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FOCAL POINT

Research, Policy, and Practice in Children's Mental Health

Corrections



Summer 2006

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CORRECTIONS:

NEW STRATEGIES FOR MEETING THE MENTAL HEALTH NEEDS OF YOUTH IN JUVENILE JUSTICE

Over the last 15 years, a general trend within juvenile justice has been an increasing focus on punishment over treatment and rehabilitation. Driven in part by “tough on crime” and “zero tolerance” policies, one effect of this trend has been that more youth—including youth who have committed relatively minor offenses—have become formally involved with the juvenile justice system. While the number of youth arrested has increased only slightly, higher proportions of these youth have been referred to, prosecuted in, and convicted by juvenile courts, and youth were incarcerated in greater numbers. This “crackdown” has not apparently produced the desired effect. In general, it appears that drawing more youth further into the juvenile justice system, relying on more restrictive settings, and focusing on punishment is less effective than well-implemented community-based and treatment-oriented alternatives.

There is particular need for correction in the way that the juvenile justice system interacts with youth who have mental health difficulties. Recent research has documented that two-thirds or more of youth involved with juvenile justice have a diagnosable mental health disorder, yet appropriate treatment is frequently unavailable. Trupin (page 10) argues that the “tough on crime” orientation in juvenile justice has been particularly disastrous for these youth, and describes the ap-



palling circumstances that they may face when they are held in secure settings. Osher (page 24) and Sage (page 28) describe how children and youth with mental health difficulties can be drawn into the juvenile justice system when they have committed relatively minor crimes, or even when they have committed no crime at all.

“Tough on crime” approaches in juvenile justice appear to be based on an unsympathetic view of juvenile offenders. But, as Huffine (page 13) and Wise (page 8) illustrate, a closer look at juvenile offenders often reveals young people whose personal histories include trauma, loss, neglect, victimization, or other difficulties. For example, one study of youth in-

carcerated in Virginia for violent offenses found that 51% of the girls had a documented history of sexual abuse, while a study of court-referred juvenile offenders in Milwaukee, Wisconsin found that 66% of male offenders had been victims in substantiated reports of abuse or neglect. When we combine this information with what we know about the high rates of mental health and substance abuse disorders among youth involved with juvenile justice, it becomes difficult to justify an exclusively punitive response to their behavior.

Around the nation, new strategies are being implemented with the aim of improving outcomes for youth with mental health difficulties who are involved with juvenile justice. The “Blueprint for Change,” developed by the National Center for Mental Health and Juvenile Justice (Skowrya, page 4), describes the most critical areas for improvement, recommends actions and strategies for each critical area, and provides examples of successful programs that are consistent with these recommendations. Two of these programs are FIT (Lee and De Robertis, page 17) and ICT (Shepler, Clemminshaw, and Canary, page 24). As the Blueprint and its model programs show us, we do have tools at hand to undertake necessary corrections in juvenile justice.

Janet S. Walker, editor



A BLUEPRINT FOR CHANGE: IMPROVING THE SYSTEM RESPONSE TO YOUTH WITH MENTAL HEALTH NEEDS INVOLVED WITH THE JUVENILE JUSTICE SYSTEM

Over 2.3 million youth are arrested each year. Of these, approximately 600,000 are processed through juvenile detention centers and more than 100,000 are placed in secure juvenile correctional facilities (Sickmund, 2004). Until the last decade, there was a lack of data and information available documenting the degree to which youth involved with the juvenile justice system were experiencing mental illness. New research has expanded our collective understanding of the nature and prevalence of mental disorders among the juvenile justice population and has provided the field with a more precise assessment of the problem.

It is now well established that the majority of youth involved with the juvenile justice system have mental health disorders. For example, we now know that youth in the juvenile justice system experience substantially higher rates of mental disorder than youth in the general population. Studies consistently document that anywhere from 65% to 70% of youth in the ju-

venile justice system meet criteria for a diagnosable mental health disorder (Skowrya & Cocozza, in press; Teplin et al., 2002; Wasserman, Ko, & McReynolds, 2004). Further, recent estimates suggest that approximately 25% of youth experience disorders so severe that their ability to function is significantly impaired (Skowrya & Cocozza, in press).

In a recent mental health prevalence study conducted by the National Center for Mental Health and Juvenile Justice on youth in three different types of juvenile justice settings, over 70% of youth were found to meet criteria for at least one mental health disorder. Disruptive disorders (including conduct disorder) were most common, followed by substance use disorders, anxiety disorders, and mood disorders. When conduct disorder was removed from the analysis, over 66% of youth still met criteria for some other mental health disorder. Even when conduct disorder and substance use disorders were removed from the analysis, almost half of the

youth (45.5%) still met criteria for a mental health disorder (Skowrya and Cocozza, in press).

Many youth with mental health needs are detained or placed in the juvenile justice system for relatively minor, non-violent offenses but end up in the system simply because of a lack of community-based mental health treatment. A survey of families with children who have a brain disorder, conducted by the National Alliance for the Mentally Ill (2001), found that 36% of respondents reported having to place their children in the juvenile justice system in order to access mental health services that were otherwise unavailable to them. More recently, a report issued by Congress in July 2004 documented the inappropriate use of detention for youth with mental health needs and found that in 33 states, youth were reported held in detention with no charges at all—they were simply awaiting mental health services (US House of Representatives, 2004).

The growing crisis surrounding

these youth is highlighted by a series of recent independent reports and media accounts. Investigations by the US Department of Justice into the conditions of confinement in juvenile detention and correctional facilities throughout the country have repeatedly found a failure on the part of the facilities to adequately address the mental health needs of youth in their care (US Department of Justice, 2005). In addition, media inquiries and reports have documented the mental health crisis within the juvenile justice systems in numerous states including New Jersey, Arizona, California, Michigan and Pennsylvania. This unprecedented exposure has put new public pressure on elected officials, policy makers, and practitioners to develop more effective responses.

As a result of this pressure and attention, significant energy has been directed to the development of new tools, programs, and resources to help the field better identify and respond to the mental health needs of youth with mental health needs. Emerging strategies include

- The wider use of standardized mental health screening and assessment procedures for justice-involved youth, such as the MAYSI-2 and the Voice DISC- IV;
- The increasing reliance on evidence-based and promising practices, such as Multi-Systemic Therapy and Functional Family Therapy, to treat mental disorders among youth in the juvenile justice system; and
- The development of collaborative programs and strategies, involving both juvenile justice and mental health agencies, across the country.

Yet, despite these trends and progress, until recently there had been no attempt made to systematically examine these existing efforts, summarizing what it is we now know about the best ways to identify and treat these disorders among youth at key stages of juvenile justice processing. A comprehensive package of this information

could provide guidance and direction to the field.

A Blueprint for Change

Recognizing this need to summarize the state of knowledge in the field, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) launched its largest investment ever in mental health research in 2001. The result of this effort is a report entitled “Blueprint for Change: A Comprehensive Model for the Identification



and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System” (Skowrya & Coccozza, in press). This Comprehensive Model, developed by the National Center for Mental Health and Juvenile Justice, offers a conceptual and practical framework for juvenile justice and mental health systems to use when developing strategies and policies aimed at improving the mental health services for youth involved with the juvenile justice system. The model captures the existing activity in the field, examining the juvenile justice system as a continuum from intake to re-entry, identifying the best ways to respond to youth with mental disorders at key points of contact, and providing recommendations, guidelines, and examples for how best to do this.

Underlying Principles. The Model is centered around a set of Underlying Principles that represent the foundation of a juvenile justice system that is committed and responsive to the mental health needs of youth in its care. These Principles represent the essential elements necessary to create a “model” system and address a range of issues including

- The importance of diverting youth with mental disorders, whenever possible and when matters of public safety allow, into evidence-based treatment in a community setting;
- The need for families to be full partners in the development of treatment plans and decisions for their children;
- The fact that multiple systems share responsibility for these youth and that all responses developed should be collaborative in nature; and
- The need for services to be developmentally appropriate and sensitive to issues of gender, ethnicity, race, age, sexual orientation, socio-economic status, and faith.

