok, 1980) found in their studies of mental disturbances within juvenile offender populations. In their original study the delinquent population in Connecticut facilities, Lewis et al.(1979) found that "black delinquent children and their parents must demonstrate flamboyantly psychotic behavior before they are recognized as being in need of treatment" (p. 59). They concluded that "many seriously psychiatrically disturbed, abused, neglected, black children are

being channeled to correctional facilities while their white counterparts are more likely to be recognized as in need of help and directed toward therapeutic facilities" (p.60).

In an attempt to further understand this racial bias, Lewis and her colleagues (1980) compared psychiatric symptoms, violent behaviors, and medical histories of an entire one-year sample of adolescents from the same community who were sent either to a correctional school or the state hospital adolescent psychiatric unit for adolescents. The initial hypothesis was that correctional youth would be as equally disturbed but more violent than those youth admitted to the state psychiatric unit. However, the assumption that the psychiatrically hospitalized adolescents would be demonstrably less violent than their incarcerated peers was refuted. They found that "violence seemed to be as characteristic of the hospitalized sample as it was of the incarcerated sample...however, for reasons that were not explicit, the courts had not sent them to the correctional institution" (p. 1212). The researchers concluded that "a most striking factor distinguishing the two groups was neither behavior or psychopathology. It was race. In the lower socioeconomic sectors of the urban area studied, violent disturbed black adolescents were incarcerated; violent, disturbed white adolescents were hospitalized..." (p. 1215).

Other studies by Lewis and her colleagues (1989), as well as others (McCarthy and Smith, 1986), continue to document the racial discrepancies in placement and availability of mental health services.

PROMISING PROGRAM MODELS AND CONCEPTS

Despite the widespread discrimination and apparent racism inherent in both the mental health and juvenile justice systems, several concepts and models are now in the process of development that show promise and some ability to address the very critical mental health needs of children of color. Perhaps the guiding concept behind current efforts to reform public child-serving agencies is "cultural competence". Cross et al. (1989) in Towards A Culturally Competent System of Care, Vol. I, indicate that cultural competence involves systems, agencies and practitioners with the capacity to respond to the unique needs of populations whose cultures are different than that which might be called "dominant" or "mainstream" America. The authors provide the following definition of cultural competence:

> "The word culture is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function in a particular way: the capacity to function within the context of culturally-integrated patterns of human behavior as defined by the group" (p.3).

Thus, cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, an agency, or among professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations.

According to the authors, five essential elements contribute to a system's, institution's, or agency's ability to become more culturally competent. The culturally competent system: (1) values diversity; (2) has the capacity for cultural self-assessment at the institutional and individual levels; (3)

is conscious of the dynamic inherent when cultures interact; (4) institutionalizes cultural knowledge; and (5) develops adaptations to service delivery to reflect an understanding of cultural diversity.

In addition, this work outlines the major values and principles that should guide the development of culturally competent systems and services for children and families of color. These values and principles include the following:

- The family as defined by each culture is the primary system of support and preferred intervention.
- The system must recognize that minority populations have to be at least bicultural and that this status creates a unique set of mental health issues to which the systems must be equipped to respond.
- Individuals and families make different choices based on cultural forces; these choices must be considered if services are to be helpful.
- Practice is driven in the system of care by culturally preferred choices, not by culturally blind or culturally free interventions.
- Inherent in cross-cultural interactions are dynamics that must be acknowledged, adjusted to, and accepted.
- The system must sanction and in some cases mandate the incorporation of cultural knowledge into practice and policymaking.
- Cultural competence involves determining a client's cultural location in order to apply the helping principle of "starting where the client is" and includes understanding the client's level of acculturation and assimilation.
- Cultural competence involves working in conjunction with natural, informal support, and helping networks within minority communities, e.g., neighborhoods, churches, spiritual leaders, and healers.
- Cultural competence extends the concept of self-determination to the community.
- Cultural competence seeks to match the needs and help-seeking behaviors of the client population.
- An agency staffing pattern that reflects the makeup of the client population, adjusted for the degree of community need, helps ensure the delivery of effective services.
- Culturally competent services incorporate the concept of equal and non-discriminatory services, but go beyond that to include the concept of responsive services matched to the client population.

On the systems level, one of the most innovative programs for identifying and treating mentally ill juvenile offenders is the State of North Carolina's Willie M. Program. It has been the prototype for so much of the community-based system of care movement in the country that it is sometimes forgotten that the program was established particularly for mentally ill juvenile offenders. In 1979, a group of plaintiffs who were youths in training schools argued that they were in institutions primarily because of a lack of mental health resources in their communities and hence were being denied proper treatment. The court concurred and the Willie M. Program was born. A consent decree was signed that stated that services for "remediation of the mental, neurological, and other physical illnesses that resulted in these youths' violent behavior would be provided and that this treatment would be carried out in the 'least restrictive environment'" (Keith, 1988, pg. 600) Along with the least restrictive environment criteria, the program operates with a legally mandated "no eject, no reject" policy that dictates that the

only condition under which services do not have to be provided is that parents or guardians have withdrawn the youth from the program.

Keith (1988) describes the Willie M. population as follows:

> "With the admission criteria of documented interpersonal violence accompanied by psychiatric disorders and/or mental retardation, it comes as no surprise that 85% have been male with an average age of 15...Black and lower socioeconomic strata youth have been overrepresented. Eighty percent of Willie M. plaintiffs initially received a diagnoses of conduct disorder by local clinicians filing the applications...many of these youths turned out to have multiple diagnoses in addition to conduct disorder...60 to 70% of the families have been unable to provide even minimal parental care. Statewide, 35 to 40%. of the plaintiffs were in custody of Social Services...Thus, the Willie M. net swept up primarily severely emotionally disturbed, dysfunctional, acting out adolescents from disorganized, demoralized, or nonexistent family systems" (p. 601).

How effective has the Willie M. program been? Keith (1988) suggests that the program has been highly effective. In a sample of 80 Willie M. children in the Durham area, 30 percent of the plaintiffs received some benefits and 50 percent received significant benefits from the massive input of supportive community services. The remaining 20 percent either did not wish services, did not need services, or the plaintiff's particular psychopathology made them unengagable by the treatment modalities. He concludes that " in the majority of Willie M. youth, actual violence or the threat of violence decreased dramatically as the youth settled into more stable living arrangements, day care programs, and psychotherapy and embarked on appropriate medication regimes" (p. 603). It appears that the components of the Willie M. Program that differ from the traditional institutional setting for emotionally disturbed juvenile offenders are its no reject policy, focus on community-based services, involvement of families and other community supports, therapeutically-trained staff, intensive case management, and individualized treatment programs.

While not as extensive as the Willie M. Program, a number of other programs have been identified throughout the country that are attempting to deliver culturally competent care to children of color in many different settings (Isaacs and Benjamin, 1991). In these programs, the unique cultural needs and difficulties of minority children and their families are used to establish the therapeutic context in which interventions are delivered.

For example, the Ada S. McKinley Intervention Services in Chicago, Illinois offers services to youth of color with emotional or developmental disabilities in a consolidated agency setting that serves many different child-serving systems. Its Unified Delinquent Intervention Services (UDIS) provides the same services to delinquents identified by the courts as is provided to those being referred to the mental health component. All staff are located together and receive the same types of training. The services offered to clients are similar and vary only in frequency and level of intensity. These service components include: home-based family therapy, individual treatment, adolescent group counseling, patient support/educational group training, psychiatric/psychological evaluations, substance abuse assessments/counseling, intensive outreach, therapeutic companion services, advocacy services, 24-hour crisis intervention, in-home and out-of-home respite care, aftercare and follow-up services.

The program acts as an alternative to institutionalization for African American and Latino males referred by the juvenile courts. In the UDIS component, the staff is experiencing a 50 to 60% success rate (keeping youth out of juvenile justice facilities). Based on a recognition of the cultural dictates of help-seeking and use of services, the McKinley Intervention Services have been able to structure services to meet the need of the primarily poor African American and Latino families it serves with considerable success.

Another program that demonstrates the benefits of a culturally-syntonic approach to care for African American juvenile offenders is the Progressive Life Center (PLC) in Washington, D.C. PLC began in 1983 with a small demonstration grant from the District of Columbia government to provide community services to habitual and repeat juvenile offenders returning to the community from juvenile detention facilities. Today, PLC provides these services as well as mental health assessments and treatment within the District's detention facilities. The PLC was founded on the concept of integrating and merging African psychology and African American cultural practices with humanistic and interactional models of psychotherapy. Through this unique combination, called Afrocentric psychology, the founders of PLC hoped to create a model that would be more effective in intervening in the lives of African Americans experiencing stress and other symptoms of dysfunctional behavior due to societal racism as well as internal conflicts. The NTU principles that form the basis of the Afrocentric philosophy, emphasize the positive strengths of the individual and his/her culture, rather than approaching the treatment process from a deficit model.

