

COALITION FOR JUVENILE JUSTICE

**HANDLE
WITH CARE**

**Serving The Mental Health
Needs Of Young Offenders**

2000 ANNUAL REPORT

The Sixteenth Annual Report to the President, the
Congress, and the Administrator of the Office of Juvenile
Justice and Delinquency Prevention

as prescribed by

Section 241 (f)(2)(C), (D) and (E) of the Juvenile Justice and
Delinquency Prevention Act of 1974, as amended

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The conclusions reached and recommendations made are exclusively those of the Coalition.



LETTER FROM THE NATIONAL CHAIR



Dear Mr. President, Members of Congress, and fellow concerned citizens:

One out of every five children in the United States will at some point need help to contain and manage strong emotions or severe stress. They may have erratic mood changes. Anxiety and depression may wash over them and drown out better judgment. These children suffer with mental health problems. These children sometimes break the law.

Unfortunately, nationwide, we too often lock away children with mental health problems, rather than providing them with effective treatment. Arrest and sentencing have become key points of entry into the arena of mental health services for tens of thousands of youth. Yet juvenile detention facilities and staff are rarely equipped to provide appropriate and adequate care—and youth are simply warehoused.

Neglect and indifference come at a high cost: an estimated 50 to 75 percent of youth in detention facilities suffer from mental health problems and are likely, without counseling and support, to become more vulnerable, more volatile and more dangerous to themselves and others. Youth with mental health problems are at high risk for attempting suicide, suffering misdiagnoses or being abused. Children in corrections have been forcibly and brutally restrained, over-medicated, beaten or killed because corrections staff misinterpret symptoms of mental illness.

The choices we must make regarding children with mental health problems are critical. Given the need to make informed decisions, the Coalition for Juvenile Justice proudly offers to you its 2000 annual report, **Handle with Care: Serving the Mental Health Needs of Young Offenders**. The report illustrates findings from a year-long investigation into the scope of mental health concerns and services in the juvenile justice system. It exposes myriad systematic shortcomings and a lack of effective, integrated mental health assessment and treatment services.

If you care about children, families and community safety, this report is a “must read.” **Handle with Care** proves how pervasive mental health problems are among youth in general and young offenders in particular. The report explains why parents may be forced to surrender their children to the juvenile court because they cannot receive assistance with mental health problems anywhere else. The report reveals how poverty, race, gender and sexual orientation may unjustly block young offenders from accessing services.

Handle with Care also identifies the excellence we can create. Treatment methods that focus on rebuilding a child’s family structure while ensuring that he or she receives intensive therapy have reduced recidivism among young offenders by as much as 80 percent. Imagine if such approaches were replicated and part of routine practice. Moreover, there are early detection, prevention and intervention efforts that reach children before emotional distress turns into a mental health problem or a mental illness, and before children engage in dangerous or delinquent activity.

Think of how safe our communities could be if we are to become more proactive.

Mr. President, members of Congress, local leaders and fellow citizens, I urge you, on behalf of the Coalition for Juvenile Justice, to read this report for understanding and guidance. I encourage you to carefully consider the

recommendations to policy makers, practitioners and the public that appear on its final pages. Our Coalition is hopeful that the proposed action steps will provide children—especially those in the juvenile court system—and their families with wider access to high quality mental health assessment and treatment services. Let us focus on children and shape their futures anew and for the better.

With sincerest greetings and great hope,

A handwritten signature in black ink, appearing to read "Robert Pence". The signature is fluid and cursive, with a large initial "R" and a long, sweeping underline.

Robert Pence
2000 National Chair
Coalition for Juvenile Justice

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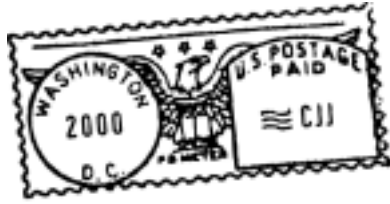
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Note to Readers: Diagnostic and technical terms are used throughout this report. Such words have been highlighted by the use of bold type when they first appear in the text. Definitions for each may be found in the Glossary.

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O

n a January night in San Jose, California, police picked up a 15-year-old boy who was wandering the deserted, rain-swept downtown streets. A wiry boy with a wispy mustache, Thomas was no stranger to the juvenile justice system. He had previously appeared before judges on minor delinquency charges and had done short stints in juvenile hall.

At one of those hearings, it was finally determined

what everyone who knew Thomas had long suspected. He was suffering from mental illness. Agitation and inability to concentrate were followed by long bouts of depression. The diagnosis was **Bipolar Disorder**.

The judge then placed Thomas into a locked mental health facility and for several weeks, the boy went to group therapy sessions and had individual counseling. He was put on medication to help stabilize his moods. There were educational and social programs Thomas was supposed to follow.

But Thomas could not adjust to the program. Although the facility was costly, it offered, in essence, “generic” programming with rigid rules and schedules. Thomas was supposed to fit into the established program, rather than the program being flexible and individualized enough to adjust to his mental health needs. In Thomas’ case, the closed institutional setting and by-the-book staff only exacerbated the young man’s anxiety, depression and feelings of isolation. Again and again, he told staff that he desperately missed his girlfriend. He felt estranged from his peers in the program. The medical staff responded by increasing his medication, but still the

Between 50 to 75 percent of incarcerated youth have diagnosable mental health disorders.

boy grew more unmanageable. Sometimes, he felt too tired and groggy to participate in programs. Other times, he threw a tantrum and followed it with another tantrum, turning the facility into chaos.

MENTAL, EMOTIONAL & BEHAVIOR DISORDERS OF CHILDHOOD AND ADOLESCENCE

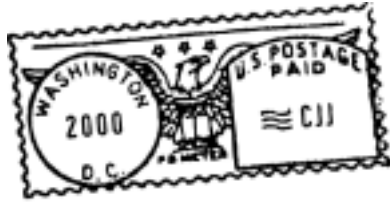
(See glossary for full definitions)

- ✓ Anxiety Disorders, such as Phobias, Panic Disorder, Obsessive-Compulsive Disorder and Post-Traumatic Stress Disorder are the most common of the childhood disorders, affecting 8 to 10 of every 100 children.
- ✓ Depressive Disorder: Studies show that up to six percent of children may be affected.
- ✓ Bipolar Disorder (also referred to as Manic-Depressive illness): As common as one in 100 people, with symptoms appearing during the teenage years.
- ✓ Attention-Deficit/Hyperactivity Disorder (ADHD): Occurs in up to five of every 100 children.
- ✓ Learning Disorders: Approximately five percent of children are identified.
- ✓ Conduct Disorders: Estimates range from 4 to 10 percent of youth.
- ✓ Eating Disorders, including Anorexia Nervosa and Bulimia Nervosa: Anorexia affects one in every 100 to 200 adolescent girls and a smaller number of boys. Reported rates of Bulimia range from one to three percent of youth.
- ✓ Autism: The disorder affects seven to 14 of every 10,000 children.
- ✓ Schizophrenia: It is rare in children under 12, but occurs in about three out of every 1000 adolescents.

Soon, not even locked doors or barred windows could stop Thomas. At every opportunity, he ran away. The first thing he did was to free himself from his medication. It was true that the drugs made his mood swings less dramatic, but the heavy dose also made him feel lethargic and dazed, not at all like himself. Free of the drugs, Thomas roamed the streets day and night until the police picked him up and the cycle of his life began anew: A short stay in juvenile hall; then back to the locked mental health facility, then back to the streets.

When the police found him that wet Saturday night, he was soaked and shivering. His behavior was erratic. But this time, the cycle broke. The facility had a long waiting list of youth who would be far more docile and cooperative than Thomas. The director refused to take him back.

Not knowing what else to do with the boy, the police took him to the only place left that would take him in: Juvenile Hall.



O

ur society has long been in denial about mental health issues – especially among its youth. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), “Most often, children’s and adolescents’ mental health problems are not recognized for what they are...even among people who work with and care for them.”

Among the general youth population, the rate of

mental health disorders is startlingly high. It is estimated that 20 percent of children and adolescents experience some kind of mental health problem during their childhood. This can be anything from Anxiety to an eating disorder to substance abuse to **Schizophrenia**. (See sidebar: Mental, emotional and behavior disorders of childhood and adolescence, page 3.) Nine to 13 percent experience a serious emotional disturbance.

Among youth in the juvenile justice system, the percentage is substantially higher. Between 50 to 75 percent of incarcerated youth have a diagnosable mental health disorder; one out of every five has a serious emotional disturbance. (See sidebar: What is Serious Emotional Disturbance?, page 8.)

“Prior to 1990, mental health problems weren’t given much thought or it was assumed to be a very small number of incarcerated kids,” says Karen Stern, a licensed clinical psychologist and program manager for the Office of Juvenile Justice and Delinquency

WHAT IS SERIOUS EMOTIONAL DISTURBANCE?

(Research and Training Center on Family Support and Children’s Mental Health)

Serious Emotional Disturbance, Disability or Disorder (SED or ED) may also be known as Behavioral Disability or Disorder; EBD for “emotional or behavioral disorder;” or EH for “emotional handicap.”

Laws vary, nationwide, but a youth is considered to be seriously emotionally disturbed (SED) when:

- ✓ Emotional and/or social impairment disrupts his or her academic and/or developmental progress;

- ✓ Disrupts family and/or other interpersonal relationships;
- ✓ Such impairment of functioning has continued for a period of at least one year;
- ✓ Or such impairment is of short duration and high severity

The Federal Standard Definition for Children with Serious Emotional Disturbance, from the Center for Mental Health Services, includes the following characteristics:

- ✓ Impairment that interferes with or limits a child or adolescent's role or functioning in family, school or community activities;
- ✓ Impairment that interferes with or limits a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills;
- ✓ Functional impairments of episodic, recurrent and continuous duration are included unless they are temporary and expected responses to stressful events in the environment.

Prevention (OJJDP). “Since then, there’s been a growing recognition of the number. It’s of great significance.”

The exact figures vary by study. And even the definition of **mental illness**—particularly in regards to juvenile law—changes from state to state. Still, a consistent picture has emerged. And it is a dramatic one:

- In one well-documented study, 73 percent of youth in juvenile facilities reported mental

health problems during screening (ABT Associates, 1994). The same study found that 57 percent had previously received mental health treatment.

- Fifty-five percent of youth in the juvenile justice system have symptoms associated with

WARNING SIGNALS OF TEEN SUICIDE

(American Academy of Child and
Adolescent Psychiatry)

- ✓ Change in eating and sleeping habits.
- ✓ Withdrawal from friends, family and regular activities.
- ✓ Violent actions, rebellious behavior, running away.
- ✓ Drug and alcohol use.
- ✓ Unusual neglect of personal appearance.
- ✓ Marked personality change.
- ✓ Persistent boredom.
- ✓ Frequent complaints about physical symptoms.
- ✓ Loss of interest in pleasurable activities.
- ✓ Not tolerating praise or rewards.
- ✓ Complaints about being “rotten inside.”
- ✓ Verbal hints, such as “I won’t be a problem much longer.”
- ✓ Giving away favorite possessions, or other signs of putting affairs in order.
- ✓ Sudden cheerfulness after a period of depression.

clinical depression; half have Conduct Disorders; up to 45 percent have Attention-Deficit/Hyperactivity Disorder (ADHD). Many have multiple diagnoses.

- Between one and six percent have Schizophrenia and other psychotic disorders, a rate significantly higher than that of the general population.
- Up to 19 percent of youth involved in the juvenile justice system may be suicidal (See sidebar: Warning signals of teen suicide, page 10.)
- At least half of the youth with mental illness in the juvenile justice system also have a co-occurring substance abuse disorder, according to Joseph J. Coccozza, director, National GAINS Center for People with Co-Occurring Disorders in the Justice System. In effect, what many of the adolescents are doing is self-medicating for untreated mental health problems.

“It’s tragic. If you are a young person and mentally ill, you have to get arrested to receive treatment.”

- Many youth in the system have what experts refer to as dual diagnosis (e.g. depression and a developmental disorder; ADHD and learning disabilities.) This combination makes recognition and treatment especially challenging.

Despite these disturbing numbers, the role of mental illness in delinquency has generally gone unacknowledged. The overriding public perception is that teenagers commit crimes because they are without morals or discipline. But the reality is much more complicated. As Michael Faenza, president and CEO of the National Mental Health Association, points out: Like Thomas, many of the children and adolescents in the nation's juvenile justice system have mental and emotional health problems "that remain untreated, even though they contribute to the youth's delinquency."