Cornerstones. From the Principles emerged four Cornerstones that provide a framework for putting the underlying principles into practice. The Cornerstones reflect areas of improvement that are most critical for enhancing the delivery of mental health services: Collaboration, Identification, Diversion and Treatment. The Comprehensive Model includes a discussion of each Cornerstone, as well as detailed recommended actions that provide direction on how to implement strategies consistent with the Cornerstone. A brief summary of each Cornerstone is presented below.

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

Despite the large numbers of youth with mental health needs in the juvenile justice system, service delivery

for these youth is often fragmented and inconsistent, and operates without the benefit of a clear set of guidelines specifying responsibility for the population. An effective response to this problem must include the development of collaborative approaches involving both the mental health and juvenile justice systems. The recommended actions for this Cornerstone stress that the juvenile justice and mental health systems engage in joint strategic planning, funding, and evaluation activities; that family members be included in all collaborative efforts; and that cross-training be provided to help systems learn about each other.

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

The development of a sound screening and assessment capacity is critical in order to effectively identify and ultimately respond to mental health treatment needs. Screening and assessment should be routinely performed at a youth's earliest point of contact with the system, and standardized instruments should be used. Further, the results of mental health assessments and risk assessments should be linked to help guide decisions about a youth's suitability and need for diversion to community-based services. The recommended actions for this Cornerstone propose

that the mental health screening process include the administration of an emergency mental health screen as well as a general mental health screen, that mental health assessments be administered to any youth whose mental health screen indicates a need for further assessment, and that policies protecting the confidentiality of pre-adjudicatory screening information be in place.

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

Many youth end up in the juvenile justice system for behavior brought on by or associated with their mental health disorder. Some of these youth are charged with serious offenses; many, however, are in the system for relatively minor, non-violent offenses. Mental health experts agree that it is preferable to treat youth with mental disorders outside of juvenile correctional settings (Koppelman, 2005). However, a youth's mental illness and level of risk to community safety must be considered when determining whether a youth can be diverted into community-based treatment. The recommended actions for this Cornerstone advocate that procedures be in place to identify youth appropriate for diversion to treatment, that effective community-based services be available to diverted youth, and that diver-

sion mechanisms and programs be instituted at key decision-making points within the juvenile justice continuum.

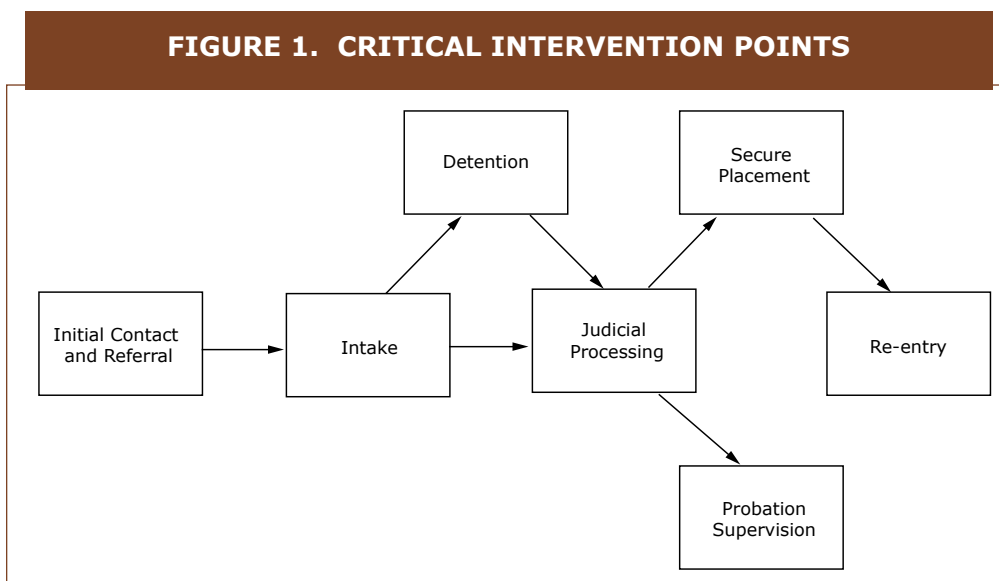
Treatment. Youth with mental health needs in the juvenile justice system should have access to effective treatment to meet their needs.

Enormous advances have been made in this area over the last decade and there are now evidence-based interventions that are well-documented and proven effective for treating mental disorders among youth. Currently, however, the vast majority of mental health services and programs available to treat youth involved with the juvenile justice system are not evidence-based. The recommended actions for this Cornerstone advise increasing the availability and application of evidence-based services for youth in the juvenile justice system, regardless of the setting or level of care; sharing responsibility between the juvenile justice and mental health systems for providing services; involving families as fully as possible in the treatment of their children; and providing services that are trauma-informed and gender responsive.

Critical Intervention Points

The Cornerstones of the Model were then applied to the juvenile justice processing continuum to identify places within the entire continuum—from intake to re-entry—where opportunities exist to make better decisions about mental health needs and treatment. Seven Critical Intervention Points (Figure 1) were identified where the Cornerstones could be addressed or implemented. For each Intervention Point, the Model discusses what happens to youth at that point in the processing and reviews

FIGURE 1. CRITICAL INTERVENTION POINTS



the mental health issues associated with each point.

Program Examples

Over 50 programs are highlighted in the Model, providing illustrations of how communities across the country have taken steps to develop or enhance services at key stages of juvenile justice processing. Among these programs are two that are the focus of articles within this journal. One program is the FIT Program, which provides integrated individual and family services to youth who are transitioning from incarceration back into the community. The other program is the Integrated Co-Occurring Treatment Model, which serves as both a diversion program and a re-entry program for youth with mental health and substance use disorders involved with the Akron, Ohio juvenile court.

What Happens Next?

The Model represents the first-ever systematic, comprehensive review of the ways in which mental health service delivery strategies can be strengthened within the juvenile justice system. While the document is targeted to state and county administrators and program directors from the juvenile justice and mental health systems, any community stakeholder can benefit from the information and examples provided. The Model offers a blueprint for how mental health issues can be better addressed within the juvenile justice system as a whole. By focusing on a series of critical intervention points, the Model also allows jurisdictions to consider implementing individual components of the Model as a first step in improving their systems.

The premise is not complicated: Stronger partnerships between the juvenile justice and mental health systems can result in better screening and assessment mechanisms at key points of juvenile justice system contact, enhanced diversion opportunities for youth with mental health needs to be treated in the commu-

nity, and increased access to effective mental health treatment. The Model provides a detailed blueprint for how communities can achieve these goals. What it cannot do, however, is actually effect the change. That must come from the leaders in the juvenile justice and mental health fields who have



been struggling to develop solutions for these youth. The Model provides a tool to move forward. The energy, hard work and political will to make this happen must come from them.

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This article was excerpted from a 2006 Research and Program Brief produced by the National Center for Mental Health and Juvenile Justice entitled "Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System." For a copy of the Research and Program Brief or further information, please visit the National Center for Mental Health and Juvenile Justice website at www.ncmhjj.com.

VIEWS FROM THE RAD

These essays stemmed from a writing workshop held for young men in the Secure Residential Alcohol and Drug Program (RAD) in Multnomah County, Oregon. The workshop was facilitated by Sara Brant of Write Around Portland (www.writearound.org). Write Around Portland transforms lives by using the power of writing to connect the diverse people of the city—people affected by HIV/AIDS, people in prison, survivors of domestic violence, individuals recovering from addictions, people with physical and/or mental disabilities, refugees, and others.

Since I was three years old, I have been involved with services that were supposed to help me—foster care, individual counseling, jail, probation, and substance abuse treatment. In my case, most of this helping did not work out very well. By 14, I was basically living on the streets and progressing towards using more

Once you're in, it's hard to get out. Harder than any other gang because it's on paper. It's the biggest gang ever; besides, it's the government—it's institutional. I got in when I was eleven—I was doing stupid little kid stuff and was caught during a burglary. It has been a good experience, but one of the hardest things I've ever done. Little stuff that cops would let you off on, once they find out you're on probation—down you go. When I first got put in, I knew I could have gotten out that night but my parents didn't want to come pick me up. If only I'd known it was a turning point. Now I've been in the system for six long years and I feel like it has robbed me of my childhood.