These principles are realized through a treatment process that occurs primarily in the family's home rather than in other sites. The exception, of course, involves those youth that are detained in juvenile facilities; however, their families are seen in their homes when the therapeutic contact is established. Based on the cultural preferences of African Americans, treatment interventions tend to be relationship-oriented and are more visual, action-oriented and spiritual. One of the more innovative and unique programs offered by the PLC is the adolescent Rites of Passage program. This program has become an effective way to guide young African American males into more responsive manhood roles. The essential components of the Rites of Passage model include (Perkins, 1986):

- Manhood and womanhood training
- Sex education
- Physical fitness and self-defense
- Survival training
- Health maintenance and hygiene
- Life management and values clarification
- Cultural enrichment
- Political awareness
- Educational reinforcement
- Financial management
- Racial awareness
- Spiritual enrichment

Finally, for youth within the juvenile justice facilities, PLC therapists make the assumption that many of these adolescents become involved in crimes and other antisocial behavior because they have become emotionally numb and cannot feel or empathize with their victims. The goal of treatment, therefore, is to reconnect the youth with his feeling, spiritual self and, thus, begin the healing process.

Within this framework, there are certain techniques that appear to be very responsive to the needs of these youth including hypnotherapy and creative visualization.

POLICY IMPLICATIONS

There are a number of policy implications that grow out of this review of the plight of emotionally disturbed youngsters of color in the juvenile justice system. One of the most critical and obvious ones is that the arbitrary nature of placement decisions in the juvenile justice system based on race and ethnicity must cease immediately. Priority should be given to solutions and settings that emphasize treatment and rehabilitation rather than punishment. It would also appear that the level of discrimination that appears to be associated with the placement of youth of color should be the subject of more thorough investigation and administrative review at the federal, state and local jurisdictions responsible for juvenile delinquency.

In order to reduce the arbitrariness of placement, based primarily on race and ethnicity, states and local communities should explore the feasibility of establishing single entry points which would provide comprehensive assessments for all children in need of mental health, juvenile justice, child welfare and/or special education services. Although single entry points would not necessarily reduce the discrimination currently found in placements, they would offer an opportunity for multidisciplinary teams to work closely and to ensure that the needs of children are reviewed across more life domains than presently occurs. For instance, if all children entered through a single entry point, then regardless of the referral source, each might receive an assessment that includes mental health, health, education, child abuse, substance abuse, etc. This would present a great improvement over our current categorical system that essentially utilizes a uni-dimensional approach to children. Recent lawsuits in Oklahoma, Florida, the District of Columbia, and other states have begun to mandate a more comprehensive and inclusive array of services for children entering the juvenile justice system.

Another critical conclusion is that all children, regardless of other characteristics, need to be maintained in an optimal, safe, and therapeutic environment. Juvenile justice facilities, even the most modern, are not usually designed to create an effective therapeutic environment. Nor are they staffed or are staff properly trained to deliver such services. Locating mental health services in juvenile justice facilities should be viewed as an interim measure only. Ultimately, placement in a juvenile justice facility has too many long-range negative repercussions, especially for the vast numbers of children of color, to ever be considered a placement of choice except under the most dangerous of circumstances. Therefore, whenever possible, every attempt should be made to maintain youth in the least restrictive environment. Certainly, the data from the North Carolina Willie M. Program and other such models throughout the country (Ventura County, California is another one) should be better utilized to develop policies.

As the old adage states: you can wait for the bodies to float upstream or you can go downstream and find out who's throwing the bodies in. In the most simplistic of terms, our policies must begin to focus more on prevention and early intervention and less on treatment and rehabilitation. We are losing too many of our precious commodity -- our children -- with our current policy focus. We know a considerable amount about the social conditions and structures that give rise to juvenile delinquency and violence in our society. Yet, we do little to prevent juvenile delinquency. Rather, we depend on the criminal justice system to punish after it has been allowed to fully bloom. According

to Deborah Prothrow-Stith (1991), the criminal justice system is fundamentally reactive, not proactive. "Little happens until a crime has occurred. By then , it is too late for prevention strategies" (p. 5). The goal is to prevent children from having to get into the juvenile justice system rather than rehabilitating them once they are there. The need to shift to a preventive approach to the problems plaguing our youth, especially those of color, is critical.

For youth of color, the systems that they confront -- whether mental health, substance abuse or juvenile justice -- have proven to be ineffective, costly, and culturally incompetent. These systems tend to be culturally-biased from the initial assessment through the course of treatment and rehabilitation. These systems have proven to be inflexible when assessing or serving youth of different racial and cultural orientations. They lack the level of cultural diversity and competence needed to be effective in addressing the very real needs of groups of color in our country. For example, assessments of young African American males fail to take into account the types of defense mechanisms, such as 'cool pose' (Majors and Billson, 1992) that are used for survival in a majority-controlled, hostile, discriminatory environment. Treatment interventions are individualistic and cognitive rather than group-oriented, interactive and emotive -- characteristics that appear to be associated with more effective interventions for youth of color (Gibbs and Huang, 1989; Oliver, 1989; Isaacs and Benjamin, 1991). There is a need to develop more effective, culturally-appropriate assessment instruments and to support the development of more culturally competent programs and services for children and families of color.

However, none of these policy shifts or program innovations can come about without massive training and retraining of professionals at the policy, administrative and direct service levels. It is the attitudes and biases of individuals within our society that influence the decisions that are made. We must begin to retrain current workers so that they become more culturally competent as well as develop curricula in our training institutions that facilitate the ability, skills, and willingness to work with culturally diverse populations. Certainly, such training is no easy undertaking, but one that is critical to the development of effective services and policies for the increasing numbers of youth of color in our country. Simultaneously, we must also ensure that more professionals of color are trained to work with populations that are culturally similar.

Concluding Comments

The overrepresentation of children and adolescents of color, especially African American male youngsters, in the juvenile justice system, leaves one angry, saddened, and disheartened. It is difficult, as a member of a group of color, to quote numbers and statistics about the rates of incarceration and deaths of a very important and vital component of any community -- its male offspring, without remembering that in the midst of these numbers and charts and graphs stand your son, or brother, or nephew, or cousin, or lover, or just your best friend ever. When we get caught up in the numbers, in the drama of television reenactments and commentaries, it is often difficult to imagine that these youngsters of color paraded before our eyes are human beings and often children. These youngsters are often more victims than victimizers; more endangered than dangerous; more a product of our society than its inventor. Certainly we are capable of policies and services that nurture healthier and more productive generations.

REFERENCES

Ablon, J., Metcalf, A. and Miller, D. An Overview of Mental Health Problems of Indian Children. Report to the Joint Commission on the Mental Health of Children. Washington, D.C.: U.S. Government Printing Office, 1967.

The Annie E. Casey Foundation. Kids Count Data Book: State Profiles of Child Well-being. Washington, D.C.: The Center for the Study of Social Policy, 1992.

Blum, R.W., Harmon, B., Harris, L., Bergeisen, L. and Resnick, M.D. American Indian-Alaska native youth health. JAMA, 267 1637-1644, 1992.

Brandenburg, N.A., Friedman, R.M. and Silver, S.E. The epidemiology of childhood psychiatric disorders: Prevalence findings from recent studies. Journal of the American Academy of Child and Adolescent Psychiatry, 29: 76-83, 1990.

Braxton, E. "The Violence Within and Without: Failure of the Mental Health System in Treating the Angry Black Child". Unpublished paper presented at the NIMH/MCHB workshop on The Impact of Community Violence on African American Children and Families: Collaborative Approaches to Prevention and Intervention", June 13-15, New York, New York, 1991.

Burns, B. J. Mental health use by adolescents in the 1970s and 1980s. Journal of the American Academy of Child and Adolescent Psychiatry, 30, 144-149, 1991.

Canino, I.A., Earley, B.E. and Rogler, L.H. The Puerto Rican Child in New York City: Stress and Mental Health. Monograph No. 4. Bronx, NY: Hispanic Research Center, Fordham University, 1980.

Cashmore, E. and McLaughlin, E., eds. Out of Order? -- Policing Black People. New York: Rutledge, 1991.

Cohen, R., Parmalee, D.X., Irwin, L., Weisz, J.R., Howard, P., Purcell, P. and Best, A.M. Characteristics of children and adolescents in a psychiatric hospital and a corrections facility. Journal of the American Academy of Child and Adolescent Psychiatry, 29, 909-913, 1990.

Commonwealth of Pennsylvania County Planning Data Kit: 1991 Supplement, Interdepartmental Human Services Planning Committee, 1991.

Costello, E.J. Developments in child psychiatric epidemiology. Journal of the American Academy of Child and Adolescent Psychiatry, 28, 836-841, 1989.

Cross, T.L., Bazron, B.J., Dennis, K.W. and Isaacs, M.R. Volume I: Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who are Severely Emotionally Disturbed. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center, 1989.

Dembo, R. Delinquency among black male youth. In J.T. Gibbs, ed. Young, Black, and Male in America: An Endangered Species. Dover, MA: Auburn House Publishing Company, 1988.

Elliott, D.S., Ageton, S.S., Huizinga, D., Knowles, B.A. and Canter, R.J. The Prevalence and Incidence of Delinquent Behavior: 1976-1980. Boulder, CO: Behavioral Research Institute, 1983.