The Story of Thomas: His Early Years

This was true for Thomas. For much of his childhood, his mental health disorder went undiagnosed and untreated. Complicating the situation, he was the product of a broken home plagued by poverty and disorder. His mother struggled to raise him and a younger brother the best she could, but she was weighed down by her own mental health problems.

Over the years, an occasional teacher would become concerned about Thomas' increasingly disruptive behavior and poor academic level. However, the compassionate but untrained and haphazard attempts to help the boy and his mentally ill mother were regarded with suspicion and then rebuffed.

The county social service/mental health system did little better. Thomas' hometown – Santa Clara County, California – had once been known as "Santa Claus" county for the largesse with which it delivered services. But after years of cost cutting, the county had come to resemble so many other jurisdictions around the country. As elsewhere, prevention and **early intervention** programs were sparse and fragmented. The kind of community-based, coordinated, cross-system programming that would have identified and treated a boy like Thomas had all but disap-

peared. In the early '90s, when the local economy was in recession, supervisors closed a 54-bed juvenile psychiatric care unit in the county hospital, leaving 1.5 million residents without a publicly accessible **residential treatment center** for juveniles.

The bottom line: For Thomas, the public social service and mental health systems acted like overwhelmed relatives. When a crisis hit, the family was bounced back and forth between systems. A mental health worker would be involved with the family one week, then absent for years. A well-meaning social worker would rush in with some patchwork services to get the family stabilized, and then disappear.

**By their nature, short-term
detention facilities are not
designed to be surrogate mental
health centers.**

Eventually, Thomas' trajectory mirrored that of so many youth around the country with unacknowledged and untreated mental health disorders. He reached adolescence and broke the law. Like most youth who wind up in juvenile hall, his crime was not a violent one.

Christine Siegfried, senior community mental health consultant for the National Mental Health Association, sees this tragic pattern time and time again. "If communities were equipped to deliver high quality mental health services to children, many young people would have their problems addressed before their behavior results in juvenile court involvement."

A research paper prepared for the Center on Crime, Communities and Culture concurs that mental illness has become increasingly “criminalized.” “Jails are becoming America’s new mental hospitals. Mentally ill offenders are often jailed because community-based treatment programs are either nonexistent, filled to capacity, or inconveniently located. Police report that they often arrest the mentally ill when treatment alternatives would be preferable but are unavailable.”

Youth suicide in juvenile detention and correctional facilities occur four times more often than youth suicide in the general public.

As Judge Hal Gaither of the Dallas County Juvenile Court summed up in an article in the *New York Times* (Butterfield 1998), “It’s tragic. If you are a young person and mentally ill, you have to get arrested to receive treatment.”

For Thomas, The Possibility Of Help

In Thomas’ situation, it was certainly appalling that he had to be charged with a crime in order to be diagnosed with a mental illness. But maybe, there was a bright side to his arrest. Finally, he would be seen as not just a “bad, incorrigible kid,” but as a complex youth with mental health issues who needed individualized treatment. His probation officer, the attorneys and the judge all agreed that Thomas was not so much a danger to public safety as a danger to himself.

Under ideal conditions, the time a youth like Thomas spends in a detention facility can be used wisely and productively. The hiatus gives the boy time away from the chaotic streets. A physician takes the opportunity to stabilize his mental condition and provide a thorough evaluation of his medical and emotional needs. Medication certainly has the potential of bringing relief to youth suffering from mental illness. But had Thomas been getting the right medications? Was his dosage too low or too high? Did he need medication at all?

At the time of Thomas' stay, the Santa Clara County Juvenile Hall was generally regarded as a decent detention facility. For the most part, procedures were followed and the staff was friendly to Thomas and as caring as they could be with so many other charges. Yet when it comes to dealing with mental health problems, even a well-run juvenile hall is far from ideal.

By their nature, short-term detention facilities are not designed to be surrogate mental health centers. They are not equipped to handle the increasing number of fragile and volatile youth coming under their roofs. At best, services are sketchy. The line staff, even those with good intentions, have not received the kind of intensive mental health training that would equip them to recognize symptoms or deal effectively with formidable emotional needs.

In detention centers around the country, mental health care—if there is any—typically comes via a local mental health provider or public mental health agency with an outreach program. Youth are frequently seen quickly and en masse. While these youth present some of the most complex symptoms and behaviors known to mankind, they are often assigned to mental health workers with minimal experience, sometimes interns working towards their credentials.

“Institutions limp along without cohesive treatment philosophies and mental health staff typically exhaust themselves treating the few ‘mad’ residents while the other staff members are left to control the rest of the ‘bad’ residents,” explains nationally-recognized juvenile justice consultant Margaret Beyer.

One veteran staffer at the Santa Clara County facility describes his place of employment as feeling “like a psych ward some days. We don’t have any special training on how to deal with psychotic behavior or how medication works. We do have mental health people here who work so hard. They put in very long days. But they do interviews with the kids. They bring up bad issues and the kids get very upset. And then they bring them back to the unit, where we have to deal with them. We just don’t have that kind of skill.”

Clearly, Thomas was beyond the reach of staff in this kind of temporary setting. But finding a meaningful long-term placement for even a routine juvenile offender is often complex and time-consuming. The opening in a group home does not become available when it is supposed to; papers a judge must sign are late getting to her chambers.

Therefore, finding a suitable placement for a youth with serious mental health problems is “the single, greatest problem that we face,” according to Shirley Cantu, the Santa Clara County Juvenile Hall superintendent when Thomas was in custody. “These kids have diagnosable mental health problems and are acting out. This setting is not appropriate. They need therapeutic placements, but there are very, very few facilities available.” Professionals around the country echo her frustrations.

So Thomas became one of thousands of youth inappropriately detained in a detention facility. He was stuck in limbo, going through a routine that is

designed to control youth, not treat them. A day passed. And then a week. And then a month.

Depressed then agitated, Thomas began fighting with other residents. For the safety of himself and others, he was locked down in his cell more and more often. Staff kept promising that he would be leaving soon, but children and adolescents do not have the same sense of time and tolerance for being alone as do adults. For Thomas, the days between promises seemed to grow longer. The isolation made him more and more despondent.

But one Saturday, Thomas' unit supervisors noticed that his spirits had improved considerably. Suddenly, he was happy and joking around with the other residents. Staff had no idea why Thomas' spirits had risen, but it was a big relief.

Thomas was in his cell when he heard voices in the hall saying that a counselor had brought in candy. He yelled out in a joking manner: "Hey, what about me?"

"You'll get your share," the counselor promised. "I'll come by with it later on."

The counselor left to perform a few duties. Seven minutes later, he returned to Thomas' room with the candy. He looked through the meshed glass window.

The boy was hanging by his neck, his bed sheet ripped and fashioned into a noose.

By the time the frantic counselors got Thomas down, his heart had stopped. They performed CPR and managed to get his heart started.

Thomas' life was saved. But, in reality, his life is over. Today, Thomas remains on life support, his brain damaged beyond repair.

The Legacy of Thomas

The story of Thomas is a horrifying one. But it is a story that must be heard. How else can we learn from it and take steps to keep it from being repeated?

Luckily, such tragedies do not happen every day. And yet every day, there are thousands and thousands of other smaller, quieter tragedies.

Every day, according to the National Mental Health Association, only one-third of youth who need mental health interventions receive them.

As a result, their mental illness worsens. Those facing legal charges—commonly only minor, non-violent offenses—are inappropriately detained for long periods of time in secure juvenile justice facilities (National Mental Health Association 2000).

Every day, inside these locked facilities, youth with mental illness are being neglected, mishandled, even abused. For instance:

- Seventy-five percent of our nation's confined juveniles are in facilities that fail to conform to even the most basic suicide prevention guidelines, according to the OJJDP. This is a terrible oversight, considering that more than 11,000 boys and girls engage in more than 17,000 incidents of suicidal behavior in juvenile facilities each year. Youth suicide in juvenile detention and correctional facilities is more than four times greater than youth suicide in the general public, according to a study by J. Memory (1989) which was cited in a recent article by Lindsay M. Hayes, assistant director of the National Center on Institutions and Alternatives.
- An increasing number of youth in the justice system are receiving medication for their mental health needs. Yet, every day, medica-

tion is being misused. The result can be that youth are given no medication or ineffective dosages. Or, youth are over-medicated into lethargy as a quick and reliable form of

“One child in a boot camp was punished for making involuntary noises that were symptoms of his Tourette’s [disorder].”

behavior control. “Medication helps some kids get through the system, but we are not dealing with their underlying issues,” says Michael Green, a supervising probation officer in California. “So, when they age out at 18, you’ve got a young adult on meds who has the same issues he or she had when they first appeared in court because no one has worked with them in any meaningful way.”

- In the name of “safety” or “discipline,” youth with mental illnesses are being placed into restraints or locked into isolation cells for extended periods of time. Reports from around the country confirm a scandalous pattern:
 - ✓ In Georgia, the U.S. Department of Justice found that youth have been disciplined for manifestations of their mental illness, restrained, hit, sprayed with pepper spray, involuntarily injected with psychotropic drugs, and shackled to beds or to toilets. (Since

the February 1998 finding, the state signed a Memorandum of Agreement to improve facility conditions and quality of services. The most recent findings by a federal monitor conclude that there have been improvements, but there are still many areas of concern, including the use of force and the quality of mental health care.)

- ✓ A lawsuit filed this year by the Youth Law Center alleges that youth in a North Dakota facility who are suffering from severe depression and suicidal ideation have been subjected to unreasonable bodily restraint, and arbitrary and excessive isolation.
- ✓ According to an article in the Orlando (Florida) Sentinel, a 12-year-old, 65-pound boy with a 7-year history of mental illness was suffocated when a counselor at a state-contracted juvenile justice facility pinned him to the floor to restrain him. The National Alliance for the Mentally Ill (NAMI) complained that the death was not an isolated incident, but an indication of a larger pattern of mistreatment of the state's mentally ill youth.
- ✓ According to Faenza and Siegfried of the National Mental Health Association, "Staff in juvenile facilities fail to recognize, and in fact, punish them (incarcerated youth) for, the symptoms of their disorder...Children have been beaten by guards or shot with stun guns in efforts to control their behavior...One child in a boot camp was punished for making involuntary

noises that were symptoms of his
Tourette's [disorder]."

"It's the most bizarre kind of 'treatment,'" emphasizes nationally-recognized juvenile justice consultant Paul DeMuro. "In the name of 'suicide prevention,' we lock up a depressed, alienated kid for days on end. When a kid doesn't stand in line, he's a problem. So we restrain him to teach him discipline. But the problem is, that kid can't stand in line. It's part of his illness that he can't stand in line."

Every day, we have an opportunity to make sure that youth with mental illnesses are not treated with such wanton disregard. If we move backwards through Thomas' path, we can see so many potential points of contact, so many missed chances to make a difference in his life. We must ask ourselves:

Where would Thomas be today if he had not languished untreated in a crowded juvenile hall? If the staff had been better trained to recognize symptoms? If he had been moved quickly to a more appropriate setting?

**Emotionally fragile teenagers
quickly learn to emulate their
most aggressive and difficult
peers.**

Where would Thomas be if he had not been incarcerated at all, but had received comprehensive, individualized mental health treatment in his own community?

Where would Thomas be if he had not been

bounced between systems? If there was effective collaboration between mental health, social services and juvenile justice?

Where would Thomas be if he had been diagnosed in early childhood and received support as soon as his symptoms began to manifest?

Where would he be if his family, teachers, neighbors, community groups and faith communities were plugged into a network that could help them help Thomas?

Where would Thomas be today if he had been empowered to help himself?

If the life of a suicidal boy can serve some greater

RISK FACTORS FOR CHILDHOOD MENTAL ILLNESS

(Substance Abuse and Mental Health Services Administration)

- ✓ Genetics.
- ✓ Chemical imbalances in the body.
- ✓ Damage to the central nervous system, such as a head injury.
- ✓ Exposure to environmental toxins, such as high levels of lead.
- ✓ Exposure to violence, such as witnessing or being the victim of physical or sexual abuse, drive-by shootings, muggings or other disasters.
- ✓ Stress related to chronic poverty, discrimination or other serious hardship.
- ✓ Loss of important people in the life of a young person through death, divorce or broken relationships.

purpose, it must be to illustrate how many opportunities there are to reach youth with mental illnesses and their families. As a society, we must adopt a “No wrong door” approach. We must reach out whenever and wherever there is an opportunity to do so.