-- Vincent Gilbert

and more serious drugs. All this investment in helping me might have been more useful if two things had been different. First, people could have been a lot more honest with me. What people have said they care about and what they have said they are doing has not matched what they actually seemed to care about or what they actually did. Second, I should have had some input or chances to make choices about what I needed. Instead, people were constantly dictating to me or giving me ultimatums. There have been times when I knew exactly what kind of help I wanted, but people either acted like what I needed was completely unreasonable, or pretended that there was no problem at all. Now, I have chosen to be sober. I am living in a home, going to school, and making a plan for a future I want. Partly this is because of help I received in the substance abuse program, but I did not really buy in to what staff there were telling me. They were not always honest about the program or themselves. Mostly I took in the information and then made my own choices to help myself.

My dad was an alcoholic. My mom was a drug addict. She didn't take care of my two brothers and me, and she gave us to state custody when I was three. I haven't seen either of my parents in more than 12 years. From when I was three to when I was 13, I was in foster care in one home. When I was 13, I began running away. At that time, I was also drinking and smoking marijuana. I would stay away for a while, then get caught and do eight days in jail. What made me run was that the foster parents were not providing a home for my brothers and me.



My foster mother was gambling away money that was supposed to be for our care. She was playing video poker, buying scratch-offs, and going to casinos. There wasn't any food in the house. It was not a happy place to be. From ages nine to eleven, I had been getting individual counseling. I would try to tell them that where I am living, there is no food. They are not feeding us or caring for us. We need a different placement. But no one seemed to care, they wouldn't listen to that and there was no help. Counseling me was not going to fix that situation. I tried to tell my PO [probation officer] the same thing.

I first got arrested for being drunk in public, and then got dirty UAs for marijuana. The guidelines of my probation were very strict. They wanted me to never miss school, keep my job, not miss one appointment. And the consequences were extreme. They'd send me to jail for a dirty UA. To me

I got into the judicial system by hanging out with the wrong crowd. It all started by someone asking me if I smoked weed and I wanted to be cool so I was an idiot and said, "Of course." And then I was always a troublemaker—doing stupid stuff like having the cops come for breaking my neighbor's window because I threw a brick at my older sister and she ducked. And as I got older, when I was around twelve, I started to get into major trouble. The little things added up: shoplifting, breaking into cars and stealing stereos, robbing houses. Then I broke into a store but my parents paid my debt and I still wasn't in the judicial system until I was in 8th grade. Then I met a kid and we broke into three schools and caused \$35,000 of damage. I got probation for about five years—until I'm 18—and while I've been on probation I've been terrible; failing drug tests and breaking into more stores, doing a lot more shoplifting. It's just an ongoing tornado of negative things. After so much stuff, my probation officer was taking it easy on me and I was lucky. But my life went downhill when I got a male probation officer. I started getting longer sentences than I usually would have and then my attorney said that they were thinking of MacLaren. And I didn't think I could handle it so they said, "You've got a choice." And my choice was that I got to go to MacLaren or RAD. I picked RAD and here I am. Been in two months and my counselor thinks that I'm doing very well; so do I. All I really want is to finally succeed and be someone who is sober and not a drug addict.

-- Kyle Malone

there was no way I was going to be able to meet the expectations, no matter how hard I tried. It would either be that I'd try to do what they wanted and get put in jail, or run and end up in jail. So I ran for good. For about a year and a half I lived on the streets. I would go from friend's house to friend's house or stay in abandoned

cars. I slowly progressed from smoking meth to using IV drugs. In the end, after about a year and a half, I just got tired of it all. It's tiring living that way and looking over your shoulder all the time, trying not to get caught. I knew that if I just told the police my name I would be in jail. But eventually that's what I did.

I spent a month in detention and then I had a choice to go into drug treatment. They told me that if I completed drug treatment for six months and stayed on probation for six months I could be done, so I focused on that. For the first four months in the program I didn't think it was helping at all. I thought it was a waste of time. We had individual sessions and groups, and they would show a lot of videos to try to raise your awareness of what drugs would do to you. They would force it on you, and you would get consequence for it if you said anything negative. You had to put on a mask and act like it was helping. If you didn't put in that effort, they'd kick you out. Some kids would get kicked out and go to MacLaren [the state secure facility], which is a way more horrible place where you have absolutely no protection.

Day in and day out, staff in the program tell you that they want to make it so that you can help yourself in the future. At first I didn't believe it, but day in and day out they'd be there and if I wanted to talk they were there. Eventually I realized that being sober was not going to kill me. I couldn't be in drug treatment for six months and not learn something, and after a while it was hard to deny that they were there to help. But I never wanted to participate, it just got easier to fake it. I never did feel like I let the mask down.

When I completed the program, I went to live with the family of a friend I have had for a long time. I had stayed with them some when I was couch surfing. When I got finished with the program, his parents said they would be foster parents, so now I am living in a house and have food and am working toward my GED, things I

would never have had if I hadn't gone through the program. I am planning to continue my education and get a decent job in construction. My foster dad has a construction business where my younger brother and I both work.

I do feel like I was helped, but I think the drug treatment program would have been more effective if staff had given honest explanations about what the program was really like. They say it's better than jail but you are locked in. They say that the staff is only positive, but all in all 80% of what they have to say is negative. They are supposed to inspire you but what we heard was "You're not going anywhere, you're not going to get anything in life, you're a drug addict." You are forced to do what they say be-

Continued on Page 12

The system locks you up and you're supposed to make good decisions and get your life back on track. But when they lock you up, they surround you with people that are just as bad as you, if not worse. And if someone wants to challenge you then you have to meet that challenge or be branded as the bitch on the unit.

Incarceration is supposed to be an experience that teaches you and sets you forward in life. But from my perspective incarceration is a punishment that only holds you back. I personally think that the Juvenile Justice System is a test of strength. If you got what it takes then you can get off with probation. If you don't, then MacLaren is in your future. I honestly think that running from the law would be easier than abiding by it.

When you get into the system there is no turning back. And that's exactly how they made it. When they lock you up, that's when they see your soft spots. And they use your every weakness to their advantage. So basically, the justice system is a black hole that targets adolescents—once it gets a grasp on you, there is no return.

-- Eric Wise

INVESTIGATIONS AND LITIGATION IN JUVENILE JUSTICE



The threat or use of litigation has prompted much of the progress made in the past fifteen years in ensuring adequate mental health services for youth detained or committed to juvenile justice facilities. Both public interest law groups and the U.S. Department of Justice's (DOJ) Civil Rights Division have been responsible for initiating these legal actions.

During the 1980's and until the early 90's, "tough on crime" policies brought about a tripling of the number of youth held in secure settings. Though this dramatic increase in detained youth has stabilized, the "tough on crime" orientation and the rapid increase in population were instrumental in creating a culture in juvenile settings that emphasized an adult model of corrections. The orientation of policy makers and of facility staff shifted away from a rehabilitative approach.

The consequences of this shift were often catastrophic for youth with emotional or behavioral disorders and their families. Youth with serious

mental health disorders were not adequately screened upon entering these facilities, nor were they diverted to more appropriate settings. Understaffing of mental health and medical staff was common within many jurisdictions' facilities. Even when these services were available, the perspectives of mental health and medical staff were frequently overruled by custody staff concerns around security and population management. Suicide rates soared. Youth with psychotic disorders were "managed" with psychotropic medications, and they were often punished by being placed in isolation or restraints.

Worsening of youths' mental health problems was more common than either stabilization or recovery. Recidivism rates (committing new crimes and being rearrested) greater than 70% had become common. Because of the adult orientation of juvenile justice, secure settings limited access for parents and guardians—thus often exacerbating the youth's sense of isolation and disengagement from

family. Rarely were attempts made to engage family members in an integrated rehabilitation approach. Even telephone calls and visiting were discouraged. In addition, a disproportionate number of youth sentenced to these secure settings were and still are minority youth.