Friedman, R.M., Burns, B.J. and Behar, L.B. Major issues in improving mental health and substance abuse services for adolescents. Paper prepared for the American College of Mental Health Administration, 1991.

Gibbs, J.T. Black american adolescents. In J.T. Gibbs and L.N. Huang, eds. Children of Color: Psychological Interventions with Minority Youth. San Francisco, CA: Jossey-Bass Publishers, 1989.

Gibbs, J.T. (Ed.) Young, Black and Male in America: An Endangered Species. Dover, MA: Auburn House Publishing Company, 1988.

Gibbs, J.T. and Huang, L.N. eds. Children of Color: Psychological Interventions with Minority Youth. San Francisco, CA: Jossey-Bass Publishers, 1989.

Goldman, S. Volume II: Crisis services. Series on Community-based Services for Children and Adolescents who are Severely Emotionally Disturbed. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center, 1988.

Greenbaum, P.E., Prange, M.E., Friedman, R.M. and Silver, S.E. Substance abuse prevalence and comorbidity with other psychiatric disorders among adolescents with severe emotional disturbances. Journal of the American Academy of Child and Adolescent Psychiatry, 30, 575-583, 1991.

Hacker, A. Two Nations: Black and White, Separate, Hostile, Unequal. New York, NY: Charles Scribner's Sons, Macmillan Publishing Company, 1992.

Huizinga, D. and Elliott, D.S. Juvenile Offenders: Prevalence, Offender Incidence and Arrest Rates by Race. Paper presented for the meeting on Race and the Incarceration of Juveniles, Racine, Wisconsin. Boulder, CO: Institute of Behavioral Science, 1986.

Hutchinson, J. "Challenging perceptions of youth: "Bad" or "disturbed"? In P. Sheehan, ed., Health Care for Incarcerated Youth: Report from the 1991 Tri-regional Workshops. Washington, D.C.: National Center for Education in Maternal and Child Health, 1991.

Isaacs, M.R. and Benjamin, M. P. Volume II: Towards a Culturally Competent System of Care: Programs which Utilize Culturally Competent Principles. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center, 1991.

Keith, Charles R. Case study -- Community treatment of violent youth: Seven years of experience with a class action suit. Journal of the American Academy of Child and Adolescent Psychiatry, 27, 600 - 604, 1988.

Knitzer, J. and Cole, E.S. Family Preservation Services: The Program Challenge for Child Welfare and Child Mental Health Agencies. New York, NY: Bank Street College of Education, 1989.

Knitzer, J. Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services. Washington, D.C.: Children's Defense Fund, 1982.

Krisberg, B., Schwartz, I., Fishman, G., Eisikovits, E., Guttman, E. and Joe, K. The incarceration of minority youth. Crime and Delinquency, 33, 173-205, 1987.

LaFromboise, T.D. and Low, K.G. American Indian children and adolescents. In J.T. Gibbs and L.N. Huang, eds. Children of Color: Psychological Interventions with Minority Youth. San Francisco, CA: Jossey-Bass Publishers, Inc., pp. 114-147, 1989.

Lewis, D.O., Shanok, S.S., Cohen, R. J., Kligfeld, M. and Frisone, G. Race bias in the diagnosis and disposition of violent adolescents. American Journal of Psychiatry, 137, 1211 - 1216, 1980.

Lewis, D.O., Balla, D.A. and Shanok, S.S. Some evidence of race bias in the diagnosis and treatment of the juvenile offender. American Journal of Orthopsychiatry, 49, 53-61, 1979.

Lewis, D.O., Lovely, R., Yeager, C. and Femina, D.D. Toward a theory of the genesis of violence: A follow-up study of delinquents. Journal of the American Academy of Child and Adolescent Psychiatry, 28, 431-436, 1989.

Lewis, D.O. and Shanok, S.S. The use of a correctional facility for follow-up care of psychiatrically disturbed adolescents. American Journal of Psychiatry, 137, 935-953, 1980.

McCarthy, B.R. and Smith, B.L. The conceptualization of discrimination in the juvenile justice process: The impact of administrative factors and screening decisions on juvenile court dispositions. Criminology, 24, 41-64, 1986.

McManus, M., Alessi, N.E., Grapentine, W.L. and Brickman, A. Psychiatric disturbance in serious delinquents. Journal of the American Academy of Child Psychiatry, 23, 602-615, 1984.

Majors, R. and Billson, J.M. Cool Pose: The Dilemmas of Black Manhood in America. New York, NY: Lexington Books, An Imprint of Macmillan, Inc., 1992.

Meinhardt, K., Tom, S., Tse, P. and Yu, C.Y. Southeast Asian refugees in the 'Silicon Valley': The Asian health assessment project. Amerasia Journal, 12, 43-66, 1986.

Milin, R., Halikas, J.A., Meller, J.E., and Morse, C. Psychopathology among substance abusing juvenile offenders. Journal of the American Academy of Child and Adolescent Psychiatry, 30, 569-574, 1991.

Miller, J.G. Hobbling a Generation: Young African American Males in Washington, D.C.'s Criminal Justice System. Alexandria, VA: National Center on Institutions and Alternatives, 1992.

Morales, A., Ferguson, Y. and Munford, P.R. The juvenile justice system and minorities. In G.J. Powell, ed. The Psychosocial Development of Minority Group Children. New York, NY: Brunner/Mazel, Inc., pp. 515-537, 1986.

Myers, H.F. Urban stress and mental health in Afro-American youth: An epidemiologic and conceptual update. In R. Jones, ed. Black Adolescents. Berkeley, CA: Cobb and Henry, 1990.

Nagata, D. Japanese American children and adolescents. In J.T. Gibbs and L.N. Huang, eds. Children of Color: Psychological Interventions with Minority Youth. San Francisco, CA: Jossey-Bass Publishers, pp. 224-250, 1989.

Nelson, D. Working Paper Series: Recognizing and Realizing the Potential of 'Family Preservation'. Washington, D.C.: The Center for the Study of Social Policy, 1988.

Office of Technology Assessment. Children's Mental Health: Problems and Services. Washington, D.C.: U.S. Government Printing Office, 1986.

Oliver, W. Black males and social problems: Prevention through afrocentric socialization. Journal of Black Studies, 20, 15-39, 1989.

Perkins, U.E. Harvesting New Generations: The Positive Development of Black Youth. Chicago, IL: Third World Press, 1986.

Prothrow-Stith, D. Deadly Consequences: How Violence is Destroying our Teenage Population and a Plan to Begin Solving the Problem. New York, NY: Harper Collins Publishers, 1991.

Ramirez, O. Mexican American children and adolescents. In J.T. Gibbs and L.N. Huang, eds. Children of Color: Psychological Interventions with Minority Youth. San Francisco, CA: Jossey-Bass Publishers, pp. 224-250, 1989.

Rog, D. The Status of Children's Mental Health. Alexandria, VA: National Mental Health Association, 1990.

Stroul, B.A. Volume I: Home-based Services. Series on Community-based Services for Children and Adolescents who are Severely Emotionally Disturbed. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center, 1988.

Tuma, J.M. Mental health services for children: The state of the art. American Psychologist, 44, 188-199, 1989.

Wallace, H.M. The health of american indian children. Health Service Report, 87: 867-876, 1972.

Watts, W.D. and Wright, L.S. The relationship of alcohol, tobacco, marijuana, and other illegal drug use to delinquency among Mexican-American, black, and white adolescent males. Adolescence, 25, 171-181, 1990.

Whittaker, J.K., Kinney, J., Tracy, E.M. and Booth, C. (Eds). Improving Practice Technology for Work with High Risk Families: Lessons from the 'Homebuilders' Social Work Education Project. Seattle, WA: Center for Social Welfare Research, 1988.

CHAPTER 7

THE NATIONAL WORK SESSION: ISSUES AND RECOMMENDED ACTIONS

John Whitbeck

INTRODUCTION

In May 1992, the National Coalition for the Mentally Ill in the Criminal Justice System sponsored a three-day National Work Session in Seattle, Washington. The work session brought together experts from across the country to discuss the key issues facing mentally ill youth in the juvenile justice system and to recommend actions that would begin to more effectively address the needs of this population.

Prior to the National Work Session, several planning meetings were held. As part of this preliminary work, a mission statement for the National Coalition regarding their efforts on behalf of mentally ill youth in the juvenile justice system was established. This mission statement is:

1. Resources of the juvenile justice system, mental health, substance abuse, social service, educational and other systems must be developed and integrated to assure that children with severe emotional disturbance or mental illness in the juvenile justice system are identified, assessed and appropriately treated.
2. No child or adolescent should be placed or detained in juvenile detention facilities or correctional facilities or any unduly restrictive care only because of mental illness or severe emotional disturbance and/or lack of appropriate services.
3. Every child or adolescent, in or diverted from the juvenile justice system with serious emotional disturbance or mental illness should receive all needed mental health services wherever they reside.
4. Every child or adolescent suffering from mental illness or serious emotional disturbance whose offenses are directly related to that condition should be treated in a manner and setting appropriate to his or her condition.
5. Police should never have to charge a child in order to get them to mental health services.

