

## BRIEF

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# Merging Care with Control Brief I: Why Engage Juvenile Justice in System of Care

## The Issue

Adolescence is a period of developmental transition, characterized by changes in family, school, peers, self-concept, and general physical development (Bergman & Scott, 2001). Although most youth successfully navigate this developmental period, incidents of rule breaking and behavioral problems are common and can result in involvement with law enforcement. Further, youth with untreated or undiagnosed mental health needs may engage in behaviors that are viewed as delinquency. It has become common knowledge that youth with mental health needs are disproportionately represented within the juvenile justice system.

Consequently, private foundations, federal agencies and state and local stakeholders have joined together to address juvenile justice and mental health reform. At the forefront of recent juvenile justice reform efforts are the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative and the John D. and Catherine T. MacArthur Foundation's Models for Change. Recognizing the unique challenges presented by youth with mental health needs involved with or at risk of involvement in the juvenile justice system, the John D. and Catherine T. MacArthur Foundation extended their Models for Change efforts by creating the Mental Health and Juvenile Justice Action Network coordinated by the National Center for Mental Health and Juvenile Justice (NCMHJJ). The Action Network initially targeted four states (Illinois, Louisiana, Pennsylvania, and Washington) and eventually expanded to include four additional states (Colorado, Connecticut, Ohio, and Texas), all focusing on efforts to address both policies and practices for mental health and juvenile justice reform. This collaboration resulted in the development of the Mental Health and Juvenile Justice Collaborative for Change. The Collaborative for Change is a resource center coordinated by NCMHJJ to share information on mental health reforms and to provide guidance for effectively implementing those reforms in communities and states throughout the country (for more information go to [cfc.ncmhjj.com](http://cfc.ncmhjj.com)).

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In a 2013 publication by the National Research Council (NCR), *Reforming Juvenile Justice: A Developmental Approach*, national experts assessed recent research and initiatives in juvenile justice and endorsed a framework of reform based on a scientific understanding of adolescent development. Upon publication, the administrator of the Office of Juvenile Justice and Delinquency Prevention (OJJDP) requested a follow-up study to develop an implementation plan for OJJDP. With support from the Annie E. Casey Foundation and the John D. and Catherine T. MacArthur Foundation, an expedited study resulted in the publication of *Implementing Juvenile Justice Reform: The Federal Role* (NCR, 2014). Grounded in knowledge about adolescent development, the plan sets forth seven hallmarks of a developmental approach to juvenile justice reform:

1. Accountability without criminalization;
2. Alternatives to justice system involvement;
3. Individualized response based on assessment of needs and risks;
4. Confinement only when necessary for public safety;
5. A genuine commitment to fairness;
6. Sensitivity to disparate treatment; and
7. Family engagement.

While the plan was designed to provide specific guidance to OJJDP regarding the steps that it should take, both internally and externally, to facilitate juvenile justice reform, it is also valuable in designing and implementing juvenile justice reform in states, localities and tribal communities. Further, this developmental approach to juvenile reform aligns with system of care values and principles and is instructive when integrating such efforts within system of care planning and implementation.

To further facilitate juvenile justice and mental health reform, a two-part policy series titled *Integrating Juvenile Justice with System of Care: Merging Care with Control* examines the following topics: (1) the importance of engaging the juvenile justice system in a system of care; and (2) how to integrate juvenile justice into a system of care. This brief, *Why Engage Juvenile Justice in a System of Care*, is the first in this two-part series and explores specific reasons why integrating juvenile justice in a system of care is essential and necessary.

## Background

Although prevalence rates differ depending on which point in the juvenile justice system the study was conducted (i.e., intake, detention, probation, or incarceration), most estimates of prevalence range from 50% to 75%, with approximately 20% to 25% of youth having a serious emotional disorder (Cocozza & Skowrya, 2000; Colins et al., 2010; Kazdin, 2000; Shufelt & Cocozza, 2006; Teplin et al., 2002). When compared to general population estimates of between 9% and 20% of youth indicating a mental health need (Cocozza & Skowrya, 2000; Hubner & Wolfson, 2000; Skowrya & Cocozza, 2007), it is clear that youth experiencing mental health challenges are disproportionately represented within the juvenile justice system. Furthermore, youth involved with the juvenile justice system often have not one, but several comorbid psychiatric disorders. In an examination of youth processed through intake in six urban probation departments, Wasserman et al. (2005) found the prevalence of youth meeting criteria for at least one psychiatric disorder to be 39%, with 16% meeting criteria for three or more disorders.