Congress passed legislation in 1980 as a way to provide remedies for these issues, but it wasn't until the mid 90's that the federal government began taking aggressive action. Congress authorized the Department of Justice Civil Rights Division to protect the constitutional rights of youth in juvenile detention and correctional institutions. The relevant legislation is the Civil Rights of Institutionalized Persons Act (called CRIPA). CRIPA authorizes the Attorney General to investigate conditions in juvenile institutions and bring litigation when necessary in order to realize systemic "fixes." The Judiciary Committee report that accompanied the bill that became CRIPA called the Act "the single most effective method for redressing systemic

deprivations of institutionalized persons' constitutional and federal statutory rights." The work of DOJ under CRIPA is to seek systemic, policy, and programmatic remedies rather than representing individual youth in actions against jurisdictions. Monetary damages are not sought, but remedies in the form of settlements or consent decrees often require significant infusions of new resources by and to the identified jurisdiction in order to support the required reforms.

Since its inception, DOJ's Civil Rights Division has investigated over 115 juvenile correctional facilities. After an investigation, a "findings" letter is issued. To date most investigations have been resolved without contested litigation and with states or other jurisdictions signing either a consent decree, a settlement agreement, a memorandum of understanding, or a court order.

CRIPA investigations focus on three sources of Federal rights: 1) The Constitution—particularly the 8th (cruel and unusual punishment) and the 14th (due process) amendments. 2) The Individuals with Disabilities Education Act (IDEA) and 3) the Americans with Disabilities Act (ADA). Identified areas of concern fall into the categories outlined in Table 1.

Investigations of these issues are conducted by consultants and attorneys with expertise in juvenile justice. The investigations are designed not only to ascertain whether a pattern of violations exists, but also to provide direct feedback and assistance to the site on appropriate professional standards.

A Case Study

The State of Louisiana offers an extraordinary example of improvement. At the outset, the state's secure juvenile facilities had a pervasive adult correctional orientation, and maltreatment of youth was endemic. By 2006 Louisiana's system was being hailed by both local advocates and the Justice Department as a progressive model for the rest of the country.

TABLE 1. PROTECTION OF JUVENILES' RIGHTS: AREAS OF CONCERN

Protection from Harm Concerns:

- *Impact of crowding—60-youth units are not uncommon, creating dangerous settings*
- *Mix of young offenders with older juveniles, creating opportunities for abuse*
- *Mix of juveniles with minor offenses with those committing serious offenses, offering negative modeling opportunities*
- *Other abusive practices (inappropriate and coercive staff-youth relationships; easy access to drugs and alcohol)*

Suicide Prevention Concerns:

- *Insufficient assessment of youth at risk for suicide*
- *Inadequate mental health services for youth on suicidal precautions*
- *Unsafe housing of youth at risk of self-harm*
- *Inadequate supervision of youth on suicide precautions and in seclusion*
- *Lack of staff preparedness for suicide attempts and other acts of self-harm*

Inadequate Educational Instruction of Youth with Disabilities Concerns:

- *Inadequate assessment*
- *Inadequate individualized education programs (IEPs)*
- *Lack of related services—speech, hearing, and occupational and physical therapies*
- *Lack of adequate instruction for youth with disabilities*
- *Inadequate vocational education for youth with disabilities*
- *Lack of multi-lingual materials*

Inadequate Medical Care Concerns:

- *Inadequate access to medical treatment*
- *Inadequate health assessment*
- *Inadequate medical treatment of chronic conditions and physical injuries*
- *Inadequate medication administrative practices*
- *Inadequate dental care*

Inadequate Mental Health and Substance Abuse Services Concerns:

- *Inadequate screening, identification, and assessment*
- *Inadequate follow-up clinical assessment, treatment planning, and case management*
- *Inadequate psychotropic medication management*
- *Inadequate mental health and substance abuse counseling (i.e., evidence-based practices)*
- *Lack of family involvement*
- *Failure to place youth in court-ordered treatment such as sex offender or substance abuse treatment*
- *Inadequate staff training in behavior management principles*

Inadequate Transition Planning Concerns:

- *Rehabilitative needs/achievements inadequately communicated to parole counselors, families, and community providers*
- *Inadequate transition of youth to community mental health and substance abuse services*

The circumstances for detained youth in Louisiana's secure facilities in the late 1990's were appalling. Louisiana had one of the highest rates of youth in secure facilities in the United States: 582 juveniles per 100,000. Facilities were crowded, violent places with poorly trained staff that used physical force and threats as their primary "strategy" for managing youth.

Youth with mental health and developmental disabilities were neither identified nor appropriately treated. Facilities were located long distances from the youths' communities and the absence of public transportation made it very difficult for families to visit. Seventy-three percent of the youth were incarcerated for non-violent offenses. Sixty percent of these youth

had sentences of three years or more with a quarter of these serving more than five years!

A Department of Justice CRIPA investigation was initiated and the findings were startling. The four large “juvenile prisons” were found to be fostering unsafe and inhumane conditions. In a five-month period at one facility housing 178 youth, 40 youth required treatment in an emergency room for either broken bones or injuries requiring stitches. Youth exhibiting suicidal behavior were punished with long periods of isolation, often in restraints. Every child interviewed reported being hit or kicked or threatened by facility officers. Older youth preyed on younger youth as well as on those with cognitive and emotional challenges.

As a consequence of these findings, a federal judge required the state to immediately initiate comprehensive remedies. In the settlement with Louisiana, the Justice Department delineated over 100 pages of detailed obligations and responsibilities with

timetables and monitoring mechanisms. A key component was the requirement that the juvenile justice system contract with Louisiana State University to provide medical, dental, and mental health services.

Since the settlement, the number of youth held in Louisiana’s secure facilities has been cut in half. One of the four facilities has been closed. National experts have helped the state develop programs that enhance youth strengths and build a positive peer culture. Both the Casey Foundation and MacArthur Foundation have funded comprehensive systems change initiatives in support of the strides Louisiana has made in reforming its system. Although violence still occurs, it is the exception rather than the rule. Non-violent youth are routinely diverted to community based programs. All youth have quality medical and mental health screening and assessments. Treatment programs are utilizing evidence based practices. The system now emphasizes the importance of engaging families and guardians in

the rehabilitation of their children.

The vast majority of the CRIPA investigations have resulted in major remedies with significant and measurable improvement in the areas of concern. There is positive momentum in juvenile justice towards more community-based diversion of juvenile justice youth, greater emphasis on implementing evidence-based practices in working with these youth, and the expectation that families will be active members in the rehabilitation process. Perhaps in the future this momentum will become self-sustaining, and threatened litigation will become less important as a driver of positive change in juvenile justice.

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Continued from page 9: Views from the RAD

cause if you don’t, they send you to jail. I learned in the program, but I did not trust the program.

What happened around when I was 13 was definitely not helpful. It will ruin your life trying to live with someone you don’t want to live with—someone who is abusive or neglecting. I tried to tell people that this was not the place for me, but nothing changed. And when I got put on probation, I knew I could not possibly succeed in meeting their expectations. It might have worked out better if people had cared about what I thought and what I had to say, and if they had worked with me some instead of only telling me what I had to think and do.



-Eric Wise

BAD CONDUCT, DEFIANCE, AND MENTAL HEALTH



The majority of youth in detention have a pattern of aggression, oppositionality, and/or defiance of authority that meets the criteria for a diagnosis of conduct disorder (CD), oppositional defiant disorder (ODD), or both. As a society, our approach to dealing with these young people appears to be based on the presumption that they are “bad”—willfully and perhaps even irredeemably so. Yet we know that between 40% and 70% of youth in the juvenile justice system have mental health problems *other* than CD or ODD. Conduct disorder has a rate of high co-morbidity (co-occurrence) with a host of other mental health and substance abuse diagnoses including depression, bipolar disorder, post-traumatic stress disorder, attention-deficit/hyperactivity disorder, and attachment disorders. CD is also often co-morbid with neurodevelopmental disorders caused when a fetus has been exposed to alcohol, drugs, or other toxins.

When we start to see “conduct

disordered” young people as individuals and begin to explore their unique histories, it becomes more difficult to maintain the image of them as essentially “bad.” Often their stories reflect a skewed developmental process, complicated or ruptured relationships with families and community, traumatic experiences, and/or underlying complex mental health issues. If we build our understanding of problematic conduct around these facts, we are more likely to see these young people as deserving our compassion and our best efforts to help them.