Beyond a Moral Obligation— Financial and Public Safety Ramifications

Providing youth with humane and effective mental health support—a full **continuum of care**, including prevention, intervention, treatment and aftercare—is clearly an ethical and moral imperative. It also makes strong financial and public safety sense. Taking care of youth *is* taking care of society.

Every year, Americans spend between \$10 and \$15 billion on the juvenile justice system, according to an American Youth Policy Forum publication. Unfortunately, the majority of our dollars do not go toward the least costly, most effective front-end prevention, intervention and treatment services.

By far the vast majority of our dollars are spent on the most costly, least effective “solution” to delinquency and mental illness, namely, incarceration in traditional, punishment-oriented large-scale facilities that have “all too often failed to yield the successful results we desire,” says Shay Bilchik, former administrator of the OJJDP.

Yet, this is where we continue to sink our tax dollars.

- According to *Mental Health: A Report from the Surgeon General*, roughly two-thirds of all dollars now spent on juvenile justice go to housing delinquent and mentally ill youth in costly lock-ups that provide little more than warehousing. For example, a youth prison with little or no mental health programming like the California Youth Authority costs

taxpayers \$37,000 a year per youth. That is more than room, board and tuition at Stanford University.

- Roughly one-half of all mental health dollars for minors pay for inpatient hospitalization, and another 25 percent is spent to place youth into residential facilities and group homes. The cost of Thomas' ineffective therapeutic lock-up? \$7,000 a month or \$84,000 year.

Such staggering price tags might be more understandable if the administrators could provide data that prove they get positive results. But here, the law of commerce perversely works in reverse. You don't get what you pay for.

According to U.S. Surgeon General David Satcher, 75 percent of youth treated in costly traditional residential mental health treatment centers were either readmitted to a mental health facility or incarcerated within seven years of release.

And virtually every study examining recidivism among youth sentenced to juvenile training schools in the past three decades has found that at least 50 to 70 percent of offenders were rearrested within one or two years after release, according to an American Youth Policy Forum report.

To anyone who has ever set foot in such institutions, the reason is apparent. Warehousing in large, impersonal, often abusive facilities can not improve mental health. Discipline by staff can be harsh and inflexible. Youth spend their waking hours ruled by gangs and fearful for their own safety. With little or no programming or recreation, the mind-numbing boredom causes stress levels to soar. Emotionally fragile teenagers quickly learn to emulate their most aggressive and difficult peers. These institutions are extremely "criminogenic," meaning they create criminals or exacerbate criminal behavior.

In such a tense, disheartening atmosphere, even youth who are admitted to the facility with a relatively clean mental health slate can quickly become depressed, aggressive, anxious, even suicidal. For youth with pre-existing problems, the result can be disastrous.

When youth grow up in this kind of milieu and are then released, their teenage problems become costly adult-sized problems. These are the people who populate the public mental health systems and county hospitals. Who wind up on the streets, drifting in and out of homeless shelters. Who are never able to work. Who depend on tax dollars to survive. These are the people who have children they cannot care for who, in turn, must be placed into the foster care system. These are the people who sometimes commit inexplicable crimes and who cycle in and out of local jails and prisons.

Every year, mental health disorders cost this country more than \$150 billion for treatment, social services, disability payments, lost productivity and premature mortality, according to the National Institute of Mental Health. That figure will continue

Frequently, youth of color, particularly males are misdiagnosed or not diagnosed at all.

to grow unless we make strong strides in reaching our most vulnerable citizens. Public safety and public finances depend on it. When we fail, no one escapes the consequences.

The Most Vulnerable – Race, Gender, and Sexual Orientation

All youth with mental health problems are vulnerable. But the most vulnerable are those who are already living on the margins of society.

RACE

For youth of color, the situation is particularly chronic and severe. In jurisdictions across the country, minority youth are over-represented in the juvenile justice system at all stages, including arrest, detention, commitment to an institution and transfers to adult courts. Minority youth make up two-thirds of the population of public detention and long-term facilities. (OJJDP: Juvenile Offenders and Victims: 1999 National Report)

There have been many attempts to understand these disproportionate numbers. One partial explanation is that more youth of color wind up in the juvenile justice system because inequitably harsh social and economic conditions make them both more prone to developing mental illness and less likely to receive proper diagnosis and timely treatment.

Poverty, exposure to personal violence, pre-natal drug/alcohol exposure, witnessing community and/or family violence, being subjected to racism, being exposed to environmental hazards (for example, lead poisoning) are all heavy risk factors (See Sidebar: Risk Factors of Childhood Mental Illness, page 22.)

For example, the loss or death of a loved one puts any youth at risk of developing mental health problems. By the time an American Indian youth living on a reservation is nine years old, he or she has, on average, seen the death of three to five people close to him or her. The resulting despair can trigger severe and persistent depression, according to American

Indian activist Rick Thomas. It should come as no surprise then that the suicide rate for American Indian youth is nearly three times higher than that of youth in the general population, according to the 2000 CJJ report, *Enlarging the Healing Circle: Ensuring Justice for American Indian Children*.

Frequently, youth of color, particularly males, are misdiagnosed or not diagnosed at all. Such youth may present what several mental health and juvenile justice professionals interviewed for this report refer to as an “aggressive tenor,” which means that they psychologically overcompensate for feelings of vulnerability, hopelessness, depression and anxiety. Often, assessment tools and untrained personnel perceive these young people as “threatening,” not mentally ill. Thus, they wind up in disproportionate numbers in confinement settings meant to control them, not treat them.

Dr. Jerome H. Hanley of the South Carolina Department of Mental Health, points out that public mental health services for youth of color are often unavailable until the youth is jailed or diagnosed as “severe.” “This policy limits services for the majority of children and adults who are poor and/or of color during the times at which they may be at risk or manifest early signs of behavioral/psychological problems that do not meet the criteria for SED (seriously emotionally disturbed), but are worthy of clinical intervention.”

The 1999 Surgeon General’s Report on Mental Health concurs that our “systems are not well equipped to meet the needs of racial and ethnic minorities.”

But why? Why are youth of color so poorly served at every step—from prevention to diagnosis to treatment to aftercare?

In many cases, services are simply not available. A number of factors, including societal indifference, make them easy targets for budget cuts.

In other cases, available services are so far from the community and schools, so steeped in bureaucracy and difficult to access, they might as well be non-existent.

Even when support is available, it can be a challenge to get people to accept it. Some members of minority groups are raised with the notion that it is shameful to seek help outside the immediate family. In these tightly-knit units, mental health workers are seen as intruders. In some communities, social workers have the reputation of not coming into the home to help, but to snoop and gather information for taking children away.

Mental health services especially can have a negative social stigma attached to them. In some communities, clinics are seen as being synonymous with the state hospital, which is where “crazy” people are sent.

Before accepting services, many minorities must overcome an ingrained, and sometimes valid, fear of government. Mental health and juvenile justice experts interviewed for this report have cited that African Americans, for example, report a strong distrust of government authority. Recent immigrants or those in the country without proper documentation are often wary of seeking help. Mental health workers ask personal questions and fill out forms just like immigration officials. Seeking services can be perceived as risking deportation or otherwise damaging tenuous legal status.

Far too often, available treatment does not “speak the language” of a particular culture, both literally and figuratively. For example, Mexican Americans and other immigrant groups have historically shown low rates of use of mental health services due to language differences (National Mental Health Association 2000).

Service providers often do not understand and have empathy for the youth's tradition, history, family and community structure. They do not embrace the style of communicating, the subtleties and specific needs of a minority youth. They are not trained to see that these cultural "differences" are often strengths that can be used to empower a youth, his family and community.

As Marva P. Benjamin, director, Cultural Competence Initiative, National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center, emphasizes: "Social scientists have paid little attention to the unique developmental issues of children from these populations. Educators have demonstrated little understanding of their special needs, and mental health professionals have expressed little awareness of their special problems."

All told, racial and ethnic minorities have been – in the words of researcher J.T. Gibbs – "mislabeled

BEHAVIOR OF SEXUALLY ABUSED CHILDREN MAY INCLUDE

(American Academy of Child and Adolescent Psychiatry)

- ✓ Unusual interest in or avoidance of all things of a sexual nature.
- ✓ Sleep problems or nightmares.
- ✓ Refusal to go to school.
- ✓ Delinquency.
- ✓ Unusual aggressiveness.
- ✓ Aspects of sexual molestation in drawings, games, fantasies.
- ✓ Secretiveness.

and miseducated by the schools; mishandled by the juvenile justice system, mistreated by mental health agencies and neglected by the social welfare system.”
For example:

- Incarcerated African American adolescents are less likely than their white counterparts to have previously received mental health services (Marsteller, 1997).
- It has been difficult to develop and implement financially feasible and culturally-sensitive screening and **assessment** tools. Therefore, it is hard to make meaningful and equitable adjudication, treatment and placement decisions (e.g. which youth would benefit from at-home mental health services and which youth should be locked up for public safety reasons) (Benjamin 1999).

“When girls are angry,
frightened, or unloved, they are
more likely to strike inward.”

- Upon arrest, young American Indian offenders living on reservations can be confined in facilities hundreds of miles away from their tribes. This disconnects them from loved ones at a time when emotional support is crucial for their emotional well-being (Coalition for Juvenile Justice).
- Because of the shortcomings and failures of the juvenile justice system, youth of color are therefore less likely to undergo a thorough psychological assessment and less likely to

receive therapeutic treatment, according to the National Mental Health Association.

GENDER

Girls are another vulnerable population. This is particularly important to consider since more and more teenage girls are being arrested and incarcerated than ever before. As they enter the system, they bring with them myriad complex mental health issues.

- In general, multiple studies have shown that girls have a higher incidence of Depressive Disorder than boys do. They experience more low esteem, more eating disorders, like Anorexia Nervosa and Bulimia Nervosa, and are more likely to practice self-mutilation and to attempt suicide (Green, Peters & Associates).
- Nearly 60 percent of female juvenile offenders had symptoms that were diagnosed as an Anxiety Disorder, as compared to 32 percent among boys, according to a study cited by the National Mental Health Association (Marsteller 1997).
- In another study, researchers concluded that nearly half of incarcerated girls meet the psychological criteria for **Post-Traumatic Stress Disorder (PTSD)** (Cauffman 1998).
- More than half of young women in training schools [large scale correctional facilities for juveniles] have reported attempting suicide; of those, 64 percent have tried more than once to kill themselves (Bergsman, 1994).
- Substance abuse among girls is particularly severe. A study by the American Correctional Association cited by Girls Incorporated (1996) found that 60 percent of girls in state training schools need substance abuse treatment as

well as mental health treatment. Experts conclude that many of these young women use illegal substances in an attempt to cope with feelings of stress, anxiety and depression.

These figures are clearly alarming. Yet, little attention and emphasis has been given to the specific mental health needs of adolescent girls. As researcher Dr. Sheila Peters emphasizes in *Guiding Principles for Promising Female Programming* (Greene, Peters & Associates), “Boys commit the overwhelming number of juvenile crimes and their offenses tend to be more violent and dangerous than the status offenses most girls commit. It’s no wonder, then, that female delinquents have been overlooked and neglected by a system engineered to help troubled boys become law-abiding men.”

Why is this? Why don’t girls fit neatly to the already established system?

The answer is that developmentally, girls are different than boys. For instance, they have different communication styles and experience different psychological, physiological and societal routes into adulthood.

As such, girls are subjected to unique gender-specific risk factors that can derail their mental health development and eventually lead them into delinquency. Girls, for example, are three times as likely as boys to have been sexually abused, according to the U.S. Department of Health and Human Services (1996). Sexual abuse has long been acknowledged as an underlying factor in mental health disorders and correlated with increased truancy, low self-esteem, inability to trust, eating disorders, prostitution, violence, gang-related activities and substance abuse. Among girls in the justice system, research consistently shows that “over 75 percent have been sexually abused and in trying to escape the abuse, they often

become labeled as delinquent,” according to a GAINS Center report (Prescott 1997) (See Sidebar: Behavior of Sexually Abused Children, page 29.)

Yet over and over, when it comes to getting support and services, girls fall through the cracks, often because their uniquely “female” behavior is misread and/or not taken into consideration. The neglect runs throughout the system from a lack of gender-specific research, prevention, diagnosis, treatment and after-care.