### Mental Health Needs and Delinquency

In addition to the high prevalence of youth with mental health challenges in the juvenile justice system, studies also indicate that mental health disorders are correlated with delinquent behavior. Several prospective studies indicate that hyperactivity (Lynam et al., 2000), conduct disorders, and internalizing emotional disorders (Copeland et al., 2007; Boots, 2007; Boots & Wareham, 2009) serve as key indicators for involvement with the justice system. Specifically, Copeland et al. (2007) found, after controlling for offense level and poverty, 21% of female juvenile offending and 15% of male juvenile offending was attributable to mental health disorders. Among specific psychiatric profiles, the findings indicate co-occurring anxiety and depressive disorders had the strongest association with delinquent behavior. Boots and Wareham (2009) extended on these findings, demonstrating a moderate correlation between depression and anxiety with future offending.

### Juvenile Justice as a Form of Access to Mental Health Care

The prevalence of youth with mental health needs in the juvenile justice system has led several prominent organizations and researchers to suggest that these youth end up in the juvenile justice system not because they have committed a serious offense but rather because their need for coordinated mental health treatment has not been met (Casey Strategic Consulting Group, 2003; Skowryra & Coccozza, 2007). In 2004, the U.S. House of Representatives published the results of a survey of juvenile detention facilities across the country, finding that two-thirds of those facilities reported holding youth in detention because they were awaiting mental health care, not because of the seriousness of their offenses. In 1999, the National Alliance on Mental Illness (NAMI) highlighted that over 36% of families responding to their survey decided to have their child arrested and detained because mental health services were not available to them. In 2001, the U.S. General Accounting Office reported that approximately 13,000 youths in the juvenile justice and child welfare systems were relinquished by their parents to access mental health care. This trend was corroborated in 2004 when NCMHJJ and the National Federation of Families for Children's Mental Health convened a series of focus groups across the country to examine this issue (Osher & Shufelt, 2006).

### Mental Health Needs and Juvenile Justice System Processing

Across the nation, the majority of youth with cases processed in court are placed on probation or some form of supervision within their community (OJJDP Statistical Briefing Book, 2014). Those with identified mental health disorders are often required to participate in treatment as a condition of their probation. Research has shown that offenders with mental health disorders are much less successful under supervision in the community than those without mental health disorders (Monahan et al., 2005; Skeem, Emke-Francis, & Loudon, 2006; Solomon, Draine, & Marcus, 2002). Specifically, when compared to juveniles without mental health needs, those with mental health challenges are more likely to be unsuccessful under community supervision and charged with a violation of probation, resulting in their removal from the home (Porporino & Motiuk, 1995; Espinosa, Sorensen, & Lopez, 2013).

A similar picture emerges with informal pressure to participate in treatment. Mental health case managers within the community are likely to use treatment pressures with youth who have severe symptoms, recent drug use, and arrest histories (Neale & Rosenheck, 2000). Mental health case managers for probationers often fall prey to the "treater turned monitor"

syndrome, whereby the mental health treatment provider's activities become primarily that of monitoring for treatment non-compliance and elevating the probationers' risk of incarceration on a technical violation (Solomon, Draine, & Marcus, 2002). Ultimately, mental health services can be generally associated with some level of coercion whether by the juvenile justice system or the treatment provider (Solomon & Draine, 1995; Lidz, 1998). More significantly, for offenders with the triple stigma of a primary mental health diagnosis, substance abuse, and criminal justice involvement, treatment relationships are often infused with multiple sources of quasi law enforcement-based social control through formal service providers in their community (Hartwell, 2004).