Some of the reasons juvenile offenders are misunderstood can be found in the failings of our system for diagnosing youth. Most psychiatrists have become comfortable with the criteria-based Diagnostic and Statistical Manual (DSM), which since 1973 has been heralded as an objective, scientific document. In reality the diagnostic criteria create a false notion that mental health disorders described in the DSM are well bounded, discrete,

and applicable to people of all ages. In fact most disorders are defined with criteria that apply best to adults. CD and ODD are artifacts of this system. They both have clear criteria allowing for reliable diagnosing. In other words, clinicians presented with the same information will reliably make the same diagnosis. But does the diagnosis mean anything? In the terms of those who seek to define things scientifically, are CD and ODD “valid” disorders?

Many clinicians, myself included, doubt that there is any substance to either of these two diagnoses. Both CD and ODD are known to be extremely heterogeneous (have many causes), and both have high rates of co-morbidity with other diagnoses. Furthermore, a diagnosis of CD or ODD offers no guidance for treatment. Some of us believe that the behavior that is highlighted in the CD and ODD diagnoses is usually an unrecognized manifestation of a co-morbid condition. For example, it is not uncom-

mon to find that a child who meets the criteria for CD is suffering from post-traumatic stress disorder, anxiety disorders, or bipolar disorder. However, the diagnostic criteria for these other conditions were derived from clinical experience and research with adults. Adolescents and children with these disorders are often misdiagnosed because their symptoms—expressed as “bad” conduct—are different from

adult diagnosis of antisocial personality disorder (APD). Having APD is widely (and incorrectly) understood to be synonymous with being a sociopath, that is, having a criminal mind that is fixed and irredeemable. Due to the association between CD and APD, children and youth with CD are often (and incorrectly) presumed to be juvenile sociopaths and thus not worth the effort to treat.

When disruptive behavior is ascribed to CD, there is often little effort to diagnose other disorders or conditions that may be quite amenable to treatment.

the symptoms typical of an adult with the same disorder. A more appropriate view might be that these youth are not actually “conduct disordered with co-morbid disorders,” but rather that they have some developmentally understandable manifestations of a disorder that has been defined in terms of adult behavior and symptoms.

When disruptive behavior is ascribed to CD, there is often little effort to diagnose other disorders or conditions that may be quite amenable to treatment. When treatment focused on CD is pursued, it may well be ineffective, since the root cause of the behavior—the undiagnosed co-occurring condition—remains unaddressed. Worse, the consequences of a CD diagnosis can be quite destructive to a young person’s life chances, due to the stigma attached to the conduct disorder label. Conduct disorder in children and adolescents is linked in the DSM to the

The CD diagnosis is frequently made under sub-optimal conditions. Picture a mental health professional who is charged with evaluating an angry, stubbornly mute youth in a juvenile justice facility. The evaluator has only 15 minutes, no cooperation from the youth, and a long rap sheet of the youth’s alleged offenses. It is easy to see why, with the data available, the diagnosis is CD. There is no opportunity to look deeper for other symptoms or to understand family conflicts or social factors including poverty and racial discrimination. These are supposed to be considered before one makes such a diagnosis. So either the CD or ODD diagnosis—the only di-

agnoses for which available data easily fit criteria—becomes the assigned diagnosis and the youth is unwittingly branded as a juvenile sociopath or an incorrigible. It is then easy to rest with the statistics indicating no specific treatment has been found to treat CD or ODD. We forget to take into account that the causes of CD are variable. No one treatment could ever fit all cases. As a result, many youth felt to have “behavioral problems” (as opposed to mental health problems) are not considered good subjects for mental health treatment. Instead, these youth are seen as “bad” and deserving of juvenile “rehabilitation” in a jail-like facility. If more classic symptoms of a mental health diagnosis emerge during their juvenile justice placement, these will be handled separately, on the side, and won’t alter the presumption that the youth is primarily bad and in need of “correction.”

As adults, we may have difficulty seeing defiant, problematic behavior in a social-developmental context. During adolescence, youth begin to define their social identities, and to understand that the choices they make have important consequences for their current and future social and economic position in society. Making these choices can be exhilarating for youth as they seek to realize personal ambitions, explore talents, and build new kinds of relationships. Making choices, however, can also bring enormous social and psychological stress. This stress is compounded for youth who have some form of social disadvantage, including a mental illness. Given that the developmental task of adolescence is to find one’s place in the social order, it makes sense that youth who encounter difficulties in that task will communicate their frustration, anger, or sadness in socially meaningful ways and behavior—either verbal or action-oriented. Troubled or angry behavior is a prime means by which individuals express social distress. When we look at the behavior of troubled adolescents, be it self-harm, self-starvation, shoplifting, or graffiti, we are well advised to



try to read the behavioral message the young person is communicating.

Troubling behaviors can also be understood as a young person's effort to find relief from emotional distress. Many youth say that "acting out"—cutting, gorging and purging, drugging, drinking, shoplifting, or stealing cars—is primarily a way to escape pain. Some of these behaviors offer distraction or temporary relief from the problem at hand, and extreme antisocial acts may serve to replace distress with excitement or drama. Despite the risk and the possibility of further pain or other negative consequences in the future, these behaviors are reinforcing because they do provide immediate relief, distraction, or escape from pain.

As adults, we react in confused and angry ways when confronted with behavior that we do not understand. Blaming the youth may be easier for us than acknowledging the social ills that the behavior highlights: alienation, oppression, or a lack of opportunity or social justice. Our own anger leads us to try to contain, repress, and control the behavior. But this response, however natural, serves to exacerbate the alienation, despair, and anxiety that young people often feel. Most adults are unaware of the angst that underlies adolescents' behavior. Unwittingly, we engage with them in an angry dance, and by participating in that dance, we may aggravate the problems.

The juvenile justice system has a dual mandate: protecting society from dangerous youth and rehabilitating youth so that they will no longer be dangerous. It is clear that our current systems are not satisfying this mandate and that they are particularly unsuccessful in the area of rehabilita-

tion. One strategy for improvement is to get away from the idea that noncompliant youth have a series of separate behavior, mental health, or substance abuse problems that require separate (though possibly coordinated) services. Fragmented care plans reflect a poor understanding of these youth and their needs. Instead, when we understand each youth in terms of his or her unique story, context, and communications, we can develop a



comprehensive plan that fits with his or her needs. We can also do better by integrating the meaning of socially offensive behavior into our understanding of youth, and then by building a relevant treatment plan that responds to their underlying emotional pain and social alienation.

Let me illustrate how these concepts play out in a case example. Andre is a thoughtful, introverted 17-year-old boy with an exceptional artistic talent. A high school art teacher recognized Andre's talent, and she facilitated his receiving a scholarship to attend an art school. However, a pattern of "tagging" on the sides of buildings all over town led to six arrests and time in juvenile detention for graffiti. Approaching his 18th birthday, Andre had a series of missed court appearances and a bench warrant for his arrest. He was told that any new charge would

lead to a remand to adult court, a long sentence, and transfer to an adult jail at age 18.

After several arrests a court psychiatrist diagnosed Andre with CD based on a pattern of property destruction with graffiti, stealing art supplies from stores, and chronic truancy. A new probation officer requested a more in-depth evaluation with a therapist familiar with the wraparound process. Clinical evaluation revealed a severe

anxiety disorder and depression, both of which were partially helped by medications. Andre essentially lived alone in a trailer. His mother was often gone with boyfriends, drinking for weeks. An outreach to Andre's mother and maternal uncle was made, and both agreed to be on his wraparound team. The team supported Andre's uncle in his effort to get Andre's mother into a chemical dependency treatment program. Andre

was terrified to be at school, except for his art class where he felt cared for by the art teacher. She saw his strengths and was delighted to be on the wraparound team. The team arranged for Child Protective Services to place Andre briefly in a group home so that he could qualify for an Independent Living Skills program. This program helped him find housing with good supports. Several of those involved in his transitional housing program joined Andre's wraparound team, as did his probation officer. A peer-to-peer outreach worker was able to help his fellow taggers understand their friend's legal peril and they too supported Andre in abstaining from graffiti. One of these peers agreed to be on the wraparound team. The team found money to buy art supplies on the condition that Andre would use them in legal and responsible ways.