- Early signs of mental illness frequently go unrecognized and unaddressed, which puts girls at great risk of future delinquency. Unlike boys who typically act out and get attention by aggressive acts, girls are more likely to internalize their frustrations. “When girls are angry, frightened, or unloved, they are more likely to strike inward. They may hurt themselves by abusing drugs, prostituting their bodies, starving or even mutilating themselves,” according to researcher Joanne Belknap. This behavior makes them appear to be less of a threat and thus easier to overlook

Gay youth talk of therapists who try to “cure” them of their sexual orientation.

in crowded schools and stressed communities.

- The legal system often treats female offenders more harshly than boys because there are fewer community-based services for them and fewer placement options, particularly for girls with mental health problems. As a result,

detention typically lasts five times longer for girls than for boys (Girls Incorporated 1996).

- Within facilities, mental health screening and assessment tools have traditionally been geared to boys. A girl's warning signs can easily be overlooked. A GAINS Center report emphasizes that females in the system are rarely asked "specific questions about issues relevant to adolescent girls. The lack of sensitive and uniform assessment...sends an implied message to girls that they are better served by remaining silent."
- When they do receive treatment, girls are typically squeezed into mental health programs designed for young men. Therefore, gender-specific issues, such as sexual abuse, pregnancy, promiscuity and self-abuse, are not addressed in any meaningful fashion.
- Such male-centered programs also fail to take advantage of and build upon female "strengths," (e.g. the high value that girls place on verbal communication and emotional relationships).
- Institutional policies and procedures can frequently worsen existing mental health problems. For behavior control, girls may be surrounded, restrained and then strapped to their beds spread eagle by a group of male staff. In the name of suicide prevention, girls may be forced to disrobe in front of male staff. Given the high history of sexual abuse, such insensitive "interventions" can mirror previous rapes or incest and escalate pre-existing feelings of shame, humiliation and vulnerability.

Ignoring the unique gender-specific needs of female adolescents has long-term consequences. As

researcher Belknap sums up: “Warehousing ...usually results in them being in and out of court, prison, and mental health systems for a good portion of their lives—and warehousing costs a lot of money. More importantly, this warehousing “breeds” crime. These girls often have children at some point and their children are usually placed in foster homes or relin-

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Parents of mentally ill youth can be left with essentially only three paths: “Beat ‘em up. Lock ‘em up. Give ‘em up.”

.....

quished for adoption, or are moved about from one “home” to another...in turn, placing these children at risk for offending.”

SEXUAL ORIENTATION

The situation is also disturbing for gay, lesbian, bisexual and transgender (GLBT) youth. Among the general population, 80 percent of such youth report a high level of social and emotional isolation, for no other reason than society’s perception and rejection of their sexual orientation. A study published in the May 1998 edition of the journal *Pediatrics* found that gay and bisexual youth “were more likely than their straight peers to have been victimized and threatened.” Half report parental rejection because of their sexual orientation.

This isolation and harassment put GLBT youth at greater risk of developing mental health problems, according to Dr. Rob Garofalo, lead author of the study. Delinquency, risky sexual activity, suicide

attempts and suicidal thoughts are all more prevalent among GLBT youth than in their straight counterparts.

“The study doesn’t mean that gay kids are inherently pathological,” Garofalo said. “It has to do with

WARNING SIGNS OF MENTAL ILLNESS AMONG YOUTH

(Substance Abuse and Mental Health Services Administration)

- ✓ Sad and hopeless without good reason and the feelings don’t go away;
- ✓ Very angry most of the time; cries a lot or overreacts to events;
- ✓ Feels worthless or guilty a lot;
- ✓ Extremely fearful;
- ✓ Constantly concerned about physical problems or physical appearance;
- ✓ Does much worse in school;
- ✓ Wants to be alone all the time;
- ✓ Daydreams and can’t get things done;
- ✓ Inability to sit still or focus attention;
- ✓ Thoughts that “race”;
- ✓ Persistent nightmares;
- ✓ Need to wash, clean things or perform certain routines hundreds of times a day;
- ✓ Uses alcohol or other drugs;
- ✓ Eats large amounts of food and then makes self vomit;
- ✓ Does things that are life threatening.

the social rejection they experience. That’s what puts them at risk.”

This is where social service/mental health services are supposed to step in with support that could curb more chronic mental health and delinquency problems. Yet, GLBT youth are often rejected and disenfranchised by the very agencies that should be serving them. Gay youth talk of therapists who try to “cure” them of their sexual orientation. Those who live in group residential settings and juvenile halls routinely complain of physical and verbal harassment by other youth and even staffers, and that the counseling and other services are virtually worthless because they either ignore or criminalize the youth’s sexuality.

Kevin TeCarr, a staffer at the Gramercy Residence, a residential group home for GLBT youth in New York City, sums up the situation. “Gay kids have a very hard time accessing any services. There’s often too much of a stigma for them to get help at a place that isn’t gay friendly.”

Economics – The Public System and the Repercussions of Managed Care

Economics also play a decisive role in whether or not a youth gets timely and significant mental health support. Children who live in poverty and children of the working poor are dependent on a fragmented and under-funded public system that typically fails to provide them with safety nets.

Accessible prevention and intervention services are scarce. At local mental health clinics, waiting lists are long and there are shortages of doctors and therapists. Children who are lucky enough to get an appointment are often not given a comprehensive assessment and an appropriate treatment plan and follow-up.

Just figuring out if a youth is covered under a

particular federal or state insurance plan can be a daunting task. Some parents do not speak English or are intimidated by bureaucracy or are unskilled in navigating through the morass of paperwork. As Robert Bernstein, executive director of the Bazelon Center for Mental Health Law explains: “Although, under Medicaid law, children are eligible for all appropriate care (physical and mental conditions), the lack of specificity in many state rules makes it very hard for families to access many critical services, or even to know that their child has such coverage.”

But it is not only youth who are dependent on the public system who cannot get the services they need. Youth with private insurance are also being denied comprehensive coverage.

Managed care providers have stringent rules, guidelines and restrictions about mental health treatment. Inpatient hospitalization and the number of outpatient sessions are limited. Co-payments are frequently hefty, four or five times the amount paid to see a primary care doctor or a medical specialist. Since the managed care system is structured around “curing” and “reducing symptoms,” many early warning signs are often not considered “serious enough” to qualify for treatment. Certain mental health problems are not covered at all.

One middle-class mother of a teenage boy diagnosed in kindergarten with ADHD talks with frustration about the time her employer switched HMOs. The new plan quickly paid for her son’s medication, but rejected her request for counseling sessions. ADHD was not covered, despite previous success with the medication-therapy combination.

So what happens if this parent cannot afford to pay for therapy? What happens if her son becomes increasingly disruptive or aggressive and she can no longer control him?

He could wind up in the public mental health system. Or perhaps, his behavior could land him in the juvenile justice system. As Shay Bilchik, former administrator of the OJJDP, points out in an article in Focal Point Bulletin: Managed care presents some “new and yet unknown challenges. If managed care restricts availability of mental health services, placement facilities in the juvenile justice system would receive substantially more referrals without the benefit of adequate treatment.”

Some advocates lament that distraught parents of

Early screening often means that a youth can be diverted into a safer and more appropriate mental health setting.

mentally ill youth can be left with essentially only three paths: “Beat ‘em up. Lock ‘em up. Give ‘em up.” Faced with these untenable options, some parents have chosen to voluntarily give up custody of their children to the child welfare or juvenile justice systems in hopes of getting them help.

Says Laurie Flynn, former executive director of NAMI: “Families struggle on the brink of disaster, facing unimaginable, but very real risks of family dissolution, financial bankruptcy, wrongful imprisonment, or giving up custody of children just to get them treatment.”

According to a 1999 national survey conducted by NAMI:

- ✓ 36 percent of survey respondents said their children were in the juvenile justice system because mental health services outside of the system were unavailable to them.
- ✓ 23 percent of parents were told that they would have to relinquish custody of their children to get needed services.
- ✓ 20 percent said that they actually relinquished custody to get services.

This practice must be stopped. Giving parents no option but to relinquish custody has severe social and economic consequences. It wastes public funds by forcing children into foster care and expensive mental health and juvenile justice residential placements. It also leads children to feel abandoned, often creating irreparable damage in the bond between youth and family and thus, worsening the child's mental health forecast.

Positive Steps for the Future – Better Understanding, Better Treatment

Despite the pervasiveness of mental illness in this country, the picture is not an entirely grim one. Today, we, as a society, are moving towards a clearer and more sophisticated understanding of the underlying causes. Researchers tell us that mental illness is sometimes the direct result of biological factors, such as genetics, chemical imbalances, prenatal exposure to alcohol and drugs and/or damage to the central nervous system, as in the case of a head injury.

In other cases, physical and emotional environmental factors—such as exposure to high levels of lead, the stress of poverty, exposure to childhood violence and the loss of loved ones through death or divorce—can put young people at extra risk. In many cases, the “cause” is a mixture of both (See sidebar: Warning signs of mental illness among youth, page 36.)

As our understanding of the causes of mental illness has evolved, so has our understanding of treatment. For example, an enormous amount of research has gone into new pharmaceuticals that, if used judiciously, offer great potential to ease suffering.

There is no doubt that we are at the beginning of what is sure to be a long journey. But for at-risk youth and those who have already come in contact with the juvenile justice system, we are seeing—if not giant steps—then some small, steady progress in a number of areas.

The good news: Overall, the mental health needs of youth in the juvenile justice system have “received more attention at the federal level in the past two years than in the past three decades combined,” according to Joseph Cocozza of the National GAINS Center. For instance: The U.S. Department of Health and Human Services’ Center for Mental Health Services initiated the first national survey of juvenile justice facilities to identify mental health services.

We must continue these positive steps. The first one – recognition – is crucial. Youth who suffer from mental illness have traditionally been difficult to target, especially in a crowded juvenile detention setting. Adult staffers are often busy and frequently untrained in developmental, racial, gender and sexual orientation differences. As such, they can easily miss clues and misjudge a youth’s state of mind.

To this end, new, easy-to-use, cultural and gender sensitive screening tools have been developed and are being put into use. One example, the Massachusetts Youth Screening Instrument (MAYSI), is a simple list of 52 questions that can be scored and interpreted quickly by juvenile hall staff without a lot of training or expertise in mental health. So far, the results—targeting suicidal youth and others with serious mental illness—have been impressive. Early screening

often means that a youth can be diverted into a safer and more appropriate mental health setting.

“Staff can’t always pick up things just by talking to a kid or watching his behavior,” says Dr. Thomas Grisso, who developed the tool. “Child disorders often don’t look like adult disorders. For example, in adult depression, you are dragging, seeing the world in black and white. But with kids, depression often doesn’t look like depression. They look angry, but the anger you see is the depression.”

In the area of treatment, juvenile justice and mental health professionals have a good idea of what doesn’t work. As single-solution, one-shot “treatments,” traditional incarceration, home confinement, unstructured counseling, “scared straight” programs, wilderness programs and boot camps are typically ineffective for mental illness. In some situations, they can actually worsen mental illness and produce a higher recidivism rate than no treatment at all.

Researchers do point with enthusiasm to many innovative models that show success in terms of clinical effectiveness, cost and public safety. Among youth who receive structured, meaningful, and sensitive treatment, recidivism rates are 25 percent lower than those among untreated control groups. The most successful programs reduce recidivism up to 80 percent (National Mental Health Association 2000).

Promising models are described below:

- Multisystemic Therapy (MST) is an intensive family-and-community based treatment that addresses the multiple factors of serious antisocial behavior in juvenile delinquents, including those with mental health disorders. Therapists with small caseloads work intensively with parents to empower them with the skills and resources to raise a difficult, chal-

lenging youth. They also empower youth to cope with their own disabilities, their family, peers, school and neighborhood problems. A recent report from the Center for the Study and Prevention of Violence, *Blueprints for Violence Prevention*, concluded that MST was the most cost-effective of a wide range of intervention programs aimed at serious juvenile offenders. (For an in-depth look, see Inside Look: Youth Villages, page 45.)

- Functional Family Therapy (FFT) is an “outcome-driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out behavior and related syndromes.” The treatment, which utilizes probation officers and mental health professionals, requires as few as eight to 12 hours of direct service and typically no more than 26 hours for the most severe situations. At a cost of \$1,350 to \$3,750, FFT has demonstrated positive outcomes in, among other things, effectively treating youth for various mental illnesses and preventing adolescents from entering the adult criminal system.

“Child disorders often don’t look like adult disorders.”