The approximately seventy individuals who attended the National Work Session (a complete list of participants in the work session and planning meetings is provided in the Appendix) represented universities, national associations, advocacy organizations and mental health and criminal justice agencies. Each of the work session attendees were provided with a draft conference copy of the preceding chapters of this monograph prior to the meeting. The information and findings served as a starting point and provided a context for the deliberations. An authors' panel was convened on the first

day to provide an overview of the research on the issues relevant to the mission of the session. Predetermined working groups then met over the next two days focusing upon five primary issues which paralleled each of the main monograph chapters. These included the population, service systems, legal context, program models and cultural competence.

Each working group had a researcher, typically the author of the relevant chapter, a facilitator, an expert in the area being addressed, a recorder, and other attendees of the session. Each group facilitator was given the charge from the National Coalition to identify major problems experienced by youth and major factors contributing to these problems, and to identify possible interventions and solutions. From these small group interactions came the policy discussions and recommendations which were reported back to the full conference at a series of large group meetings. Three products resulted from this intense work: authors were given feedback on their draft chapters; small groups hammered out policy recommendations to put forward around the assigned small group issues; and the group as a whole considered, debated, and then created a series of national policy recommendations for improving the delivery of mental health services to youth in the juvenile justice system. What follows are the layers of policies and recommendations that came out of this intense inter-active work session. Often there was creative tension around topics of interest. Consensus on issues was arrived at with diligence and perseverance. Occasionally, consensus did not occur. No format could capture totally the range of ideas and the massive amount of information that was reviewed. Thus, the following summary of the three-day work session provides only a taste of the charged, creative, and productive atmosphere that characterized the meeting. The information will be given in two sections:

The Work Groups: Issues and Recommendations

The work of each of the five groups around the pre-determined issues areas (population, service systems, legal context, program models and cultural competence) will be summarized seperately. Each group summary will include: an overview of the monograph chapter that informed the discussion, a review of the issues raised by the group in the substantive area, and the group's recommendations for action.

National Policy Action Plan

This section will summarize the discussions of the full group which met several times in the course of the national work session to consider the information from the small work groups, and to debate the national policy. The outcome was a focussed discussion aimed at informing the National Coalition about an action plan based upon the larger body of recommendations developed by the work groups.

THE WORK GROUPS: ISSUES AND RECOMMENDED ACTIONS

Work Group One: The Population[1]

Part 1: Chapter Summary -"Prevalence of Mental Disorders Among Youth in the Juvenile Justice System."

The authors summarize their complex findings as follows:

1. The prevalence of mental disorders in the youngsters in the juvenile justice system is over 22%.

2. One-fifth of the youngsters in the juvenile justice system can be diagnosed as having a conduct disorder and perhaps as high as 60%.

3. The rate of psychotic disorders was consistently found to be low. This is an important group of youngsters in terms of the severity of their problems, and the inappropriateness of correctional placement. The prevalence rate in the studies ranged between 0% and 5%.

4. It is obvious that attention deficit disorders and depressive disorders are a significant problem in this population. However, there seems to be less clarity about the prevalence of these disorders than there is about other disorders, largely because of the measurement procedures used and the focus on only one diagnosis per youngster.

5. It is also clear that substance abuse disorders represent an important problem, and that there is a high degree of co-morbidity between mental disorders and substance abuse disorders.

6. Although data was limited, it is clear that many youngsters have multiple diagnoses and that more attention has to be paid to the whole area of co-morbidity. Unless this is done, information on the rates of specific disorders may be misleading. This should include learning disabilities as well as more traditional disorders.

7. Although this review has not had a major focus on this area, the emerging area of developmental psychopathology would seem to have great potential for helping to understand the characteristics of youngsters in the juvenile justice system and the types of services that may be needed to prevent and/or treat their disorders. The focus on developmental pathways, and on risk factors has great potential for advancing the field.

8. Another important area that is often neglected in focusing on youngsters with emotional disorders is the whole area of individual strengths, family strengths and social competence. In understanding the nature of this population, and in developing treatment and prevention strategies, it is essential that a holistic perspective be considered that examines not only the

---

[1]. The summaries of this and the other chapters reflect the information available at the work session in the conference draft of the monograph and, therefore, may vary from the final work contained in the preceding chapters.

presence or absence of disorders but also strengths, and that incorporates not only a diagnostic perspective but also an ecological perspective on family issues, cultural issues and social issues.

Part 2: Issues

There were three primary issues which dominated the discussion. The first related to the attempt to define the target group. This issue was seen as central to the policy discussion. This discussion ranged from focusing on a relatively narrow definition of serious emotional or neurobiological disorders to more inclusive definitions. As part of this deliberation, existing definitions were reviewed and options were discussed with the group as a whole in a plenary session.

A second important discussion centered around those issues or conditions considered under the label "co-morbidity." This issue organized around inclusivity -- what other critical conditions should be included in a working definition of the target population. The strongly felt position of those advocating inclusion through the term "co-morbidity" was that children involved with the juvenile court who have a range of presenting conditions, such as substance abuse disorders or conditions typically defined as developmental disabilities, should be included in any definition of the target group. A final, important issue was the felt need for universal screening in order to systematically identify the needs of youth in the juvenile justice system.

Part 3: Recommended Actions

The following recommendations were made relative to defining, targeting, and identifying the population.

- The target population should be those children in the juvenile justice system suffering from one or more serious emotional or neurobiological disorders. These children shall be treated in a culturally competent manner and setting appropriate to their condition.

- The definition of mental illness should include children with mental disorders who are suffering from severe, acute or chronic emotional, cognitive, behavioral, or neurological disorders, including mental retardation and substance abuse disorders that co-occur with other mental disorders which require intervention or treatment to improve functioning or prevent developmental dysfunction.

- With regard to treatment priorities, the first priority of service should be children who are emotionally disturbed, schizophrenic or having a bipolar disorder. Other priorities are those children identified as suffering from neuropsychiatric disorders which require intervention or treatment to prevent harm or improve functioning.

- Clinical screening should be conducted on all children entering into the system, for the purpose of identifying children in need of immediate treatment/intervention/diversion, and children in need of more involved and detailed mental health evaluation.

- All children identified as mentally ill should receive comprehensive medical, psychological, neuropsychiatric, and social evaluation to assist in disposition and treatment planning.

- Screening and evaluation procedures must be racially and culturally sensitive.

- Clinical screening should be available at all points in the system, and should be mandatory when children are in custody (e.g., detention centers, training schools).

- Legal requirements and standards that currently require screening and evaluation procedures should be identified, reviewed and used as the basis for extending these services to all youth entering the juvenile justice system.

Work Group Two: Service Systems

Part 1: Chapter Summary - "Issues in Systems Interactions Affecting Mentally Disordered Juvenile Offenders."

Barnum and Keilitz introduce their chapter noting the difficulty of the interaction of two systems: juvenile justice and mental health. Juvenile justice typically see all juvenile offenders as "troubled" and in need of "treatment". Further, juvenile justice, as an institution, has difficulty in responding to the "special behavioral and emotional problems of juvenile offenders who may be mentally ill, and mental health agencies are often reluctant to become involved with youth whose behavior may have been violent or otherwise anti-social." These system responses are further complicated when the whole child is examined -- these youth "tend to have multiple serious problems in many areas of functioning...Establishing useful interactions among these institutions -- families, social service agencies, schools, mental health agencies, courts and correctional institutions -- can be a daunting task."

The authors note that when critical issues are "solved" around definitions of "mentally disturbed", then central questions about care surface, and these questions tend to be handled in a system-mode: "Different jurisdictions answer these questions in different ways, depending upon resources and on the social values embodied in their laws, regulations, and policies for dealing with these youth." It is critical at this juncture to realize that differences in agency placements appear to have little to do with any difference in intrinsic clinical features of the youth themselves. It becomes an interactive, dyadic relationship between the juvenile justice system -- the default institution for youth so identified -- and by the mental health system which "resolves questions of long term treatment by accepting or rejecting youth for placement depending upon criteria that reflect judgements of either need or amenability to treatment."

The authors state that problems of mentally disordered youth are complex and multi-faceted. Professionals and institutions need a capacity for personal flexibility to foster communication and work across boundaries to solve problems. They examine a range of programs and models that address the multiple concerns addressed above. They urge that institutions interact with each other in support of individual children and, in doing so, be "rational, efficient, and accountable in the pursuit of services."

In order to achieve desirable outcomes for children across multiple institutions, they focus on evaluation and assessment procedures. The ideal interactive evaluation would be: efficient, appropriate, require a screening technique prior to an evaluation, discriminate dangerousness, discriminate between amenability to, and need for, treatment, have a clear working definition of what areas of mental disturbance the system wishes to discover and treat, determine which problems were functionally significant with regard to underlying delinquency, and be stepwise, "requiring only more expensive or intrusive evaluations when screening devices indicate that they were necessary."