The team was able to convince the court not to place Andre in detention on the condition that he complete his GED and enroll in art school. Once in that program Andre was able to lead a project creating a mural on the side of a county building.

Andre escaped the dreadful dance with the court that could have led him into a criminal lifestyle. Committed professionals, including a probation officer, a teacher, and a mental health counselor, helped Andre get beyond the dead-end CD diagnosis and get adequate treatment for his anxiety disorder and depression. Friends and family joined the professionals on Andre's wraparound team, and as a group, they facilitated a series of individualized family and social interventions that were developmentally sensitive and that honored his peer connections and recognized his peer support. The team supported his mother as she addressed a problem that had left Andre prematurely on his own, thus giving him additional peer and adult supports.

Andre's situation highlights a possible resolution of the often-colliding forces from deferent child-serving systems: courts, social services, mental health, and schools. The wraparound process focused on practical issues. This boy was not seen as a walking diagnosis, even though getting medication for his chronic anxiety disorder was a part of the resolution of his problems. As the professionals working with Andre came to understand the meaning of his behavior, they were able to join family and peers in addressing Andre's challenging behavior. "Conduct disorder" was not mentioned by his wraparound team. That term was not helpful and did not offer guidance for planning. The appropriate diagnosis of his anxiety disorder did lead to treatment that contributed to his successful outcome. However, the primary factor underlying this success was that the people around Andre were able to see him as an individual, and to respond in a manner that acknowledged his strengths, his needs, and his adverse

social and family circumstances. A practical planning process based on this perspective helped Andre give up his behavioral distress signals and helped the professionals around him avoid branding him as a sociopath.

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DIAGNOSIS OF CONDUCT DISORDER

According to DSM-IV criteria, conduct disorder is a repetitive and persistent pattern of behavior in which the basic rights of others, or major rules and values of society are violated, as shown by the presence of three (or more) of the following behavior patterns in the past 12 months, with at least one behavior pattern present in the past six months:

Aggression to people and animals:

1. Often bullies, threatens, or intimidates others.
2. Often initiates physical fights.
3. Has used a weapon that can cause serious physical harm to others (for example, a bat, brick, broken bottle, knife, gun).
4. Has been physically cruel to people.
5. Has been physically cruel to animals.
6. Has stolen while confronting a victim (for example, mugging, purse snatching, extortion, armed robbery).
7. Has forced someone into sexual activity.

Destruction of property:

8. Has deliberately engaged in setting fires with the intention of causing serious damage.

9. Has deliberately destroyed others' property (other than by fire setting).

Deceitfulness or theft:

10. Has broken into someone else's house, building, or car.
11. Often lies to obtain goods or favors or to avoid obligations (in other words, "cons" others).

12. Has stolen items of nontrivial value without confronting a victim (for example, shoplifting without burglary; forgery).

Serious violations of rules:

13. Often stays out at night despite parental prohibitions, beginning before age 13 years.
14. Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period).
15. Is often truant from school, beginning before age 13 years.

OVERVIEW OF THE FIT TREATMENT MODEL



It is estimated that 65-70% of youth in the juvenile justice system have a mental health diagnosis, and approximately 20% have a serious mental health disorder (Teplin et al. 2002; Cocozza & Skowrya, 2000). Juvenile justice systems in the United States are recognizing the need to treat mental health concerns among youth detainees to reduce the risk of recidivism and improve the overall well-being of detained children. When youth receive treatment while in an institution, their adaptive functioning may increase; however, youth may face difficulties in maintaining these gains when they are released. As they return to their communities, they may face a variety of risks that challenge their ability to maintain sobriety and avoid illegal behavior. These risks include troubled family environments, exposure to friends or family members who use substances or engage in illegal behaviors, unstructured time, problems with school or occupational performance, and lack of reinforcement for improved behavior. Research

supports the importance of providing support during this critical transition period (Bullis et al., 2002; Trupin et al., 2004).

Family Integrated Transitions (FIT) provides integrated individual and family services to juvenile offenders with mental health and chemical dependency disorders during the period of the youth's transition from incarceration back to the community. The goals of the FIT program include lowering the risk for recidivism, connecting the family with appropriate community supports, achieving youth abstinence from alcohol and other drugs, improving the mental health status of the youth, and increasing prosocial behavior. FIT has been implemented in four counties in Washington State (King, Pierce, Snohomish, and Kitsap) by two clinical provider teams, and has provided an unprecedented level of service to youth who are among the most difficult to treat in the juvenile justice, chemical dependency, and mental health treatment systems.

The FIT approach combines three evidence-based interventions with the goal of targeting multiple determinants of noncompliant behavior. The overarching framework of the intervention is derived from Multisystemic Therapy (MST), a scientifically-validated, cost-effective, intensive family preservation model for community-based treatment that has been shown to be effective with youth with non-compliant behaviors (Henggeler et al., 1998). Intervention targets the various systems that are involved with the child, including family, peers, schools, probation/parole, and other community supports, in order to create an environment that supports positive behavior in the long term. Because caregivers are recognized as the key to the youth's long term success, MST strongly emphasizes parents' empowerment, both within systems that affect their families and in relations with their children. Therapists coach caregivers in establishing productive partnerships with schools, community supports, parole, and other systems;

and help caregivers develop skills to be effective advocates for their children. Therapists also work intensively with parents to bolster their family management skills, including monitoring, contingency management, conflict resolution, and relationship enhancement. The objective is to help the parent create



a home environment that holds the youth accountable for his/her behavior and that makes prosocial behavior more rewarding than antisocial behavior. The University of Washington is an MST Network Partner, and the standard MST fidelity and quality assurance procedures are incorporated into FIT. One difference is that FIT provides monthly booster training sessions for FIT therapists and supervisors, whereas standard MST provides booster training quarterly. Other non-MST treatments used by FIT (described below) are also topics for booster sessions.

uting factors to a youth's criminal behavior, poor functioning at home and in the community, and substance use. Emotional dysregulation within a family can also have an indirect effect on the youth's behavior, since such problems can interfere with a parent's ability to effectively monitor a youth, consistently implement contingency management plans or maintain a warm, caring relationship. Recognizing that enhancing the ability of both the youth and the parent to manage impulses and distressing emotions is pivotal to a behavior intervention, FIT incorporates elements

Engaging and retaining families in treatment by enhancing their motivation to change is a cornerstone of the FIT intervention.

MST focuses on increasing the extent to which environments around a youth support prosocial behavior. However, a youth's own skills and capacities must also be bolstered if he or she is to be successful in the community. Poor impulse control, anger management problems, mood swings, and other types of emotional and behavioral dysregulation are hallmark symptoms of a range of mental health diagnoses common among youth in the juvenile justice system. These problems are often primary contrib-

of Dialectical Behavior Therapy (DBT) into the intervention. DBT is an empirically validated treatment designed to replace maladaptive emotional and behavioral responses with more effective and skillful responses. Clients are taught a series of skills that enhance the capacity to monitor emotional states, control emotional arousal, tolerate distress, and interact with others in a more effective manner (Linehan, 1993). In Washington State, DBT skills are taught to youth who are incarcerated in Juvenile Re-

habilitation Administration facilities. FIT therapists build on the skills that youth have acquired in the institution and coach youth in using these skills in real-world settings. Therapists also teach these skills to parents so that parents can both use these skills themselves and support the youth in maintaining the skills in the long term. A DBT consultant participates in the weekly telephone consultation to the FIT teams, and provides DBT booster sessions.

Youth involved in the juvenile justice system and their families are often reluctant to participate in therapy and have a high probability of dropping out of treatment. Even if a family enrolls in and completes treatment, treatment is unlikely to have lasting positive outcomes if the family is not committed to change. Thus, engaging and retaining families in treatment by enhancing their motivation to change is a cornerstone of the FIT intervention. FIT relies heavily on the engagement techniques of Motivational Enhancement Therapy (MET), an approach developed by Miller and Rollnick (1991) to engage clients in treatment with the objective of increasing their commitment to change. It is a focused and goal-directed approach, with the overarching objective of helping clients to explore and resolve ambivalence about change. In FIT, change happens at several levels: the parent's monitoring and contingency management practices; the parent's and the youth's interactions with the school, peers, and the community; the youth's criminal behavior and substance use; and the parent's and the youth's ability to regulate emotions, tolerate distress, and interact with others in a respectful, effective manner. All of these changes require sustained effort and commitment if they are to be maintained in the long term. The FIT therapist uses MET techniques to develop initial engagement of all parties (the youth, parents, school personnel, probation officer, and others) and to maintain commitment to the changes that are being made. MET permeates every aspect of the FIT intervention.