- Multidimensional Treatment Foster Care (MTFC) is another cost effective alternative to group or residential treatment, incarceration and hospitalization for adolescents with chronic antisocial behavior, emotional disturbance and delinquency. Community families

are recruited, trained and supervised to provide adolescents with treatment and supervision at home, in school and in the community. When compared to a control group, MTF youth spent 60 percent fewer days incarcerated; had significantly fewer subsequent arrests; ran away from their programs, on average, three times less often; had significantly less hard drug use. The cost? \$2,691 per month for an average seven months enrollment in the program.

- SAMHSA's Center for Substance Abuse and Prevention touts several model programs including the Residential Student Assistance Program, a demonstration project in Westchester County, New York, that has dramatically reduced substance use (alcohol use fell 72.2% and marijuana use fell 58.8%) among institutionalized adolescents. Facilities in the project included a residential treatment center for adolescents with severe psychiatric problems, a locked county correctional facility and a non-secure residential facility for juvenile offenders.
- The National GAINS Center applauds the state of Colorado for breaking down unnecessary barriers between agencies and systems to bring together representatives of juvenile justice agencies with other providers of services for youth to form an integrated network of care. The network includes state and local agencies involved in mental health services, juvenile justice, substance abuse treatment, public education, family advocacy, employment training and pro-social activities. Among other things, the agencies have collaborated to develop and implement mental health screening and to form a co-

occurring disorders task force for juvenile offenders (GAINS Center 1999).

Many of the promising models are founded on the same premise: Youth have a better chance of success when receiving help and treatment in the least restrictive, most appropriate setting, particularly within the context of their communities and families. However, for many reasons—the nature and severity of their crimes, lack of alternatives—many youth continue to be placed in institutions.

For such youth, it is essential that these settings do more than “warehouse” them. Given a cohesive treatment philosophy, a well-trained staff, and a strong aftercare component, meaningful treatment can take place behind locked doors.

- For example, the Coalition for Juvenile Justice’s 1999 Annual Report highlighted the intensive programming at the Giddings State School, operated by the Texas Youth Authority. The facility houses youth with an array of serious mental health issues. Yet, the facility boasts an extremely low recidivism rate. Of the 90 youth who have completed an intense 100-day specialized treatment program for capital offenders, only six have been rearrested for a violent offense, none for murder. Of the 262 youth who have completed the facility’s Sex Offender program, none have been rearrested for a violent sex offense. The overall statistics are equally impressive. The overall reoffense rate in 1998 was 18.5 percent.

What do these and other promising programs and models have in common? What can be learned from them? What is most effective in helping youth? Is there one “treatment” that always guarantees success?

To the last question, the answer is no. No one approach is going to be effective for every youth.

Human beings are social animals living in a web of interrelated causes and effects. Delinquency is rarely, if ever, the result of a single, isolated “cause.” Anti-social behavior springs from many factors that make up the life of a youth: his own psychology (e.g. mental health issues) and propensities, (e.g. drug use), his family (e.g. ineffective discipline, psychiatric conditions), his peer relations (e.g. association with deviant peers), his school (e.g. low achievement) and neighborhood (e.g. criminal subculture).

“Yet, the vast majority of traditional mental health treatment approaches focus on only one or two of these characteristics,” explains Scott W. Henggeler, director of Family Services Research Center, Department of Psychiatry and Behavior Sciences, Medical University of South Carolina. “If delinquency is caused by a multitude of factors, how can we expect effectiveness from treatments that only focus on one or two of these factors?”

Keeping that in mind, experts say that many effective mental health treatment programs share the following common characteristics:

- Highly structured, intensive and focused on changing specific behaviors.
- Emphasize the development of basic social skills.
- Provide individual counseling that directly addresses behavior, attitudes and perceptions.
- Sensitive to a youth’s race, culture, gender and sexual orientation.
- Use community-based treatment rather than institution-based programs.
- Involve family members in the treatment

and rehabilitation of their children.

- Coordinate care to “wrap” services, support and supervision around a child and family in an individualized way.
- Within institutions, use mental health professionals, rather than corrections staff as treatment providers.
- Offer developmentally driven services, that is, services that recognize adolescents think and feel differently than adults, especially when under stress.
- Strong aftercare component.
- A focus on measuring program effectiveness.
- A focus on quality implementation.

For this year’s report, we profile two programs with excellent track records. Both keep public safety and cost in mind, while helping youth with mental health issues return to their families and communities.

AN INSIDE LOOK

YOUTH VILLAGES



MEMPHIS, TENNESSEE

Youth Villages is a private, nonprofit organization with headquarters in Memphis, Tennessee and a staff of 700. Youth Villages provides a wide range of services tailored to the individual needs of youth and their families. Its programs include three residential treatment centers, group homes, **home-based counseling**, outpatient psychiatric services, an alternative school,

therapeutic foster care, an emergency shelter for homeless and runaway teens, transitional living program for youth aging out of state custody, community-based services and prevention services to prevent at-risk children from entering state custody.

MISSION: To treat children more cost-effectively and “buy a ticket home” by reuniting youth in state custody with their families.

HISTORY: Twenty years ago, a juvenile court judge asked Patrick Lawler, a juvenile hall detention monitor, to help a struggling residential center housing 24 youth get on the right track. Lawler thought there was no hope. Today, he heads the organization that serves more than 2,000 boys and girls each year in Tennessee, Mississippi and Arkansas. There are 24 locations in 13 mid-south cities. Most of the youth are referred to Youth Villages by the Tennessee Department of Children’s Services, which includes the juvenile justice system.

APPROACH: For the past several years, Youth Villages has incorporated the tenets of Multisystemic Therapy (MST) into most of their programs. “Although family problems can certainly contribute to delinquency behavior, parents are seen as the solution rather than as the problem,” says Scott Henggeler, who developed the system. “Therapists come and go, while parents have a 24-hour a day, lifelong commitment to their children.”

SUCCESSSES: Evaluations of MST have demonstrated reductions of 25 to 75 percent in long-term rates of rearrest; reductions of 47 to 64 percent in out-of-home placements, extensive improvements in family functioning and decreased mental health problems. Cost is \$4,500 per youth for approximately 60 hours of contact over four months.

KUDOS: Youth Villages has been awarded the highest level of accreditation from the Joint Commis-

sion on Accreditation of Healthcare Organizations, the nation's oldest and largest accrediting body. Recipient of the United Way of America Silver Excellence in Service Quality Award.

YOUTH QUOTE: “When I’d get depressed, I’d do stupid things. I would sit there on my own little stage. If anyone talked to me, I’d get aggressive. Now, I’ve learned to walk away. The counselors helped. They taught me coping skills. It seems I spent most of my teenage years in treatment centers. Now I’m hoping to see the outside world.” – Robert, age 17, resident of Youth Villages’ Dogwood Village

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On a warm, early spring day, the 40-acre campus of Dogwood Village (one of Youth Villages’ residential treatment centers) was bright with its namesake blossoms. Inside the cafeteria, boys and girls joked with each other while eating lunch. In the gymnasium, other kids burned off energy shooting hoops with a staff member. Nearby, at the on-site school, teachers were preparing youth for the day when they would be returning to public school.

Around the pristine campus are eight clean, pleasant cottages that serve as temporary homes to up

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“Each time I got arrested, I just did my time. There was no treatment or anything.”

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to 90 youth, ages 7 to 18. Most have been diagnosed with a **DSM-IV** mental illness. Most have long, involved histories of symptoms of Depressive Disorder, Conduct Disorder, ADHD. Many are aggressive;

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many have engaged in self-mutilation. Approximately 60 percent of the residents are on some kind of psychotropic medication. A great number have reported previous sexual and physical abuse within their families, which is why some have been removed from parental care and placed by the state in Youth Villages.

Steven, a 16-year-old boy with a remarkably polite manner of speaking, came to the attention of the courts because he acted out the chaos of his childhood. His parents broke up when he was a toddler. His father rarely saw the boy and his mother struggled with alcohol and mental health problems. In turn, Steven terrorized teachers and neighbors. He first came in contact with the law at age 10 when he was picked up by the police for disorderly conduct.

After that, his life, he says, was a whirl of arrests, stints in juvenile hall, property theft, a sentence of house confinement, breaking curfew, court dates, driving drunk, more juvenile hall, more arrests.

“Each time I got arrested, I just did my time. There was no treatment or anything,” he recalls. “I just got into fights with the staff and other kids. I watched a lot of TV.”

And then, at age 15, Steven hit the big time: aggravated arson and 23 counts of vandalism “for smashing up” a local business one night. “My friend and me did a lot of things that night.”

Steven went to court and there, finally, it was determined that he had mental health problems. Given his long record and increasingly aggressive behavior, he was seen as a danger to both society and to himself. He was placed into a high security, state-run psychiatric hospital. His mother was seen as a part of the problem and denied visiting rights.

“The whole time I was there, they never let me see

my mom. I was heavily medicated,” he says. “I was put into a solitary cell and only came out for showers. I’d start fighting, so they put me in restraints and left me that way for 7 ½ hours. They gave me shots of Thorazine and lots of other things. It must have been too much medication because I defecated and vomited all over myself.”

Youth Villages staff put an emphasis on trust, competence, and group interaction.

Steven had been in the psychiatric facility for 13 months when a juvenile court referee approached Patrick Lawler, administrator of Youth Villages, and said, “I need a favor. Can you take a boy out of that facility?”

Lawler recalls going to the hospital and seeing a heartbreaking scene: A 97-pound boy who had been drugged and forgotten. Lawler accepted Steven into the program. Youth entering Youth Villages are placed into housing most appropriate for their needs. It could be a relative’s home or a group home. It was determined that Steven needed the most therapeutic and secure setting. He was placed into Dogwood Village.

“Everyone thought that this was a boy who couldn’t function in society. They thought that he couldn’t ever be with his family because his family is hopeless,” Lawler says. “Well, in the five months that he’s been with us, he’s only been restrained once. He’s made enormous progress. And so has his mother. He has already been home several times on visits with great success. That’s what we’re working towards—getting him home.”

There are many who believe such a goal is impossible. Many would question Youth Villages' attempt to reunite a seriously troubled boy with a mother who is severely limited in her ability to parent. They would call such a goal naïve, misguided, even dangerous. This has been the prevailing philosophy of mental health treatment for almost two centuries: Remove the mentally ill from a "sick" family and treat them in isolation. After all, how can parents with their own problems ever hope to help a teenager? And wasn't it the parents' neglect and abuse that created Steven in the first place? Why should they be given another chance?

Lawler completely understands this mindset because, for many years, he believed it himself. Before coming to Youth Villages, he worked in juvenile probation and detention.

"For a long time, I thought the best thing to do was remove these kids from their families," he says. "I looked at what they came from—the chaos, the

“Every family is doing something right. And that’s what we focus on.”

confusion. I thought, we try to give them some stability. We try to give them some socialization. Then the child just goes right back into all that family craziness. It seemed pointless.”

But after poring over the research and more importantly, after 20 years of working with some of the most dysfunctional families that society has to offer, Lawler changed his mind: “Children used to grow up in Youth Villages. We used to be in the

business of raising other people’s children. Now, we are in the business of helping families raise their own children. The truth is, no matter what they look like, parents love their children. They want them home and the kids want to be home. I’m not saying that it is easy. We have to focus on the strengths—and every family has them. We have to understand all the systems and get them into play.”

To make this happen, when a youth is accepted into Youth Villages, he or she is typically assigned a counselor who conducts a family assessment to determine family strengths and to work with parents on issues which need to be addressed in order for the child to return home. Children who are placed into a residential setting are encouraged to write and to call their parents and family members regularly. In turn, when appropriate, families are encouraged to visit their children on campus and to become involved in their treatment.

While in Dogwood Village, each child also has a treatment team that meets regularly to measure progress. The family counselor is joined by a residential counselor, the school teacher, a representative of the nursing department and the teacher-counselor, who teaches the day-to-day life skills in the cottage. Psychiatrists, psychologists and other healthcare professionals are on call.

Providing effective treatment in a residential setting is particularly challenging. Adolescents everywhere succumb to peer pressure, even more so in a setting filled with “negative peers.” Therefore, at Dogwood Village, staff put an emphasis on trust, competence, and group interaction—the “nuts and bolts” of people living together.

This means that there is not a significant difference between “counseling” and what goes on hour by hour, day after day, at Dogwood Village. Each cabin

functions as a semi-autonomous group with the idea that children learn best from other children. For example, in a more traditional incarceration or residential setting, when a youth doesn't cooperate, he or she loses privileges or is put into isolation, restraints or solitary confinement. Here, such measures are used only as a last resort, when a child needs isolation to keep from harming himself or others.