### Outcomes for Youth Placed Out-of-Home by the Juvenile Justice System

Not all youth who are involved in the juvenile justice system and removed to out-of-home placements are incarcerated in juvenile justice facilities. Some juvenile justice jurisdictions have the ability to place youth in environments other than secure juvenile justice settings such as residential treatment centers (RTCs) and foster homes. However, research on outcomes following any out-of-home placement for youth with mental health challenges show not only cost increases to the system, but also patterns of on-going system involvement, an added disruption to adolescent development (Hoagwood & Cunningham, 1992; Lyons et al., 1998).

When community mental health treatment and in-patient psychiatric care are not available resources to the juvenile justice system, youth may be placed in juvenile correctional settings where mental health care is typically inadequate or unavailable. A 2004 U.S House of Representatives study found that more than half of the 698 juvenile detention facilities that responded to a survey had inadequate staff training in mental health and over a quarter provided little to no mental health care.

In addition, the outcomes for youth placed in juvenile correctional settings do not appear very promising. Recidivism studies indicate the rates of re-arrest for juvenile offenders who have returned from residential treatment and/or juvenile correctional settings range from 40% (Taylor et al., 2009) and 65% (Benda, Corwyn, & Toombs, 2001) to as high as 85% (Trulson et al., 2005). These findings suggest that when juvenile justice youth return to the community from a juvenile justice placement, including placements with mental health treatment, there is a very high likelihood that they will cycle back through the system or become engaged in the adult criminal justice system.

Further, involvement in the juvenile justice system can have significant negative effects on adolescent development, particularly for youth with mental health needs. Juvenile justice placement can exacerbate a youth's mental health symptoms, especially when the environment within the facility stimulates or triggers a youth's memory and/or reaction to a traumatic experience (Mahoney et al., 2004). Recent research has indicated that reactions to traumatic pasts could underlie youth behavior within the facility that results in additional sanctions and further system involvement (Espinosa et al., 2013).

### Summary

Youth with mental health needs are disproportionately represented within the juvenile justice system. Additionally, youth with mental health needs are more likely to end up in juvenile correctional and residential treatment settings once they become involved in the juvenile

justice system relative to youth who do not have a mental health need. Incarceration has been shown to increase the likelihood of sustained system involvement and also has a negative effect on normal adolescent development. Ultimately, large amounts of county and state dollars are spent on out-of-home placements for these youth and then for additional costs upon subsequent system involvement.

These issues have lead national leaders and researchers to advocate for the integration of juvenile justice with system of care. Building on a system of care framework, Hoagwood and Cunningham (1992) emphasize the need for community-based supports and services to ensure that youth returning from residential care can continue to progress in their treatment in the community. Others, such as researchers with the Pathways to Desistance study, suggest that integrating system of care with juvenile justice systems should be a core strategy of juvenile justice reform (Schubert & Mulvey, 2014).

By integrating juvenile justice into system of care, as no less than an equal partner, communities and states have the opportunity to create more community-based options for youth involved in the juvenile justice system and to influence the juvenile justice response toward youth whose behaviors may be the result of an unmet mental health need. By exploring and expanding on current juvenile justice and mental health reform efforts, communities and states can implement diversion strategies proven effective and continue the transformation of juvenile justice and mental health in this country. Strategies for engaging juvenile justice leaders, including examples of specific approaches, are explored in more detail in the second brief of this series, "How to Integrate Juvenile Justice into System of Care."

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## ABOUT THE NATIONAL TECHNICAL ASSISTANCE NETWORK FOR CHILDREN'S BEHAVIORAL HEALTH

The National Technical Assistance Network for Children's Behavioral Health (TA Network) operates the National Training and Technical Assistance Center for Child, Youth, and Family Mental Health (NTTAC), funded by the Substance Abuse and Mental Health Services Administration, Child, Adolescent and Family Branch. The TA Network partners with states, tribes, territories, and communities to develop the most effective and sustainable systems of care possible with and for the benefit of children and youth with behavioral health needs and their families. The TA Network provides technical assistance and support across the country to state and local agencies, including youth and family leadership organizations.

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