RESPONDING TO THE MENTAL HEALTH NEEDS OF YOUTH IN THE JUVENILE JUSTICE SYSTEM

THE INNER WORKINGS OF DELINQUENT YOUTH

In the discussion on the issues of juvenile crime, the nation has ignored the prevalence of mental disorders among youth who commit crimes, and it has failed to provide policy directives on how state systems should respond. With the nation’s attention riveted on youth violence, the issue of prevalence has begun to emerge, with the realization that many of the violent acts are committed by a small percentage of young people. Policymakers are beginning to ask questions about the conditions that contribute to a young person’s tendency toward delinquency acts.

While exact prevalence rates are not known, experts in mental health and juvenile justice estimate that the rate of mental disorder among these youth is substantially higher than among the general population of youth—possibly as high as 60 percent, compared to 22 percent in the general population of youth. In 1995, an assessment conducted in the state of Virginia over a one week period revealed that more than three quarters of all youth in the state’s 17 detention facilities exhibited at least one diagnosable mental disorder. Of that number, eight to ten percent had mental health needs in the severe/urgent range and 40 percent were assessed as having needs in the moderate range.

Two visions of the same child. The co-occurrence of mental health and substance abuse problems in youth involved in the juvenile justice system has long been discussed and studied. In fact, the two problems have become intertwined as the juvenile courts move forward to rehabilitate youngsters and intervene positively in the lives of their families while the mental health system has begun to proactively treat children in their home environments.

The social science literature is abundant with references to “antisocial” youth, and juvenile justice is debating the culpability of young people and the extent to which they should be held accountable for their criminal behaviors. “Delinquency”—a legal term—has often been far removed from “conduct disorder”—a clinical term—although both describe, from different perspectives, a child who does not stay within the bounds of accepted behaviors in our society. These two visions of the same child have hampered our ability to address the mental health needs of delinquent populations. They have also sent researchers and practitioners in vastly different directions in planning policy and practice to respond to the rising fear of youthful lawlessness, violent crime, and the perceived anomie of a growing number of today’s adolescents.

FRONT END SERVICES: A LOOK INSIDE THE JUSTICE SYSTEM FOR POTENTIAL INTERVENTION POINTS

Soon after a referral to juvenile court, a decision is made to handle the case formally or informally. Informal processing is considered when decision-makers believe that accountability and rehabilitation can be achieved without the use of formal court intervention. This juncture may be an intervention point for addressing youths’ mental health needs. Informal sanctions are voluntary; the court cannot force a juvenile to comply with an informal disposition. If the decision is made to handle the matter informally, an offender may agree to perform community service work, pay victim restitution, submit to voluntary probation services, or comply with a range of other sanctions.

Informal Dispositions Present a Tremendous Opportunity as a Referral Resource for Mental and Substance Abuse Problems Identified at Intake Stage.

In many jurisdictions before juveniles are offered informal sanctions they must admit that they committed the alleged act. Cases are held open pending completion of informal dispositions. Charges are then dropped after successful completion. Informal handling is common in
the juvenile courts. In 1992, half (51%) of delinquency cases were handled informally. These cases present a tremendous opportunity for courts to become involved as a referral source for mental and substance abuse problems identified at intake stage. In 1992, informal court handling was most common for delinquency cases in which a property offense was the most serious charge. Drug cases were the least likely to be handled informally. Whereas the use of informal processing remained fairly constant between 1988 and 1992 for most offenses, informal handling declined somewhat for cases involving drug law violations.4

More than half (53%) of the informally handled delinquency cases processed in 1992 involved some type of services or sanctions beyond the warning and counseling of the youth. These cases consist of a significant number of youngsters who might have benefited from referrals or clinical interventions. In nearly a third (30%) of informally processed cases, the youth agreed to a term of voluntary probation supervision, and 23% agreed to other sanctions such as voluntary restitution, community service, or referral to another agency. In a very small number of cases, the youth and their families agreed to a period of out-of-home placement as a result of the court’s action.4