More typically, when a youth isn't cooperating—say, if the youth curses at a staff member—the entire group stops its activity and comes together “in a huddle” to work the problem out. In this situation, the most “appropriate” consequence for the youth might be to find five alternative ways of expressing frustration and to apologize to the staff.

“A lot of the kids come from homes and settings where there have been very few boundaries,” explains residential program director Leo Coughlin. “So here, the day is very structured. There is an outcome designed for each activity.”

From the day a youth moves in, staff is working to move him out. The family counselor is working with parents. In cases where there is no viable parent, the counselor looks for immediate or extended family members who, with support, could be surrogate parents. Counselors also work extensively with the child's school, church, neighborhood, and other systems that can help the child leave faster, while also insuring public safety.

“It used to be that youth would be in residential treatment for two or three years,” says Lawler. “Now, those same kids are staying only four or five months.”

That doesn't mean that the program stops. After-care is crucial to success.

Eric, an extremely taciturn 16-year-old, came into state custody on a charge of aggravated robbery and

possession of an illegal substance. It was his first involvement with the legal system, but because of the seriousness of his crime and because he was diagnosed with Conduct Disorder, he was sent to a lockdown psychiatric facility. After two months, he was referred to Youth Villages, where he was placed in residential treatment.

During his seven-month stay, he improved his leadership skills and made a lot of progress, according to his counselor, Paul Enderson. “That’s not surprising. Home has often created the problem and kids can be very successful once they are removed. But that is only a start. Our job is to continue that success at home and in the community.”

With the judge’s permission, Eric was sent home with a program in place. “That helps the courts feel more at ease that the community is being protected,” explains Enderson. “We don’t take the place of a probation officer.”

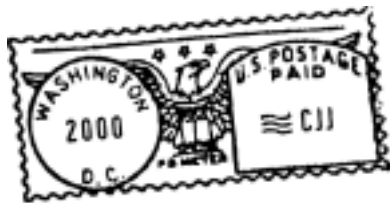
Eric and his family currently have access to a Youth Village counselor 7 days a week, 24 hours a day. Caseloads are kept intentionally small, typically four or five families per worker.

“When I first started working with Eric and his family, they wouldn’t even look me in the face,” Enderson recalls. “They are still resistant. They come from a culture that believes: We take care of ourselves and there’s nothing wrong here. At first, that was really troubling. But I’ve learned to respect that, learned to see it as one of the family’s strengths. They really stick by each other.”

For that and other reasons, Enderson has faith in the often long, often frustrating process. He sums up Youth Villages’ philosophy: “What gets me furthest with a family like this is making their goals become my goals. Every family is doing something right. And that’s what we focus on.”

AN INSIDE LOOK

WRAPAROUND MILWAUKEE



WAUWATOSA, WISCONSIN

Youth with mental health issues are often involved in more than one public system. A “Wrap-around” model formulates a single, individualized, child-centered, family-focused, community-based treatment plan that delivers services across the mental health, juvenile justice, child welfare and education systems.

GOALS: Address public safety needs, while minimizing out-of-home placements, supporting

families so they can function as autonomously as possible, building on family strengths, helping families access an array of services, coordinating care and delivering services in a cost-effective manner.

YOUTH SERVED: More than 600 youth with serious emotional disturbances who are under court order in the child welfare or juvenile justice system.

Of the delinquent population enrolled in the program, 97 percent have been diagnosed as **Conduct Disorder/Oppositional Defiant Disorder**. Most also have one or more co-existing disorders: Depression (58 percent); Attention Deficit (44 percent); serious alcohol and substance abuse problems (42 percent). One in eight youth have attempted suicide. A substantial number of the parents also have one or more mental health issues: 50 percent have significant substance abuse problems, 33 percent have histories of domestic violence and 22 percent of parents have documented mental illness.

STRUCTURE: Care coordinators with small caseloads (eight families) assemble all family members and supports, such as relatives, church members and probation officers, to help develop and implement a plan for the youth.

AVAILABLE SERVICES (PARTIAL LIST): Crisis inpatient facility, residential treatment, outpatient services including in-home therapy, housing assistance, mentoring, tutoring, day treatment, after-school programming, crisis home care, independent living support, parent aid, housekeeping services. A crisis team acts as the gatekeeper to any inpatient hospitalization.

“The hospital used to be the only place where all the needs of a youth could be met,” says Chris Morano, director of the crisis unit, the Mobile Urgent Treatment Team (MUTT). “Now, we are focusing on more ‘natural’ supports. We remain focused on what

the child needs.”

FINANCES: According to Bruce Kamradt, director of Children’s Mental Health Services Division for Milwaukee County, Wraparound Milwaukee uses **“blended funding”** by pooling funds through case rates paid by the child welfare and juvenile justice systems, and receives a monthly payment for each Medicaid child enrolled. Any additional insurance and supplemental security income is added to the pool. After funds are joined and decategorized, the program can use the money to cover any service a family needs, regardless of category.

HISTORY: The Wraparound philosophy began with a Canadian service provider who developed the idea of placing youth in small group homes with individualized care, flexible programming and a “never give up philosophy.” The Kaleidoscope program in Chicago—the oldest Wraparound program in the United States—began the philosophy of using “unconditional care” and flexible, integrated services to meet youth and family needs. Wraparound design was further enhanced by the growth of **“Systems of Care Models,”** developed under a grant from the Department of Health and Human Services.

In 1994, Milwaukee County received a five-year federal grant to initiate system reform in that community. Two years later, a pilot project targeted youth in the child welfare and juvenile justice systems.

SUCCESES: Before Wraparound Milwaukee was put into place, inpatient psychiatric placement of youth had reached record proportions – more than 360 youth were in placement on an average day at a cost of more than \$18 million per year. Under Wraparound, the use of residential treatment has decreased 60 percent and inpatient psychiatric hospitalization has dropped by 80 percent. The average overall cost of care per child dropped from more than \$5,000 per

month to under \$3,300 per month.

Criminal recidivism rates have been just as encouraging. A study measuring delinquency “One year prior to enrollment” versus “One year post enrollment” shows substantial drops in sex offenses (from 11 to 1 percent), assaults (from 14 to 7 percent), weapons offenses (from 15 to 4 percent), property offenses (34 to 17 percent) and drug offenses (6 to 3 percent).

PARENT QUOTE: “It was hell what I went through. I was afraid to let people know that I had an emotionally disturbed child. I didn’t want her arrested. I didn’t want her locked away in residential treatment. I wanted some help so I could help her.”—Margaret Jefferson, former Wraparound Milwaukee client, now director of Families United of Milwaukee Inc. (an advocacy organization for parents and youth enrolled in Wraparound Milwaukee).

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The sad reality is that when a youth with mental health issues comes into the juvenile justice system, a chorus of attorneys, therapists, judges, probation officers, and mental health administrators begin speaking up about what is best for the youth and best for society. They are sometimes more interested in proving themselves right, and in defending their turf, than they are in lowering their voices and working out the best response to complicated cases.

And just as unfortunately, the parents are frequently seen as the cause. They often have the most potential for helping, but are ignored or discounted by caseworkers.

Certainly, there are situations when parents, because of their crippling addiction to drugs or criminal behavior cannot be responsible caregivers. But Wraparound Milwaukee has been finding hope

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where there seemed to be only hopelessness.

Such is the case of Sally S., the mother of a 14-year-old boy nicknamed Junior enrolled in Wrap-around Milwaukee, who speaks from her own experience.

“A lot of parents get intimidated by professionals—especially when the professionals hit you with an attitude of ‘I’ve been here and I’ve been there,’” she says. “But good as they are, the professionals don’t always know the answers. The bottom line is, I know my child better than anyone. Wraparound has been good that way. They came out and said, ‘We want your input.’”

Sally’s family has been involved in Wraparound for about eight months. But the full story goes back a couple of years when her son Junior started acting “really wacky,” she recalls. “He got real stubborn, a real bad attitude. At first, I thought we were heading into the usual teenage business, but it got worse and worse. I didn’t know what was wrong with him.”

**“When I look back, I have to ask:
If he had gotten some help,
maybe he wouldn’t have gotten
arrested.”**

A single mother with other school-aged children, Sally was going to school at the time and also trying to start her own business. Overwhelmed, she sought help for Junior. She called a half-dozen social service and mental health agencies trying to get some sup-

port. She says she was given “number after number but when I called, no one answered the phone or they told me we weren’t eligible for this program or that one. When I look back, I have to ask: If he had gotten some help, maybe he wouldn’t have gotten arrested.”

One day—a day that Sally says turned her life around forever—one of her younger sons confessed to his mother that Junior had been “messing with him.” Sally figured out that the boy meant that he was being sexually molested. She panicked and called the police to report it. “I wanted to protect my kids,” she says. “I wanted Junior to get some help.”

She did not get the help she was expecting or seeking. Sally felt the police were treating her as if she were the biggest problem of all. At the police station, an even more painful story emerged. Junior admitted to molesting his brother. But, for years before, the boy’s father (Sally’s ex-husband) had been molesting Junior. In fact, he had molested all of the children in the family.

“I was learning all this stuff at once,” Sally recalls. “It was horrible. I had crying spell after crying spell. But then I knew I had to get over it and deal with it. I had to stay strong and help my family come out of this.”

For the first three months, the courts sent Junior to stay with an older sister who was living out of the family home. His comings and goings were monitored and he had to attend a weekly meeting “about something or other,” his mother remembers. “Mostly, they were looking for something to do with him.”

Finally, at a court hearing, Junior was referred into Wraparound Milwaukee. Because of the seriousness of his problems, he was sent to a residential treatment facility where he would receive group and individual therapy. Meanwhile, a care coordinator set up his first visit with Sally.

“They made it clear to me that if I didn’t feel comfortable with him that we would try someone else,” Sally says. “It’s such an awkward situation. Here’s this outsider coming into your home—getting right into your business, wanting to know things about you and your kids that not even your own family knows.”

Sally says that she was very fortunate to have such a positive experience. She is an African American woman; her care coordinator is a Hispanic man. But they hit it right off. “Cultural-wise, we felt similar,” she says. “And he knew how to make a joke or two.

The good news is that the younger children are all thriving, doing well in school and showing few signs of their traumatic past.

At the first meeting, when I noticed that I had kicked my shoes off, I knew this was going to work out fine.”

This first visit is a crucial one. It is here that the care coordinator and family determine strengths and weaknesses. They pinpoint immediate needs and explore what has worked in the past and what hasn’t worked for the family. The best plans have a mix of both formal and informal services. For example, a family may identify an uncle who could provide respite care to the parent.

Sally’s care coordinator asked what she thought her son needed. “A mentor,” she replied. “A strong

male that he can talk to, but who can also get in his face when he needs that.”

Gradually, an entire team came into play. The care coordinator gently insisted that Sally visit a therapist to deal with the shocks of the preceding months and the hard work ahead. Sally also realized that while she and Junior were getting a lot of attention, no one was giving much thought to the other children in the family. “I could see them thinking, ‘Hey, what about me over here? We’re the victims.’”

Wraparound helped Sally arrange therapy for the younger kids.

“It was a really hard time for me and truthfully, I had no one to talk to. I have all kinds of associates, but not people I pour out these kinds of issues to,” she explains. “So I would call the case coordinator and the therapist all the time. For awhile there, they were becoming the sister and brother I never had.”

Over time, Sally has been taking on more and more responsibility. She feels herself being weaned from her dependence on Wraparound. “I notice myself calling them less and less and see myself taking care of business.”

The good news is that the younger children are all thriving, doing well in school and showing few signs of their traumatic past.

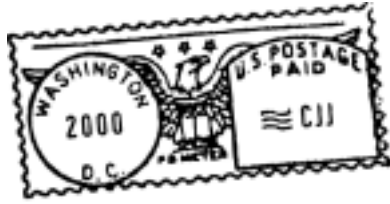
Junior remains in residential treatment. He is making progress, but there are still periods when he seems to backslide into resentment and anger. The next step is for him to show enough improvement so that he can be moved into a less restrictive group home setting and begin supervised home visits. His mother and siblings look forward to the day when he will come home for good.

“I know there’s going to be ups and downs but I’m feeling that my boy is going to make it,” she says.

“Recently he called and said that he understands now that a lot of this is up to him and that he’s going to do anything he can to get this thing done.”