Part 2: The Issues

The work group emphasized the importance of understanding that the needs of children and families are complex. It was recognized that as service systems have developed over the years, there has been a focus on separate services that a particular segment of the service system can efficiently provide. As a result, narrowly focused systems such as child welfare, juvenile justice, education and mental health have evolved and shifted the emphasis away from the unique and changing needs of individual children and their families to specialized services defined by legal mandates and eligibility. While separate pre-designed services are easily managed and may be adequate in the context of the particular program (e.g., day treatment, home-based services), they may not be adequate for meeting the needs of the more complex children who need tailored approaches that integrate resources from multiple systems and agencies.

The group also felt that, wherever possible, children -- even those with special needs -- have a right to live with their families in the community and have the most normal childhood possible. When specialized mental health expertise is combined with that of other services and all supports are integrated in a manner that responds to the unique needs of the child, it is possible to support mentally ill children in the community. This focus on children and families happens when communities come together around the needs of their children, integrate formal services, create flexibility across available resources and blend formal services with other community resource in a manner that is supportive to individual families. It is this sense of system, family, and community integration that the group articulated. The focus was always on the two systems of interest: juvenile justice system and the mental health system, but the discussion always ranged across the individual child, the family, and those other systems and resources.

In addition to this overriding issue affecting the justice system, a number of other concerns were raised by the group including:

- There are few, if any, appropriate assessments done of mentally ill children in the juvenile justice system. The group attributed this to a number of causes: poor training of those asked to do assessments, unreliability of available instruments, lack of training in cultural competence of assessors and instruments, inattention of instruments and assessors to individual and family strengths, and lack of a clear definition of the proposed target population.
- There is little coordination of mental health/treatment services with the juvenile justice system at any stage of juvenile justice system processing: from arrest and potential diversion to institutionalization and aftercare.
- The isolated and uncoordinated provision of services results in problems such as categorical funding, incapacity of mental health providers to cope with violence and transferrals from local to distant placements, all of which increase the likelihood of failure for the child.
- Inadequate attention is given to the ongoing evaluation of individual treatment programs, program effectiveness, and organizational coordination.
- There are significant problems for children and families created by a component driven system approach to problem identification and service delivery. These issues organized around power, access and "voice" for clients and families.

Part 3: Recommended Actions

Based on the issues and concerns about the service delivery systems that were raised in the group discussions and the relevant monograph chapter, the work group recommended that the following steps should be taken:

- Community and system integration strategies should be implemented for all children including those not involved with juvenile justice; and multiple entry points, not dependent upon juvenile offending, should be available.
- Clear legal standards for issues such as right to treatment, refusal of treatment, and definitions and parameters for assessing competence should be developed.
- Every child who, on the basis of evaluation, needs clinical services should receive appropriate services regardless of juvenile justice or custody status.
- Agencies collaborating in providing services for children should meet routinely to plan and evaluate ongoing and prospective service plans for children.
- Every child who is seriously emotionally disturbed, seriously mentally ill, or otherwise in need of interagency services, should have an interagency case manager assigned to integrate the efforts of all service providers. This case management shall be characterized by low caseloads and case managers shall be trained to understand multiple systems with specialties in mental health and juvenile justice service delivery and specialized training in cultural competence.
- Plans of care developed for children must involve families and children in the development, implementation and evaluation phases and must include an explicit way of evaluating the child's progress in treatment (outcomes).
- All children entering the juvenile justice system must have access to appropriate and culturally competent screening for mental health problems and every child who needs a clinical evaluation shall have one.

Work Group Three: Legal Context

Part 1: Chapter Summary - "Legal Issues Affecting Mentally Disordered Youth in the Juvenile Justice System."

The authors' premise is that the current juvenile justice system has few legal mechanisms which ensure consistent consideration of mental illness as a factor across the different stages of the decision-making process.

Intake and pretrial proceedings

There are few guidelines about how to recognize/refer a child with mental illness. From initial contact by police, through decisions of detention, and filing of a petition, there are many critical decision-junctures that could be informed by a consistently applied understanding of mental illness, and appropriate responses and resources.

The connection between pre-trial detention and mental illness is subtle. The distribution of length of stay in detention tends to be bimodal, with a large proportion of adolescents staying a short time and a smaller group staying for lengthy periods. Those who stay longer are usually adolescents with complicated placement needs, not necessarily more serious offenses. Mentally

ill adolescents would thus seem exceptionally susceptible to extended detention once processed...unless adequate provisions for identification and review are established.

Adjudication At an adjudication proceeding the traditional burden of proof is reasonable doubt. In juvenile cases it is not clear "what standard of proof will be applied in determining whether a child should be exculpated from responsibility as a delinquent due to mental illness." At adjudication hearings, several issues about the youth's ability to stand trial may be raised. The insanity defense may be raised, the appropriateness of juvenile court jurisdiction may be raised (which has had uneven application across states on mental illness as a reason for transfer to adult jurisdictions) and competency issues (the juvenile's capacity for rational understanding) may be raised.

Disposition After the finding of guilt, the judge must make a decision regarding a treatment plan for the juvenile. The question of whether there is a "right" to treatment at this stage has engendered considerable legal debate. Often the significant part of this decision turns on a clinician's assessment of a juveniles' amenability to treatment. The authors question whether "terms like treatment or rehabilitation mean the same thing to all mental health professionals" and similarly whether there is sufficient expertise in the psychiatric evaluations done for courts for the typically more serious offenses.

Monitoring Placement and Service Provision The questions that arise at this juncture are typically whether a court should continue to be involved after adjudication, and what recourse may be available when it is clear that the placement decided by the court does not meet the juvenile's mental health needs.

Part 2: Issues

A critical point that framed much of this group's discussion is the fact that the juvenile justice system represents not a single system but a series of state and local court venues organized around state statutes and mitigated by landmark decisions such as Gault, Kent, and Miranda.

The juvenile justice system is not a top-down bureaucracy that is driven by administrative codes. Rather it is a loosely knit association of 50 states, each with a given juvenile code, generally modeled on adult criminal statutes. Further, there is a constructed tension in most statutes between goals of public safety and accountability and goals of rehabilitation and treatment.

The work group discussion was formed around several key points. These discussion points included the following:

- The work group felt that the primary focus should be on persons already in the juvenile justice system, but that primary prevention issues are salient before the child becomes involved in the juvenile justice system and, therefore, more attention should be given to prevention and early intervention strategies.
- A second concern related to the relevance of competency issues for juveniles and the sense that the competency of children varies across different situations. Since the basic premise of the juvenile system is not criminal responsibility, but more civil, the critical underlying question is: "Does competency (or lack thereof) affect treatment?"

- Coexisting with the above problems of definitions of target groups and competency, the work group noted that there is not a clear, or legally applicable definition of mental illness with the express purpose of separating out a narrow mental health population which would allow juvenile courts to deal with issues raised around screening, diversion, referral and competency.
- Another concern was that the concept of "amenability to treatment" may be deceptive. Decisions around treatment are typically based on whether a child can fit into existing treatment models -- not whether the presenting mental illness is treatable. Further, treatment decisions are compounded by other factors, including the variability of expert opinions of mental health professionals and the availability of resources for treatment.
- The work group felt that there is a constitutional right of children in state custody not to have their mental health or medical needs ignored. This right, however, is significantly different from an affirmative right to treatment. Establishing a right to treatment standard should be a priority.
- Finally, there was concern that once the need for treatment is identified that it does not necessarily follow that are there is treatment available or that standards for each facility or treatment procedure exist.

Part 3: Recommended Actions

In order to respond to this set of concerns, the work group recommended the following:

- Groups of youth who come in contact with, or are at risk of coming in contact with, the juvenile justice system and who could benefit from preventative services should be identified.
- A clear framework should be established for identifying the points in the legal processes where pro-active screening requirements could be put in place.
- A screening device or devices should be developed and instituted that are compatible with different junctures of legal processes: arrest, pre-trial, adjudication, sentencing/placement.
- A specific uniform definition of mental illness should be promulgated across all states.
- A clear, specific and consistent definition of competence should be created.
- Standards for community based care and for least restrictive care must be developed.
- A minimally acceptable standard of treatment or care must be defined.
- Evaluations of treatment should be mandated to include issues of cultural relevance, access and participation by families.

Work Group Four: Program Models

Part 1: Chapter Summary - "Treatment in the Juvenile Justice System: Directions for Policy and Practice."

The authors underline two critical points:

1. Because populations vary little across youth service systems, the design of effective programs for emotionally disturbed youth in the juvenile justice system is a task that differs little from child mental health planning in general.
2. Services now typically available 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.

They suggest that the discussion of treatment also should be considered squarely in the context of legitimate competing goals of the juvenile justice system: public safety and accountability.

Outcome research on what predicts success for an individual, multi-problem child in the juvenile justice system suggests the following approach: highly integrated and highly individualized services that combine education, social, family and psychological interventions into a single treatment. As discussed by the author, the Jericho Principle means that, "metaphorically, the walls ought to come down between disciplines and, therefore various sectors (e.g., mental health, child welfare) of the child and family service system." They note that "little practical consequence is gained by attempting to compartmentalize child mental health disorders."