FIT ELIGIBILITY CRITERIA

1. Any youth 17 ½ years or younger, being released from a Washington State Juvenile Rehabilitation Administration residential commitment to four months or more of parole supervision; WITH

2. Any Substance Abuse or Dependence Disorder; AND

3. Mental health concerns as evidenced by:

a. any AXIS 1 Disorder (excluding those youth who have only a diagnosis of Conduct Disorder, Oppositional Defiant Disorder, paraphilia, or pedophilia) OR

b. currently prescribed psychotropic medication, OR

c. demonstration of suicidal behavior within the last three months, AND

4. Residence in one of the counties currently served by the program (King, Pierce, Snohomish, or Kitsap).

Youth and families who participate in FIT are assessed to determine their unique treatment needs, and services are tailored to meet those needs. Treatment focuses on family strengths, and goals are set by the family. Services are provided in the family's home with a minimum of one scheduled appointment per week. Therapists are available on a 24-hour-per-day, 7-days-per-week basis to respond to crises and provide between-session skill coaching by telephone as needed. Treatment begins approximately two months before the youth is released and continues for a total of approximately six months.

Outcome Evaluation

In 2004, the Washington State Institute of Public Policy (WSIPP) released a report on the criminal outcomes and cost effectiveness of the FIT program (Aos, 2004). Youth who received FIT services were compared to a matched comparison group who resided in counties not served by the FIT program but otherwise met FIT eligibility criteria. At 18 months post release, felony recidivism was 34% lower for FIT clients (27%) than for comparison youth (41%), a statistically significant difference. A cost-benefit analysis indicated that for every dollar spent on the FIT program, \$3.15 is saved in criminal justice expenses and avoided criminal victimizations.

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WHAT FAMILIES THINK OF THE JUVENILE JUSTICE SYSTEM: FINDINGS FROM A MULTI-STATE PREVALENCE STUDY

Families are a valuable and largely untapped resource for the juvenile justice system. When youth with mental health needs come into contact with juvenile justice, family members can contribute background information and insight into their child's condition, provide support and assurance to their child, and play a vital role in carrying out transition plans (Osher & Hunt, 2002). Juvenile justice researchers, practitioners, and policy makers are increasingly acknowledging the need to understand and work within youths' social and family contexts (MacKinnon-Lewis, Kaufman, & Frabutt, 2002). Unfortunately, parents often find themselves isolated from and confused by the complexities of the juvenile justice process, and their knowledge and skills are overlooked or underutilized.

A recently completed multi-state study of mental health problems of justice-involved youth, conducted by

the National Center for Mental Health and Juvenile Justice with support from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the Center for Mental Health Services (CMHS), was undertaken to determine what services are provided to youth with mental health needs who are in the juvenile justice system and to obtain family perspectives about the care and treatment of their children.

Gathering Perspectives

NCMHJJ researchers collaborated with the Federation of Families for Children's Mental Health (the Federation) to conduct focus groups with parents and primary caregivers of youth currently in or recently discharged from the juvenile justice system in Louisiana, Texas, or Washington. The goal of the focus groups was to obtain families' views of their children's mental health needs, their assessment

of adequacy of the services they received, and their recommendations for how the juvenile justice system can improve services to youth with mental health needs. Findings from the focus groups are reported here.

Family members tend to be "on guard" to protect themselves from the discomfort of reliving painful experiences, anxiety about revealing troubling family situations, or fear of reprisal if they are critical of people who can make decisions about their child's care or services. Ordinarily, this can leave family members reluctant to participate in research and to disclose sensitive information to researchers. Collaborating with the Federation, a family-run support and advocacy organization, allowed the research team to establish trust quickly with participants. The Federation enlisted its local affiliates in the three study states to provide background for the research team and to introduce the research

team to potential participants. The affiliates were paid to recruit participants; secure a comfortable, safe and convenient location; arrange for transportation and child care as needed by participants; provide light refreshments; and prepare participants by explaining how a focus group differed from a support group. The Federation provided a professional staff member who worked with the researchers to develop the focus group protocol and who served as the moderator for the focus groups.

To get family views of the system, researchers asked participants four questions:

1. What mental health services and substance abuse services did your child receive?
2. Were services adequate, appropriate, or effective?
3. What services helped your child the most? and
4. What happened when your child was discharged?

To get recommendations for system change researchers asked participants two further questions:

1. What prevents youth from getting effective mental health services while they are in juvenile justice facilities or programs? and
2. What do you think could help improve the mental health services provided in juvenile justice facilities and programs?

Most participants reported having worked tirelessly to get their child help prior to juvenile justice system involvement. Yet most were also dismayed and bitterly disappointed with the care and treatment their children had received. They attributed the failure of these efforts to lack of developmentally and clinically appropriate services in their community or the inaccessibility of such services. The

majority of participants felt that the mental health and substance abuse services provided while their children were involved in the juvenile justice system were inadequate and inappropriate. Parents saw juvenile justice as

the system of last resort; a number of parents reported intentionally involving their child in the juvenile justice system with the hope that they would finally be able to access services that were unavailable to them in the community. The subsequent failure of such services to materialize was very troublesome.

Focus group participants did identify some services and service approaches that had been helpful—though they also noted that these kinds of services were not widely available. Helpful service approaches included peer support and family-directed as-

sistance with information, rights, and procedures; treatment that addressed troubling behavior in a rehabilitative and therapeutic rather than a punitive manner; collaborative planning with all agencies working together with

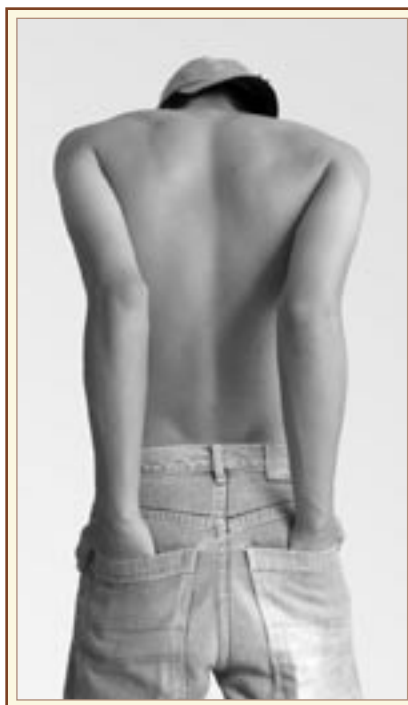
Increasing the capacity of the juvenile justice system to understand and respond to the needs and concerns of families is critical for improving the system's response to the youth in its care.

families to tailor services to the child's and family's needs; probation officers with a mental health background who provided caring, useful advice; and in-home and crisis intervention services and other direct services.

Barriers

A major barrier to good services was the nature of the relationship between the school system and the juvenile justice system. Sometimes, families encountered a frustrating lack of collaboration or continuity. For example, participants reported that becoming involved in juvenile justice was accompanied by major disruptions in their children's education. Often, after a child entered the juvenile justice system, communication with education agencies was almost nonexistent. Participants also reported that schools resisted enrolling youth after discharge from a juvenile (or adult) correctional facility. Where the two systems did work together, the linkages could be problematic. For example, several participants reported that it was school policy to allow staff to issue "tickets" for fighting, swearing, or skipping classes. These "tickets" were equivalent to a \$500 fine and required a court appearance by both the students and their parents.

Another cluster of family concerns and barriers centered around the role and performance of probation officers. Inconsistency in the amount and



quality of support from probation officers made it difficult to get accurate information, and inhibited access to services. Dramatic, negative changes were reported when probation officers placed youth into services and programs that families could not access. Poor or no follow-up by probation officers resulted in a lack of support for a successful reintegration into the community. For example, failure of probation officers to communicate and collaborate with families strains



the parent/child relationship and makes it more difficult for the parents to understand probation requirements and to encourage their child to fulfill them.