Sally pauses before summing up. “I know this sounds corny, but the Wraparound people became a part of us, of our family. Now I can feel them fading out. They are supposed to fade out. That’s their job – to put me in control. That’s how they know when they’ve done a good job.”

CONCLUSIONS



From Thomas in California, from Steven in Memphis and from Sally and Junior in Milwaukee, we can learn many crucial lessons about the importance of having a strong vision to support our nation's at-risk and mentally ill youth. From vision follows action and each of us must do our part to help construct a comprehensive, coordinated, flexible and sensitive mental

health system. For if we don't, there are serious moral, public safety and financial repercussions. Our society—now and in the future—will pay the price for our indifference.

Recognition must always come first. As a society, we must acknowledge and publicize how prevalent mental illness is among our youth. Walk into a classroom of any elementary school and most teachers can point out the troubled children, the children whose families need help. We need to take advantage of that information in the most sensitive, least intrusive way. We must work to remove the social stigma of mental illness by reaching out to these youth and their families early on.

And when we reach out, we must offer a flexible, comprehensive system of care that is easily accessible, affordable and sensitive to economics, race, culture, gender and sexual orientation. We must organize our communities, our schools, our places of worship around the goal of reaching youth early and empowering them and their families so that they can learn to help themselves.

We must recognize the significant role that mental illness plays in criminal behavior and how youth with untreated disorders are inappropriately filling our detention centers, our courts, and correctional facilities. We must reverse that tide. We must acknowledge that mental illness is not a “crime” and incarceration and harsh punitive measures are a completely ineffective “treatment.”

When youth with mental health issues do come to the attention of the juvenile justice system, we must respond. We must screen out youth with mental illness, and whenever possible, place them in comprehensive, flexible, community-based, family-focused treatment. Such treatment is not at odds with public safety. In fact, in terms of tax dollars and recidivism

rates, all of society benefits when expensive, meaning-
less incarceration can be avoided.

For those youth who must spend time in a locked facility because of the nature of their crime and illness, that time must be safe and humane. Every youth must be properly diagnosed, assessed and monitored for his or her medical/mental health needs. We must stop the widespread improper use of medications, which are too often used, not to treat illness, but for simplistic behavior control. Incarceration must be more than warehousing that does nothing more than make mental illness worse and encourage more criminal behavior. This can be society's opportunity to make sure that youth get the intense and proper medical and clinical intervention that could one day allow them to live productive lives.

Culture shock is well known to travelers who visit remote locations. It is even more unnerving for a youth to be taken from his or her home and familiar surroundings and placed into a locked facility. The

**Above all, we must empower
youth and families to learn how
to support themselves.**

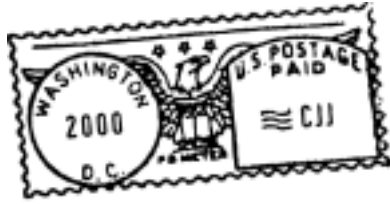
reverse can be just as jarring. Imagine the disorientation when a youth who has been under lock and key for months or years first steps outside an institution. How can we drop youth back into their homes and communities and expect them to succeed? We must support such transitions with a full range of easily accessible services. Above all, we must empower youth and families to learn how to support themselves.

And there's more. We must make sure that anyone who needs mental health services gets them and is not denied because of insurance restrictions. We must not let race, ethnicity, gender, sexual orientation or economics stand in the way of treatment. We must make sure that no family is forced to give up custody of a child in order to get help.

We must not look at mental illness in a vacuum. We must continue to learn more about its relationship to other troubling societal issues, such as poverty, racism, substance abuse, learning disabilities, developmental disorders and early childhood trauma.

If all this seems like a mammoth undertaking, consider models like Youth Villages and Wraparound Milwaukee and take heart in how far we have already come. We know what works. We know what doesn't work. We must continue that progress. All of us—from government agencies to community workers to parents to youth themselves—must make a concerted effort to demand help for society's most vulnerable members.

RECOMMENDATIONS



The Coalition for Juvenile Justice believes that youth and families should have access to high quality, integrated mental health and juvenile justice services, appropriate to their needs.

To begin, we must understand that mental illness does not exist in a vacuum, but is inextricably entwined with other troubling societal issues, such as substance abuse, learning disabilities, developmental

disorders, child abuse, racism and poverty.

For that reason, we must reach out with a “no wrong door” policy. This means that support should be available and accessible no matter when, where or how the need is identified. Such services must be available both outside and within juvenile justice facilities and across economic, racial, gender, cultural and sexual orientation lines.

This continuum of care should encompass the following:

- Prevention programs;
- Screening and assessment opportunities;
- Community-based intervention and treatment programs that address and take into consideration the many factors related to mental health disorders; and
- Institutional care and aftercare that provides appropriate treatment for youth who must be confined for their own safety and for public safety reasons.

To this end, we call on all members of society to use their unique powers and leadership. Each year, The Coalition for Juvenile Justice offers recommendations in association with its annual report. We urge the President, Congress, the Administrator of the Office of Juvenile Justice and Delinquency Prevention (OJJDP), and other groups and individuals involved with youth and mental health issues—including the Coalition and Juvenile Justice State Advisory Groups (SAGs)—to take action. In doing so, youth with mental health needs have a chance of living full and productive lives.

TO THE PRESIDENT OF THE UNITED STATES

- 1)** The President should use the visibility and power of his office to establish a national agenda acknowledging the seriousness and pervasiveness of mental illness (including the related issues of developmental disabilities, learning disabilities, and substance abuse).
- 2)** The President should embrace and publicize the notion that public safety and the humane, effective treatment of youth with mental illness are not at odds with each other. In this regard, he should advocate for comprehensive mental health treatment in the least restrictive, most appropriate setting, while balancing public safety needs.
- 3)** The President should propose and support legislation that ensures mental health benefits for youth of all races, ethnic backgrounds and economic levels.
- 4)** The President should support collaboration on mental health/juvenile justice policy between federal agencies.

TO THE U.S. CONGRESS

- 1)** Congress should acknowledge the underlying role that mental illness can play in crimes committed by youth. It should give high funding priority to support continued research on the causes of mental illness and to identify effective treatment models.
- 2)** Congress should move federal dollars “upstream,” that is, invest money and human resources at the early stages (prevention and intervention), rather than concentrate resources “downstream” (incarceration). To implement this, Congress should appropriate substantial funds (\$100 million) to further assist states in moving juvenile justice/mental health

programming to more cost-effective family and community-based settings.

3) Likewise, Congress should acknowledge the strong connection between mental illness and substance abuse by more effectively allocating dollars. Rather than concentrating resources on the “supply side” (interdiction and enforcement), greater priority should be given to the “demand side” (mental health/substance abuse prevention, intervention and treatment strategies).

4) Congress should use legislation to address the inequality of prevention, early intervention and treatment resources available to youth of color, girls, and gay, lesbian, bisexual and transgender youth.

5) Congress should legislate fair and comprehensive mental health benefits for all children, so that youth are not inappropriately incarcerated just to acquire mental health services.

6) Through funding and legislation, Congress should support a high standard of mental health assessment, treatment and staff training within detention and correctional facilities. It should also support effective community-based aftercare programs.

TO THE ADMINISTRATOR OF THE OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION

1) The Office of Juvenile Justice and Delinquency Prevention should give high priority to researching the causes and effective treatment of mental health disorders. Findings about the prevalence of mental illness, its relationship to other youth issues, available services, gaps and effective treatment should be widely disseminated.

- 2) The Office should support programming that acknowledges how family and community-based prevention and treatment are humane, cost-effective and efficient crime prevention tools.
- 3) The Office should develop and implement a wider array of technical assistance and training resources to help states, local communities and individual facilities replicate effective programs and innovative models.
- 4) The Office should put a strong emphasis on helping State Advisory Groups (SAGs) develop mental health plans that encourage a coordinated continuum of care for youth. Recommended strategies include: building integrated (cross-agency) information management systems, documenting and publicizing effective/promising approaches, and more assertive networking with fellow federal agencies.
- 5) The Office should set standards for the humane treatment of youth housed in juvenile justice facilities, and also for mental health services that are culturally-based, and sensitive to gender and sexual orientation. Such standards should be monitored.

TO THE COALITION FOR JUVENILE JUSTICE (CJJ)

- 1) We should encourage our members to become strong, vocal advocates for the improvement of mental health services for all youth whenever and wherever their need is identified. To this end, the release of this report should be followed by the development of a specific plan of action and an aggressive campaign that provides CJJ members with mental health related information, technical assistance and training opportunities.
- 2) We should take steps to facilitate a series of focus and discussion groups around this report with a diverse range of professionals, parents, youth and concerned parties.

TO THE STATE ADVISORY GROUPS (SAGs)

- 1)** SAGs have a unique understanding of the specific issues and climates of their individual states. Therefore, they should target efforts and resources to address the need for improved mental health services for youth. This can be accomplished in a variety of ways, including:
- 2)** SAGs should be encouraged to distribute Juvenile Justice and Delinquency Prevention (JJDP) Act funds accordingly, making mental health a funding and policy priority. They should support quality mental health programming for youth and their families, training initiatives for mental health and juvenile justice professionals, as well as mental health-related research and evaluation projects.
- 3)** SAGS should strengthen the mental health component of their three-year plans and annual updates.
- 4)** Each SAG should produce a “report card” that assesses the availability or lack thereof of comprehensive mental health services in their respective states.
- 5)** SAGs should facilitate public discussion and policy development on the topic of mental health and substance abuse services for youth. They should take the lead in bringing together juvenile justice and mental health professionals to develop greater understanding across professions.
- 6)** SAGs should recommend to governors that they include the appointment of mental health professionals in SAG membership.

TO THE STATES, TERRITORIES AND LOCALITIES

- 1)** Policy makers should educate themselves about the role of mental illness in delinquency. They should not promote such ineffective “solutions” as harsh punishments and longer sentences.
- 2)** Policy makers should work and collaborate with all appropriate agencies to ensure a full continuum of care for youth at risk of mental illness. They should encourage programming and funding that breaks down barriers across public systems. They should look to successful, established models and consider adapting such programs for their individual jurisdictions.
- 3)** Policy makers should mandate that no parent be forced to yield legal custody of their child solely for the purpose of acquiring mental health treatment.
- 4)** Policy makers should fund, support and monitor humane treatment and effective mental health practices within juvenile justice facilities. High priorities include thorough staff training in risk assessment, security techniques and suicide prevention; adequate ratios for line staff and mental health staff; cultural and gender-relevant programming and treatment; effective post-release treatment and supervision.

TO THE JUVENILE JUSTICE FACILITIES

- 1)** Administrators should create a safe, secure and rehabilitative atmosphere for youth. This can be achieved, in part, by maintaining appropriate staff ratios and providing ongoing staff training on mental health issues, discipline and safety procedures.
- 2)** Staff should receive specific mental health training in cultural, racial, gender, sexual orientation and developmental issues.

- 3) Staff should also be adequately trained in the proper use of medication. It must be used only to treat illness, not as a substitute for safe and humane behavior control and meaningful mental health care. Administrators should be more diligent in ensuring adequate supervision of the use of medications.
- 4) Administrators should make certain that facilities conform to suicide prevention standards. Every suicide and serious attempt should be examined through an established review process that includes recommendations for changes in policy, training, mental health services, etc.
- 5) Administrators should make certain that every youth entering a facility is screened and assessed for mental illness in a manner that is timely and sensitive to race, gender, culture and sexual orientation.
- 6) Administrators should not allow youth to be victimized by either other youth or staff. There must be discipline and safety alternatives to the pervasive over-use of restraints and long periods of isolation. No youth should be over-medicated for behavior control or neglectfully under-medicated.
- 7) Administrators should be willing to look beyond traditional punishment-oriented juvenile justice models by participating in the cross-pollination of ideas between institutions. They should be open to trying new, innovative programs, such as substance abuse treatment and life skills training that empower youth and help them succeed when released into their communities.
- 8) To initiate such programs, administrators must form new partnerships and draw on the untapped resources of community organizations, faith groups and volunteers.

TO THE MENTAL HEALTH PROFESSIONALS AND COMMUNITY

- 1)** Mental health professionals should recognize that outpatient therapies are typically ineffective with youth suffering from chronic conduct disorders. Successful mental health therapies will be based on “wraparound” models that emphasize community and family involvement.
- 2)** Mental health professionals should be open to mutual strategic planning, goal setting, and sharing of limited resources with “sister” agencies at the federal, state and local levels.
- 3)** Mental health professionals should assist facilities in the correct use and supervision of medications. To that end, they can assist with staff training and ensuring proper assessment, managing and monitoring of medications.
- 4)** Academic and community mental health professionals should join together to call for increased funding of under-researched topics, such as co-occurring disorders.
- 5)** Mental health professionals should acknowledge that youth of color, as well as girls, gay, bisexual and transgender youth, often do not benefit from current treatment models. Professionals should advocate for more research and culturally relevant assessment and treatment.
- 6)** Professionals should champion the need for diversity in their training programs by including non-Caucasians in program development and recruiting.