Part 2: Issues:

The first concern of this work group centered around the characteristics of the juvenile justice system. Typically, group treatment models of intervention are the norm, with needs of the child understood in terms of "beds" or "slots" rather than "individual service needs." The group felt that an outcome of this thinking was an emphasis on congregate treatment. Such institutionalized "treatment" is relied on to a degree that individual behavioral and psychiatric problems are aggravated. This is not to neglect the need for security and community protection, but to indicate that these concerns may well be addressed in other more collaborative, community-based models.

The group also felt that rigid boundaries, particularly financial restrictions and mandates, impair effective collaboration. While this problem is not exclusive to the juvenile justice system, the rigidity of sentencing and adjudication does stand in the way of collaborative activities at certain junctures unless care is taken to make the child the focus of attention rather than the needs or structure of the system. Inter-disciplinary collaboration and team-work must be emphasized to a much greater degree during both the assessment and intervention phases.

Also addressed by the group was the absence of proper, thorough and comprehensive assessments and/or evaluations - particularly mental health evaluations. It was asserted that these assessments need to focus on the strengths of children and families as much as possible. As a result of the lack of credible and reliable assessments, least restrictive, and appropriate, services are used too infrequently. Related both to the general juvenile justice process and the absence of adequate screening or assessment is the potential of labeling (eg. arsonist, sex offender) which can stigmatize and contribute to over-use of "component, packaged" service programs, or exclude such youth from other, more appropriate services. A juvenile justice label often allows other systems to back out of viable plans by using the label as an excuse.

The work group also raised the issue of early intervention, noting that it is largely absent, to the point that individual and social problems are being needlessly compounded. Lastly, the group observed that family involvement in the treatment process occurred too infrequently, and little respect is given to family and youth and their positions or wishes in the decision-making and treatment process. Further, youth are too infrequently involved in service decisions.

Part 3: Recommended Actions

The groups felt that there was one overriding recommendation that flowed from their discussion which was:

- Collaborative interventions must be developed and implemented in order to effectively meet the full range of needs presented by these youth and their families.

Most of the other recommendations centered on strengthening and further elaborating on this primary need. These other suggestions included:

- All collaborative interventions for children should emphasis the following principles:

  - Child and Family Focused. All aspects of evaluation, treatment and service will be conducted in a manner which fully involves and empowers the family.
  - Culturally Competent and Free-of-Gender Bias. All aspects of evaluation, treatment and service will be conducted in a culturally competent and culturally specific manner. In addition, these service elements will be free of sex-bias, and be sensitivity to differences in any sex-dependent service needs.
  - Least Restrictive. All children and adolescents who experience a severe emotional disturbance and/or mental illness should receive services within the least restrictive, most normative environment that is clinically appropriate.
  - Individualized. The population of interest is extremely varied with regards to the range of problems experienced, strengths possessed, and service challenges posed. Therefore, attention must be paid to the individualization of all aspects of evaluation, service planning, and implementation.

- Furthermore, all collaborative interventions for children should be structured to:

  - Minimize Entry into the Juvenile Justice System: To the extent possible, youth must be diverted from the juvenile justice system.
  - Minimize Stay in the Juvenile Justice System: For those who do enter the juvenile justice system, they must be removed from the juvenile justice system at the earliest opportunity.
  - Emphasis Rehabilitation and Treatment: Rehabilitation and treatment must be adopted as the mission of central importance for the juvenile justice system for those youth who suffer severe emotional disturbance. This commitment to rehabilitation need not be in conflict with protection of the public interest regarding safety and security.
  - Identify SED/MI Youth: Each and all SED/MI youth in the juvenile justice system must be identified through a mental health screening process.

- Finally, all collaborative interventions must provide individualized planning and service delivery in a manner which would ensure:

  - Service Implementation: Services that are required to respond to the identified needs of youth and families must be implemented and provided.
  - Flexible Service Dollars: Current funding structures must be modified to allow greater flexibility and discretion in how money is spent for purchase-of-services.

- Service Accountability: Responsibility and accountability will be maintained through "no eject, no reject" policies, and, providing services and treatment as long as is necessary.
- Program Evaluation: Substantive funding must be allocated for careful process and outcome evaluation studies of innovative demonstration projects.
- Human Resource Development: Training, technical assistance, consultation and quality improvement must occur at the local service delivery level and across all governmental levels.

Work Group Five: Cultural Competence

Part 1: Chapter Summary - "Assessing the Mental Health Needs of Children and Adolescents of Color in the Juvenile Justice System: Overcoming Institutionalized Perceptions and Barriers."

The author's organizing premises are:

1. Children and adolescents of color are overrepresented in the juvenile justice system, given their proportions in the overall U.S. population.
2. Children and adolescents of color are underserved and/or inappropriately served by the mental health system. When services are received they tend to be in more restrictive settings within the mental health system, i.e. state psychiatric institutions and/or long-term residential treatment centers.

The author states that "the analysis of the literature and current practices suggest that there is an immediate and critical need to overhaul current policies and treatment approaches to juvenile justice offenders who are emotionally disturbed." She lists the following nine policy implications:

1. The arbitrary nature of placement decisions based upon race and ethnicity must cease immediately;
2. All children, regardless of other characteristics, need to be maintained in an optimal, safe, and therapeutic environment in order to reap the benefits (of that placement);
3. Focus must be placed on culturally competent systems and personnel training;
4. More attention must be given to establishing and developing community-based systems of care in urban, minority communities, with greater emphasis on prevention and early intervention;
5. Better training of law enforcement and juvenile justice personnel is needed;
6. Research and programs that build on the strengths and positive attributes of ethnic minority youngsters and communities of color must be undertaken;
7. There must be greater involvement of ethnic minority communities in the identification of problems and the promotion of solutions (i.e. importance of self-help and empowerment);
8. More emphasis and greater commitment to diversion of ethnic minority youngsters at the front-end of the justice system instead of over-reliance on the nebulous "rehabilitative" aspects of confinement is needed; and,
9. Better diagnostic assessment and evaluation tools that are reliable and culturally appropriate must be developed.

Part 2: Issues

The work group organized their discussion of issues into a set of assumptions followed by a list of problems which exist across systems and communities.

Assumptions:

- Culturally insensitive services for mentally ill juveniles in the juvenile justice system are, by definition, inadequate services.
- Racism and the stigma of poverty negatively impact every aspect of the effective delivery of services for mentally ill juveniles of color in the juvenile justice system.
- An underlying goal of all system improvements is to minimize the contact of mentally ill youth of color with the juvenile justice system.

Problems:

1. Because of cultural stereotypes, youth of color are frequently not diagnosed or identified as being mentally ill.
2. The juvenile justice system is over-represented with youth of color who are mentally ill.
3. The stigma of racism and poverty negatively impact accurate diagnoses of mental illnesses.
4. Inadequate understanding of cultural differences create fear and suspicion of minority youth among treatment providers.
5. Youth of color and their families fear the juvenile justice system and, thus, are often unwilling to interact with this system.
6. Minority youth tend to fulfill in their actual behavior the negative expectations placed upon them through racism and the stigma of poverty.

Part 3: Recommended Actions

The work group recommended the following actions:

- Cultural competency training should be provided to all personnel who interact with mentally ill juveniles in the juvenile justice system, as well as to families, teachers and those who set policy for this system.
- Assessment instruments for juveniles entering the juvenile justice system must be culturally sensitive.
- Prevention and early intervention initiatives for youth in the juvenile justice system must be culturally sensitive.
- Mental health aspects of health care reform should reflect the special needs and concerns of youth of color.
- Information concerning youth of color needs to be more widely disseminated for use by service providers, policy-makers, families and the general public.
- Research and evaluation agendas need to reflect the special needs and concerns of youth of color.

SECTION II: NATIONAL POLICY ACTION PLAN

Discussion and Background

The entire group came together at the end of the national work session to hear the reports and recommendations of the smaller work groups. From these presentations and discussions came specific suggestions and recommendations to the National Coalition for the Mentally Ill in the Criminal Justice System. The recommendations were in the form of specific activities that the National Coalition might undertake to accomplish specific goals in its planning and to impact policy around its mission. Underlying these suggested activities were certain tenets that were discussed and agreed to by the majority of the work session attendees. These included:

- Youth within the juvenile justice system suffering from serious emotional or neurobiological disorders shall be treated in a culturally competent manner and setting appropriate to their condition.
- Youth suffer from severe, acute or chronic emotional, cognitive/behavioral, neurobiological and disorders which can co-occur with mental retardation and/or substance abuse disorders.
- The first priority should be for those incarcerated juveniles who have been identified as being serious emotional disturbed, schizophrenic or having bi-polar disorders but that every youth suffering from mental illness or serious emotional disturbance should be treated in a setting appropriate to his or her condition and in a culturally sensitive manner.

National Policy Context

Given the above foundations, there was agreement that action policies developed by the National Coalition should be cognizant of major national policy arenas including the specific ones named below. The listing is not exclusive, nor does it recognize every important federal or state agency, nationally based non-profit agency or association whose work may be critical to the mission of the National Coalition.