Probation Departments See Large Numbers of At-Risk Youth. The juvenile probation function within the juvenile court is the front line for identifying, assessing, planning, and delivering services to youth with substance abuse and/or mental health problems. In one fashion or another, juvenile probation, in most states, “lays hands” on every young person referred to juvenile court. With a steady flow of incoming cases, probation departments see more at-risk youth than any other social service entity, with the possible exception of schools. It is clear the working relationship between probation and the mental health system must be reliable, trusting, and rational if early interventions are to take hold in this adolescent population.5

Between 1988 and 1992, probation was the most severe disposition used by juvenile courts in nearly two of every five delinquency cases and in nearly three of every five adjudicated cases, with the annual proportions remaining consistent over this period. Therefore the growth in probation caseloads was directly related to the general growth in referrals to juvenile court.6

KEY ISSUES REGARDING DETENTION FACILITIES

One key issue is whether detention facilities provide treatment. Some advocates claim current treatment facilities have not changed in the years since the major lawsuits seeking adequate facilities were litigated. These inadequate juvenile facilities scarcely embody the therapeutic goals they are suppose to represent; and are plagued with violence, predatory behavior and punitive incarceration.

A recent study by the US Department of Justice’s Office of Juvenile Justice and Delinquency Prevention7 on conditions of confinement includes a survey of mental health treatment services at 95 private and public juvenile facilities around the nation. Researchers assessed whether juveniles are in facilities with a minimal counselor to juvenile ratio (one counselor per 25 residents). The study showed that 87% of the facilities satisfied the counselor ratio. Additionally, most treatment programs dealt strictly with drug and alcohol abuse, as opposed to mental illness. Further, the lack of an effective measure of treatment prevented researchers from determining whether facilities provide treatment or what, if any, benefits juveniles may receive from the programs.

A 1974 study by researcher Robert Martinson analyzed correctional treatment programs and concluded that “nothing works.” Critics have cited this study to oppose funding rehabilitation programs for juvenile and adults.8 Most studies show that rehabilitation programs do produce positive changes under certain conditions. Yet, there still exists a reluctance among state and local governments to allocate sufficient resources to address or improve treatment programs.9

Needs of culturally diverse youth. Advocates suggest that reforms brought about by Wyatt v. Stickney, (establishing standards for persons with mental illness or mental retardation), 10 must also address the concerns of minority overrepresentation in the juvenile justice system. One approach is the introduction of cultural competence standards. Cultural competence refers to an understanding of the beliefs, values and customs of minority youth. This approach suggests that “traditional” methods of treatment must be adapted to meet the needs of culturally diverse youth. One medical professional has suggested that, for practitioners, cultural competence includes establishing a knowledge base of differential diagnoses, developing new skills and abilities, and reexamining attitudes towards patients from different cultures.11

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In addition, many states are beginning to develop cultural competency standards for mental health services. For example, in 1995, the California Mental Health Directors Association began developing such standards in an effort to address the needs of the state’s diverse ethnic population. The proposed standards include cultural factors such as belief, values, health and healing practices. These standards also emphasize the need for cultural competence at all levels of mental health organizations including access to care, quality of care, and prevention.

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

2. **Interagency collaboration** is needed to provide an expanded range of services and to bring agencies together in a collaborative effort, in addition to developing new financing mechanisms.

3. **Neighborhood-driven programs** are needed within communities to play a catalytic role with public agencies involving families in management and decision-making.

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

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

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

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

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

9. **Stigma** must be reduced. To make progress, we need to “put a human face” on this issue. We must visualize our friends or their children as the person with mental illness or as the child “in trouble.” This will help reduce the stigma faced by families in general, and those who end up in the juvenile justice system in particular.

10. **Dissemination of information** must be increased. Emerging trends and challenges impact the retention of youth in trouble. New
paradigms for knowledge dissemination and utilization must be employed.

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

THE NATIONAL COALITION’S FUTURE.

During the years 1989-1995 the National Coalition was the recipient of a sole source federal grant. With 76 other participating organizations the National Coalition achieved its funded mission to bring the issues of youth and adults who have mental health needs in the justice system to the forefront. The National Coalition is currently in the midst of transition. Today, as the Coalition’s originator and prime mover, I have returned to child welfare and have made a two-year commitment to address child abuse issues. I am working with others to launch a grassroots national project for domestic peace. Please feel free to contact me for information on the National Coalition’s next phase.

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