TO COMMUNITIES AND FAMILIES

- 1)** Communities and families should acknowledge that no government agency can do everything to eliminate mental disorders or juvenile crime. They can begin to take ownership of these issues by reaching out to those in need, reducing the stigma associated with seeking help, and generally supporting families in all possible ways.
- 2)** Families of the mentally ill should avoid seeking simple, one-shot, one-agency solutions to complicated behavioral problems. They should take steps to become their own strongest advocates by learning how to access a variety of resources.

TO YOUTH

- 1)** Youth with mental illness have been victims, but they do not have to remain powerless. When personal circumstances allow, they can begin taking control of their own mental health and juvenile justice agenda.
- 2)** They can participate in educational programs and learn the warning signs. They can accept that reaching out for help with mental health disorders, school-learning problems, or family disturbance is acceptable and even approved by other peers and adults. They can take steps in learning how to access appropriate treatment resources.
- 3)** Youth—both those with and those without mental health needs—can join together in advocating for fair, balanced, comprehensive and community-based treatment.
- 4)** Youth can do their part in reducing the stigma of mental illness by adopting a helping, community service attitude toward one another—instead of ostracizing those who appear “different.”

TO THE AMERICAN PUBLIC

- 1)** The American public should not “write off” youth in the juvenile justice system as incorrigible. Many are troubled youth with mental health issues who, given meaningful interventions, can become productive, safety-minded citizens.
- 2)** Rather than using tax dollars to ineffectively punish such youth, the American public should demand a comprehensive and coordinated mental health agenda that serves youth and their families—and in turn, all of society—whenever and wherever they come in contact with the system.
- 3)** On the most grassroots level, each of us can recognize that youth need compassion, leadership and support. Volunteering as mentors, school volunteers, recreational assistants, etc., goes a long way toward helping youth in our own communities.

GLOSSARY

Anorexia Nervosa – An eating disorder characterized by a refusal to maintain body weight at or above a minimal normal weight for age and height; intense fear of gaining weight or becoming fat, even though underweight.

Anxiety disorders – Disorders that produce overwhelming feelings of panic, fear and extreme unrealistic worries that do not seem to be related to any recent event. Symptoms include uncontrollable obsessive thoughts, painful memories, recurring nightmares, nausea, pounding heart, chest pain, sweating, shortness of breath, dizziness, fear of dying, numbness, chills or hot flashes.

Assessment – A professional review of a child's and family's needs; a review of physical and mental health.

At-Risk Youth – Youth who display behavior or live in circumstances that, if continued, will likely bring them in contact with the juvenile justice and/or mental health systems.

Attention-Deficit/Hyperactivity Disorder (ADHD) – A disorder characterized by developmentally inappropriate impulsivity, attention, and in some cases, hyperactivity.

Autism – A developmental disability of the brain that prevents individuals from properly understanding

what they see, hear and otherwise, sense. It produces a spectrum of symptoms that can include delays in language and social functioning and marked restriction of activities and interests.

Bipolar Disorder (also known as **Manic-Depressive Disorder**) – A disorder where moods swing from depression to mania, generally with periods of normal moods between the two extremes.

Blended funding – The pooling of funds through case rates paid by various systems, including the child welfare and juvenile justice system, insurance and supplemental Social Security income which can then be used to cover any services that a family needs.

Bulimia Nervosa – An eating disorder characterized by recurrent episodes of binge eating. Youth often engage in recurrent inappropriate behavior in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives and excessive exercise.

Conduct Disorder – A complicated group of behavioral and emotional problems in which youth chronically display great difficulty following rules and behaving in a socially acceptable way. They may exhibit some of the following: aggression to people and animals; destruction of property; deceitfulness, lying and stealing; serious violation of rules (including running away and truancy).

Continuum of Care – A term that implies a progression of services – including mental health, educational, social services – that a youth and his family would move through.

Coordinated services – Youth-serving organizations, along with the family, talk and agree upon a plan of care that meets the youth's needs. Child welfare, education, juvenile justice, and mental health organizations may be included.

Depressive Disorder – A mental illness with varying symptoms, the most common being a deep feeling

of sadness. Other symptoms may include: loss of interest and pleasure; appetite or weight disturbance; sleep disturbance; agitation or loss of energy; abnormal self-reproach or inappropriate guilt; poor concentration or indecisiveness; morbid thoughts of death/suicide.

DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth edition) – Official manual of mental health problems developed by the American Psychiatric Association.

Early Intervention – A process for recognizing warning signs that individuals are at risk for mental health problems and taking early action against factors that put them at risk.

Home-based counseling – Help provided in a family's home for either a defined time or for as long as necessary to deal with a mental health problem. Examples include parent training, counseling and working with family to identify and provide help. The goal is to prevent children from being placed out of the home.

Mental illness – A disorder that affects or is manifested in a person's brain. It may impact on the way a person thinks, behaves and interacts with other people. In legal terms, states have adopted various terminology. Some examples:

- 1 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.
- 1 An illness, disease or condition, other than epilepsy, senility, alcoholism or deficiency that substantially impairs a person's thoughts, perceptions of reality, emotional process or judgment.

Multisystemic Therapy (MST) – An intensive treatment method that works to rebuild the family/care giving environment to support mentally ill youth, rather than treating youth in

isolation of family.

Obsessive-Compulsive Disorder (OCD) – A disorder with frequently occurring irrational thoughts that cause great anxiety but that cannot be controlled through reasoning. Common obsessions include preoccupation with dirt or germs, nagging doubts and a need to have things in a very particular order.

Oppositional Defiant Disorder – A disorder with a pattern of negativistic, hostile and defiant behavior. Can include the following symptoms: often loses temper; often argues with adults; actively defies or refuses to comply with adult requests or rules; deliberately annoys people; blames others for his or her mistakes; often touchy; angry and resentful; often spiteful or vindictive.

Panic Disorder – An anxiety disorder whose core symptom is an overwhelming fear of being in danger. Other symptoms can include racing heartbeat, sweating, nausea, shortness of breath and/or fear of impending death. These “panic attacks” can last minutes to hours.

Phobia – A type of anxiety disorder. An unrealistic and excessive fear of some situation, object or activity. Specific phobias center on animals, storms, water or situations, such as being enclosed in a space.

Post-Traumatic Stress Disorder (PTSD) – A disorder that occurs in individuals who have experienced a stressful event, such as physical or sexual abuse; witnessing violence; being caught in a disaster, such as an earthquake or a bombing. Symptoms include recurrent nightmares or memories of the event, and extreme emotional, mental and physical distress when exposed to situations that remind them of the trauma.

Residential Treatment Centers – Facilities that provide treatment 24 hours a day and usually serve more than 12 young people at a time.

Children with serious emotional disturbance receive constant supervision and care. Treatment may include individual, group and family therapy; behavior therapy, special education, recreation therapy and medical services.

Schizophrenia – An uncommon psychiatric illness in children that is difficult to recognize in early phases. Warning signs include: trouble telling dreams from reality; seeing things and hearing voices; confused thinking; extreme moodiness; odd behavior; ideas that people are out to get them; severe anxiety and fearfulness.

Substance Abuse – Destructive pattern of drug/ alcohol use, leading to significant social, occupational or medical impairment. Symptoms can include: increased drug tolerance; greater use of drug than intended; unsuccessful efforts to cut down or control use; great deal of time spent using drug and recovering from its effects; continued use despite knowing drug causes significant problems.

Systems of Care – Local organizations work in teams—with families as critical partners—to provide a full range of services to children and adolescents with serious emotional disturbances. The team strives to meet the unique needs of each young person and family in or near their home.

Tourette’s Disorder – A disorder producing body and vocal tics. Youth may also have problems with attention, impulsivity, obsessions and compulsions. Sometimes, youth blurt out obscene words, insults and gestures.

Wraparound Services – A “full-service” approach to meeting the mental health needs of individual children and their families.

RESOURCE LIST

American Academy of Child and Adolescent Psychiatry

3615 Wisconsin Avenue, NW
Washington DC 20016
202-966-7300
www.aacap.org

Bazon Center for Mental Health Law

1101 Fifteenth St. NW, Suite 1212
Washington DC 20005
202-467-5730
www.bazon.org

Center for Mental Health Services

Knowledge Exchange Network (KEN)
PO Box 42490
Washington DC 20015
800-789-2647
www.mentalhealth.org

Federation of Families for Children's Mental Health

1021 Prince Street
Alexandria, VA 22314
703-684-7710
www.ffcmh.org

Functional Family Therapy Project

Department of Psychology
University of Utah
380 S. 1530 E. Room 502
Salt Lake City, UT 84112
801-585-1807
www.fftinc.com

Massachusetts Youth Screening Instrument (MAYSI)

Thomas Grisso
Department of Psychiatry
University of Massachusetts Medical School
Worcester, MA 01655
508-856-3625
www.umassmed.edu/nysap/

Multidimensional Treatment Foster Care

Oregon Social Learning Center
160 E. 4th Street
Eugene, OR 97401
541-485-2711
[www.colorado.edu/cspv/blueprints/model/
ten_multidim.htm](http://www.colorado.edu/cspv/blueprints/model/ten_multidim.htm)

Multisystemic Therapy

Scott W. Henggeler
Family Services Research Center
Medical University of South Carolina
67 President Street, Suite CPP
PO Box 250861
Charleston, SC 29425
843-876-1800
www.mstservices.org

National Alliance for the Mentally Ill (NAMI)

Colonial Place Three
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201
Business- 703-524-7600
Helpline- 800-950-NAMI (6264)
www.nami.org

National GAINS Center

for People with Co-Occurring Disorders in
the Justice System
Policy Research, Inc.
262 Delaware Avenue
Delmar, NY 12054
800-311-GAIN
www.prainc.com/gains/index.html

National Mental Health Association

1021 Prince Street
Alexandria, VA 22314
800-969-NMHA
703-684-7722
www.nmha.org

National Technical Assistance Center for Children's Mental Health

Georgetown University Child Development Center
3307 M Street, NW
Washington DC 20007
202-687-5000
www.georgetown.edu/research/gvcdc/cassp.html

Research and Training Center for Children's Mental Health

Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612
813-974-4661
rtckids.fmhi.usf.edu

**Research and Training Center on
Family Support and Children's Mental Health**

Portland State University
PO Box 751
Portland, OR 97207
503-725-4040
www.rtc.pdx.edu

**Substance Abuse and Mental Health Services
Administration (SAMHSA)**

5600 Fishers Lane
Rockville, MD 20857
301-443-2792
www.samhsa.gov

Wraparound Milwaukee

9501 Watertown Plank Road
Wauwatosa, WI 53226
414-257-7611
www.wrapmilw.org

Youth Villages

PO Box 341154
Memphis, TN 38184-1154
901-252-7600
www.youthvillages.org

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AN ACT OF EMPOWERMENT. December, 1987: Report on the recommendations of the CJJ 1987 spring conference dealing with changes in the federal Juvenile Justice and Delinquency Prevention Act that would enhance the rights of juveniles.

A DELICATE BALANCE. January, 1989: Report on the issue of racial differentials in the rates of juvenile incarceration.

PROMISES TO KEEP. May, 1990: Report on problems associated with conditions of confinement for juveniles, including a re-examination of the basic arguments leading to the Juvenile Justice and Delinquency Prevention Act of 1974.

LOOKING BACK TO THE FUTURE. December, 1990: Report focusing on the history of juvenile justice and CJJ's recommitment to the basic premises of the 1974 Act.

A UNIQUE PARTNERSHIP FOR CHILDREN. December, 1991: Report focusing on reauthorization of the Juvenile Justice and Delinquency Prevention Act of 1974, with a survey of its history, recommendations for amendments and support for its re-enactment.

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AIN'T NO PLACE ANYBODY WOULD WANT TO BE: CONDITIONS OF CONFINEMENT FOR YOUTH. December, 1999: Report that surveys the conditions of juvenile confinement in the United States, ranging from deplorable to exemplary. Highlights effective programs and recommendations for change.

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