An important arena is the growing discussion around national health care reform and attendant issues of alcohol, drug and mental health benefits, guaranteed right to treatment, mandatory screening, and minimal standards of service and funding flexibility.

Another area of relevance is the reauthorization of the Juvenile Justice and Delinquency Prevention Act with the opportunities to fund prevalence and outcome studies, demonstration projects and specific training activities around critical juvenile justice issues.

Other national policy arenas include Family Preservation legislation, juvenile justice issues identified in the Omnibus Crime bill, the Center for Disease Control and its ability to mount epidemiological studies, and the Office of Minority Health and its potential to examine the overrepresentation of youth of color in the juvenile justice system as well as examining links between health and mental health issues for minority youth.

Also significant are Public Laws 99-660 and 101-639. In particular, P.L. 99-660 mandates state planning around children's mental health issues, and encourages the development of culturally competent systems of care for emotionally disturbed children.

A final, extremely important consideration, is the reorganization of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), into a new services agency: the Substance Abuse and Mental Health Services Administration (SAMHSA). As part of this, the Research Institutes of ADAMHA, including the National Institute of Mental Health (NIMH), will transfer to the National Institutes of Health (NIH). NIMH has been a major partner in the struggle to identify and serve the mentally ill child through the auspices of Child and Adolescent Service System Program (CASSP). CASSP and NIMH funded technical assistance, demonstration projects, epidemiological and outcome studies and other training related activities have done much to help communities develop comprehensive systems of care and collaborative relations across agencies at the community level.

Action Plan

The group as a whole and several of the small work groups helped to identify the initial steps that should be taken as part of an overall action plan for the National Coalition for the Mentally Ill in the Criminal Justice System. These steps include the activities of lobbying, developing position papers and statements, encouraging and promoting nationally consistent standards in certain critical areas, promoting and encouraging activities supporting the Coalition's mission across levels of federal, state and local governments and agencies through training seminars, meetings and related activities, and creating a clearinghouse for names, bibliographies and organizations to become aware of each other and current activities for the population of mentally ill children within the juvenile justice system. More specifically, steps to be incorporated into the Coalition's Action Plan for responding to the needs of these youth are listed below. In addition to these specific actions, the group also suggested that the Coalition sponsor a follow-up National State Policy Meeting aimed at working with specific states to refine and implement the suggested actions.

Activities on Standards

- The Coalition should work toward establishing a right to treatment in the least restrictive placement through state statute, case law and administrative regulations.
- The Coalition should work toward developing a uniform, culturally sensitive screening device to assess all youth entering the juvenile justice system for mental illness.

Lobbying Activities

- The Coalition should lobby appropriate federal and state agencies for resources to guarantee that the right to treatment is met, including those resources necessary to insure appropriate screening, evaluation, treatment and aftercare for mentally ill children identified at various stages of the juvenile justice system process.
- The Coalition should lobby appropriate federal and state juvenile justice and mental health agencies, either directly or through Congress, to allocate funding for research and demonstration projects regarding mentally ill youth in the juvenile justice system, including epidemiological studies and prevalence studies.
- The Coalition should lobby Congress to include a focus on the mentally ill in the Juvenile Justice and Delinquency Prevention Act and demonstration projects.
- The Coalition should work to influence state advisory groups on the allocation of Juvenile justice monies.
- The Coalition should actively pursue support from foundations currently working with complex, multi-system children (e.g. Robert Wood Johnson Foundation, Annie E. Casey Foundation).

Public Positions/Training

- The Coalition should take the position that any juvenile with mental illness should not be allowed to be waived into adult court.
- The Coalition should work with judges, probation officers and various mental health organizations to develop culturally sensitive training regarding working with mentally ill juveniles.
- The Coalition should work to identify appropriate state statutes to deal with children's rights.
- The Coalition should work to develop state level advocacy groups to focus on the problems confronting this population of youth.
- The Coalition should develop curriculum and sponsor technical assistance and training sessions around meeting the mental health needs of youth involved with the juvenile justice system.

SUMMARY

The National Coalition for the Mentally Ill in the Criminal Justice System has embarked upon an important and critical task: to insure that children with severe emotional disturbance or mental illness in the juvenile justice system are identified, assessed and appropriately treated. The Action Plan recommendations above will go a long way toward providing the climate for change.

APPENDIX A

PARTICIPANT LIST

National Coalition for the Mentally Ill in the Criminal Justice System

ADDRESSING THE MENTAL HEALTH NEEDS OF YOUTH IN THE JUVENILE JUSTICE SYSTEM

The following representatives participated in the Preliminary Planning Meeting, National Planning Meeting and/or National Work Sessions:

Pat Arthur
Evergreen Legal Services
101 Yesler Way, Suite 301
Seattle, Washington 98104
206/464-0838

Michael Arthur, Ph.D.
University of Washington School of Social Work
Social Development Research Group
146 N. Canal Street, Suite 211, XD 50
Seattle, Washington 98103
206/685-3858

Tom Backer, Ph.D.
President
Human Interaction Research Institute
1849 Sawtelle Blvd., Suite 102
Los Angeles, California 90025
213/479-3028

Richard Barnum, M.D.
Director
Boston Juvenile Court Clinic
New Court House, Room 210
Boston, Massachusetts 02108
617/725-8535

Michael Bates
Administrator
Columbia/Walla Walla Juvenile Court
PO Box 1754
Walla Walla, Washington 99362-0033
509/527-3275

Robert Battjes, D.S.W.
Deputy Director
Division of Clinical Research
National Institute of Drug Abuse
4600 Fishers Lane, Room 10A-38
Rockville, Maryland 20857
301/443-6697

Lenore Behar, Ph.D.
Chief, Division of Mental Health/SS/DD
325 N. Salisbury Street
Raleigh, North Carolina 27603
919/733-0598

Michael Benjamin
Executive Director
Employee Assistance Professionals Assoc.
Board Member, National Coalition for the Mentally Ill in the Criminal Justice System
4601 N. Fairfax Drive, Suite 1001
Arlington, Virginia 22203
703/522-6272

Jim Brannon, Ph.D.
Nat. Assoc. of Juvenile Correctional Agencies
PO Box 40
St. Anthony, Idaho 83445
208/624-3462

Marty Butkovich
Juvenile Rehabilitation Administrator
Division of Rehabilitation
PO Box 45720
Olympia, Washington 98504
206/753-4707

William Buzagamy, M.D.
Director, Adolescent Program
Mendota Mental Health Institute
301 Troy Drive
Madison, Wisconsin 53704
608/244-2411

Nancy Campbell
Executive Director
Northwest AIDS Foundation
Board Member, National Coalition for the Mentally Ill in the Criminal Justice System
127 Broadway East, Suite 200
Seattle, Washington 98104-5212
206/239-6923

Stephanie Carter, J.D.
Nat. District Attorney's Association
206 10th Avenue SE
Olympia, WA 98501
206/753-2175

Elizabeth Chadwick, J.D.
Director of Legal Services
Dept. of Human Resources
Div. of MH/MR & SA
878 Peachtree Street NE, Room 306
Atlanta, Georgia 30309-3999
404/894-6538

Joseph Cocozza, Ph.D.
Policy Research Associates
262 Delaware Avenue
Delmar, New York 12054
518/439-7415

Ray Coleman
Deputy Director
King County Dept. of Adult Detention
Board Member, National Coalition for the Mentally Ill in the Criminal Justice System
500 Fifth Avenue
Seattle, Washington 98104
206/296-1269

Lynn Davidson
Manager
King County Mental Health Division
506 Second Avenue, Suite 512
Seattle, Washington 98104
206/296-0583

Nicholas Demos, J.D.
Chief, Special Initiatives
Center for Substance Abuse Treatment
5515 Security Lane
Rockwall II, 105h Floor
Rockville, Maryland 20852
301/443-6533

Josie DeVries
Washington State Fetal Alcohol Syndrome Adolescent Taskforce
20508 Cypress Way
Lynnwood, Washington 98036
206/778-4048

Sue Dickinson
Chair, NAMI Forensic Network
202 Briarwood Drive
Simpsonville, South Carolina 29681
803/967-7583

Douglas Dodge
Office of Juv. Justice and Delinquency Prevention
Special Emphasis Divi., U.S. Dept. of Justice
633 Indiana Avenue NW
Washington, DC 20531
202/307-5914

Katherine Donner
Asst. Project Coordinator, National Coalition
925 Summerfield Road
Santa Rosa, California 95405
707/538-7545

Albert Duchnowski, Ph.D.
First Vice President
Fed. of Families for Children's Mental Health
Deputy Director, Res. & Training Center for Children's Mental Health
Florida Mental Health Institute, Univ. of S. Florida
13301 Bruce B. Downs Blvd.
Tampa, Florida 33612-3899
813/974-4657

Joel Dvoskin, Ph.D.
Assoc. Commissioner for Forensic Services
N.Y. State Office of Mental Health
44 Holland Avenue
Albany, New York 12229
518/474-3290

Wayne Edwards
500 Bond Drive
Castlerock, WA 98611

Jana Ewing, Ph.D.
Mental Health Services Coordinator
Mental Health/Mental Clinic
King County Youth Services
1211 E. Alder
Seattle, Washington 98122
206/343-2631

Mark Ezell, Ph.D.
Washington State Juvenile Issues Task Force
12325 10th Place NE, Apt. 10
Seattle, Washington 98125
206/362-5794

Larry Fehr
Executive Director
Washington Council on Crime & Delinquency
1305 Fourth Avenue, Suite 602
Seattle, Washington 98101-2401
206/461-3421

Robert Friedman, Ph.D.
Executive Director
Research & Training Center
for Children's Mental Health
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, Florida 33612-3899
813/974-4657

Sue Gilbertson
Mentally Ill Kids in Distress
2441 E. Fillmore
Phoenix, Arizona 85008
602/867-0310

James Gondles
Executive Director
American Correctional Association
8025 Laurel Lakes Court
Laurel, Maryland 20702
301/206-5100

Sharon Gross, J.D.
Dept. of Psychology
University of Virginia
Charlottesville, Virginia 22901
804/982-4750

Hon. David Grossman
Vice President
National Council of Juvenile
and Family Court Judges
Court of Common Pleas, Juvenile Division
800 Broadway
Cincinnati, Ohio 45202
513/852-8709

Steve Harris
President
Intl. Association of Chiefs of Police
Chief, Redmond Police Dept.
15670 NE 85th Street
Redmond, Virginia 98052
206/556-2521

Roy Howson
Director
Associated Council for the Accused
401 Terrace Street
Seattle, Washington 98104
206/624-8105

Barbara Huff
Federation of Families for Children's
Mental Health
1021 Prince Street
Alexandria, Virginia 22314-2971
703/684-7710

Hunter Hurst
Director
National Center for Juvenile Justice
701 Forbes Avenue
Pittsburgh, Pennsylvania 15219
412/227-6950

Mareasa Isaacs, Ph.D.
President
The Isaacs Group
1350 Connecticut Avenue NW, Suite 1100
Washington, DC 20036
202-296-1818

Yvonne Jacobs
Chair, NAMI/CAN/Alaska
4050 Lake Otis Parkway, Suite 103
Anchorage, Alaska 91908
907/561-3127

Sharon Stewart-Johnson
Director
Washington Mental Health Division
Mailstop OB-42F
Olympia, Washington 98504
206/753-4420

Ellen Kagen
Senior Program Specialist
Washington Business Group on Health
777 N. Capital Street NW, Suite 800
Washington, DC 20002
202/408-9320

Michael Kalogerakis, M.D.
American Psychiatric Association
145 Central Park West
New York, New York 10023
212/799-2020

Barbara Kelly
Coordinator
Children's Interagency Staff Team
of King County
1515 Dexter Avenue N., #300
Seattle, WA 98109
206/461-3210

Paul Lerman, D.S.W.
Professor
Rutgers University
School of Social Work
New Brunswick, New Jersey 08903
908/932-7021

Lisa MacFarlane
Staff Attorney
Public Defenders Association
810 Third Avenue
Seattle, Washington 98104
206/363-3171

John McGovern
Public Health Advisor
Center for Substance Abuse Treatment
Rockwall II, 10th Floor
5515 Security Lane
Rockville, Maryland 20852
301/443-6533

Rosalie McHale
Juvenile Justice Specialist
PO Box 45203
Olympia, Washington 98504-5203
206/753-3940

Pamela McPherson, M.D
National Juvenile Detention Association
2304 Lake Street
Lake Charles, Louisiana 70601
318/433-7918

James Mason
Project Manager
Multi-Cultural Initiative
5914 N. Commercial
Portland, Oregon 97217
503/725-4040

James Ray Merikangas, M.D.
Temple Medical Center
40 Temple Street
New Haven, Connecticut 06510
203/562-6272

Edward Mulvey, Ph.D.
Western Psychiatric Institute and Clinic
University of Pittsburgh
381 O'Hara Street
Pittsburgh, Pennsylvania 15213
412/681-1102

Don Murray
Associate Legislative Director
National Association of Counties
440 First Street NW
Washington, DC 20001
202/393-6226

Jeanie Nelson
Board of Directors
Nat. Assoc. of Blacks in Criminal Justice
1211 E. Alder, Mailstop 10
Seattle, Washington 98122
206/343-2410

Cassandra Newkirk. M.D.
President
Amer. Correctional Health Services Assoc.
600 W. Peachtree
One Georgia Center, Suite 1570
Atlanta, Georgia 30308
404/874-9207

Sheila O'Brien
Connecticut NAMI/CAN
133 Sperry Road
Bethany, Connecticut 06525
203/393-1979

Tom O'Brien
Office of Juvenile Justice Prosecutors
Superior Court Juvenile Matters
784 Fairfield Avenue
Bridgeport, Connecticut 06604
203/579-6802

Rosie Oreskovich
Coordinator for Children's Mental Health
King County Mental Health Division
506 Second Avenue, Suite 512
Seattle, Washington 98104
206/296-0583

Robert Ott
403 158th Place SE
Bellevue, Washington 98008
206/784-7276

Randy Otto, Ph.D.
Assistant Professor
Dept. of Law and Mental Health
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd..
Tampa, Florida 33612-3899
813/974-4510

James Owens, M.D.
Chairman, Juvenile Committee
Nat. Commission for Correctional Health Care
1739 N. 128th Street
Seattle, Washington 98133
206/624-6514

Pauline Pagliocca, Ph.D.
Center on Children, Families and the Law
Law/Psychology Program
Univ. of Nebraska/Lincoln
209 Burnett Hall
Lincoln, NE 68588-3130
402/472-3130

Paul Peterson, M.D.
Wash. Inst. for Mentally Ill Research
and Training
PO Box 94508
Fort Stulacoom, Washington 98494
206/256-2851

Roy Praschil
Assistant Executive Director
Division of Operations
Nat. Assoc. of State Mental Health
Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, Virginia 22314
703/739-9333

Barbara Rankin, R.N.
Kentucky AMI - Forensic Network
Board Member, National Coalition for the
Mentally Ill in the Criminal Justice System
7002 Harrods Landing
Prospect, Kentucky 40059
502/228-2807

N. Dickon Reppucci, Ph.D.
Professor
Department of Psychology
University of Virginia
Charlottesville, Virginia 22901
804/973-6669

Don Richardson
Board Member, National Coalition for the
Mentally Ill in the Criminal Justice System
3139 Colby Avenue
Los Angeles, California 90066
213/391-2823

Chase Riveland
Secretary
Dept. of Corrections
410 W. Fifth
PO Box 9699, Mailstop FN-061
Olympia, Washington 98504
206/753-2500

Susan Rotenberg
President
National Coalition for the Mentally Ill in the
Criminal Justice System
2470 Westlake Avenue North, Suite 101
Seattle, Washington 98109-2282
206/285-7422

Matt Russell
Program Director for Government Affairs
Representative, Nat. Mental Health Assoc.
102 Price Street
Alexandria, Virginia 22314-2971
703/684-7722

John B. Sikorski, M.D.
American Academy of
Child & Adolescetn Psychiatry
350 Parnasus Avenue, Suite 309
San Francisco, CA 94117
415/661-7570

Miriam Schuchman, M.D.
Robert Wood Johnson Clinical Scholars Program
Univ. of California/San Francisco
521 Parnassus Avenue, Suite C-126
San Francisco, California 94122
415/476-9021

Robert Sewell, Ph.D.
PO Box 22415
Juneau, AK 99802
907/463-5559

Marlene Smith
Administrator
Chelan County Juvenile Court
316 Washington Street
Wenatchee, Washington 98801-2887
509/664-5350

Henry Tomes, Ph.D.
Executive Director
Public Interest Directorate
American Psychological Association
750 First Street NE
Washington, DC 20002-4242
202/336-5500

Christine Trevothick
Clinical Director
Mental Health North
10501 Meridian Avenue N., Suite D
Seattle, Washington 98133
206/461-4544

Karen S. Trocki, Ph.D.
Scientist
American Public Health Association
Medical Research Inst. of San Francisco
Inst. of Epidemiology and Behavioral Medicine
Alcohol Research Group
2000 Hearst Avenue
Berkeley, California 94709
510/642-5208

Eric Trupin, Ph.D.
Professor and Vice-Chair
Dept. of Psychiatry & Behavioral Sciences
Director, Div. of Community Psychiatry
Acting Dir., Div. of Child Psychiatry
University of Washington
Mailstop RP-10
Seattle, Washington 98195
206/543-7530

John Whitbeck, Ph.D.
Division of Mental Health
Wash. State Dept. of Social & Health Services
PO Box 45320
Olympia, Washington 98504-5320
206/586-6727

William Womack, M.D.
American Academy of Child and Adolescent Psychiatry
PO Box C-5371
Seattle, Washington 98105
206/324-3814

Jennifer Woolard
University of Virginia
Department of Psychology
Gilmer Hall
Charlottesville, Virginia 22901
804/982-4750