Legal and financial issues also presented significant barriers. Poor legal representation for youth was a common concern, and families worried that their children were being labeled as criminals. Participants faulted the juvenile justice system for not involving parents in the legal decisions being made for their children or communicating court decisions with families in a timely manner. Not being able to afford services, being ineligible for Medicaid, being too poor to afford private care, and not having insurance coverage for behavioral health services were also frequently identified as primary barriers to good care both in the community and in the juvenile

justice system.

A recurring theme identified by the focus group participants was disappointment over the failure of the juvenile justice system to involve families. Many parents reported feeling blamed or looked down on by the juvenile justice system, as if they were being held responsible for their child's behavior. Participants repeatedly said that some form of peer/parent support system, while not very often provided, was extremely helpful. They spoke frequently about the complexity of the juvenile justice system and the difficulties it imposed on parents. Many told of being confused and frustrated as they tried to understand what was happening to their child. Several pointed out that there is no time when the juvenile justice system explains its processes or parental rights and options. The failure of the system to offer this support to parents makes navigation and understanding of the process almost impossible.

Many participants indicated that the burden placed on families is magnified by the lack of collaboration and communication between the mental health, juvenile justice, and school systems. They gave examples of treatment and medications being interrupted during transitions from one system to the next. The failure of any one agency to take responsibility for mental health care forces parents to take the lead in directing their child's care. This task can quickly become overwhelming and discouraging in an environment in which families are viewed as part of the problem, are isolated and ignored, and are not provided with resources sufficient to meet their children's needs.

The poor quality of care and services provided by the juvenile justice system was primarily attributed to inadequate training and high turnover of both direct care and professional staff in the facilities. Parents expressed their frustration with the "one-size-fits-all" approach to treatment typical in the juvenile justice system and considered it ineffective as well as time consuming and costly.

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The vast majority of participants felt that their children did not receive adequate treatment for mental health or substance abuse problems while in the juvenile justice system. According to the focus group participants, youth were not screened for mental health or substance abuse problems until they were already deeply immersed in the system. Furthermore, even after a mental health issue was identified, behavioral manifestations of the problem were addressed in a punitive way rather than in a therapeutic way.

According to some of the focus group participants, the juvenile justice system did not create or implement any transition plan for their children. Others reported that their children were given transition plans that were unrealistic or that set them up for failure. They saw the failure of transition plans as due in part to the system's failure to involve parents in transition planning. Yet it was frequently noted that, once a youth had been released, the system expected parents to carry out the transition plan, regardless of whether they had been involved in developing it. This overwhelming task typically required coordinating and arranging services, providing transportation, arranging for supervision of their child, and other assignments nearly impossible for the family to carry out on its own.

Recommendations

The participants in the three focus groups had several recommendations for improving the delivery and effectiveness of mental health and substance abuse services within the juvenile justice system and for increasing family involvement. In particular, participants felt that providers and administrators should be encouraged to look at families as a potential resource. Most of the participants felt that when families are perceived as part of the problem, providers are reluctant to involve them in the care of their children. They suggested that eliciting parental insight be formally included in every stage of the juvenile

justice process.

Participants also strongly recommended the widespread implementation of family support mechanisms. The sources of support could be formal or informal, but should be consistently available. Examples given



included scheduling support groups to coincide with visiting days, providing opportunities for conversations with parents in similar situations, and connecting families to advocacy organizations such as the Federation. All three groups felt that increasing the amount of support available to parents would greatly improve the delivery of services. Additional support mechanisms mentioned included providing information on parental rights, the juvenile justice process, and alternative treatment options available; and facilitating good relationships between parents and probation officers.

Participants recommended improving the overall quality of services in the juvenile justice system by attracting and retaining qualified service providers, especially in underserved rural areas. Some suggestions focused on the actual services that were provided. Frequently mentioned was the importance of screening and addressing the mental health needs of youth immediately upon entry into the ju-

venile justice system. It was pointed out that although the juvenile justice system has safety as its primary concern it must also pay attention to and provide effective treatment for mental health problems. This treatment should focus on addressing underlying clinical issues rather than simply controlling behavior. Finally, parents felt that service quality could be improved if more attention were directed to the trauma and sexual abuse histories of youth, issues that are largely ignored by the juvenile justice system.

Increasing the capacity of the juvenile justice system to understand and respond to the needs and concerns of families is critical for improving the system's response to the youth in its care. The findings from these focus groups reveal the family perspectives about the system and offer practical recommendations to policy makers, administrators, and practitioners.

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THE INTEGRATED CO-OCCURRING TREATMENT MODEL (ICT): A NEW TREATMENT MODEL FOR YOUTH WITH CO-OCCURRING DISORDERS INVOLVED IN THE JUVENILE JUSTICE SYSTEM



In recent years, it has become clear that a majority of youth involved in the juvenile justice system struggle with mental health disorders (Skowryra & Coccozza, 2006; Teplin et al., 2002). New research is also showing that a substantial number of these youth—approximately half of them—also have co-occurring substance use disorders (Hussey et al., 2005; Skowryra & Coccozza, 2006). One study found that 63% of juvenile detainees assessed as having a substance abuse disorder were also co-morbid for at least one mental health diagnosis (Hussey et al., 2005).

It is also becoming clear that for many of these youth, mental health and substance abuse disorders are not the only difficulties in their lives. A recent study (Turner et al., 2004) found that 44% of youth with substance abuse problems had *multiple* co-occurring problems (e.g., substance abuse, internalizing and externalizing problems, illegal activity, and/or victim-

ization), and one review of substance abuse literature (White, White, & Dennis, 2004) concludes that multiple co-occurring problems should be considered an expectation and not an exception for adolescents with substance abuse problems.

Therefore, when we think about treatment interventions for youth with co-occurring mental health and substance abuse disorders who are involved in the juvenile justice system, we need to adopt a perspective that encompasses more than just the various diagnoses that a young person has been given. We need to think holistically about the conditions, contexts, and constraints that impact a young person's life and behavior. This sort of holistic view encompasses not just the problems, but also the assets and abilities that are internal to youth or present in their environments. Thus, instead of using the term "co-occurring disorders," we prefer "multiple-occurring conditions," a term that

acknowledges the complex conditions and contexts that affect youth with co-occurring disorders who are involved in the juvenile justice system.

Integrated Treatment

Adopting a holistic perspective makes it clear that treatment for multiple-occurring conditions must be *integrated*. In general, there are three types of treatment for persons with co-occurring disorders.

Sequential treatment. Services are delivered in succession, one service at a time.

Parallel treatment. Services are provided in the same time period, but by different professionals, often in different agencies or systems, requiring different assessments and different treatment plans.

Integrated treatment. Both mental health and substance abuse services are provided by one provider or provider team in the same program, uti-

lizing one integrated treatment plan.

There is little evidence that sequential or parallel approaches are successful in treating the complete needs of youth—or adults—with co-occurring disorders. Dennis (2004) found that “substance abuse treatment helps to reduce the frequency of use and the number of abuse/dependence symptoms but has only indirect impact on emotional and behavioral problems.” Correspondingly, Geller and colleagues (1998) found that psychiatric treatment alone for mood disorders did not significantly reduce youth’s substance use. In addition, The New Freedom Commission on Mental Health (2003) reported that “if one co-occurring disorder remains untreated, both usually get worse.” In contrast, integrated services, in which the person is treated holistically by one provider or provider team, have been shown to be successful with adults, and are the recommended treatment modality for persons with co-occurring disorders (Mueser et al., 2003).

Integrated treatment for adolescents must be developmentally appropriate, and therefore differs from

integrated treatment for adults. Table 1 summarizes important ways that youth with co-occurring disorders tend to differ from their adult counterparts. These differences impact the conditions and contexts that youth experience, and must therefore be taken into account when designing developmentally appropriate treatment.

Appropriate treatment modalities for youth reflect many of these differences. Treatment for adults with co-occurring disorders has a decidedly individual focus featuring group therapy and support groups as the primary treatment modalities. By contrast, treatment for youth has a developmental and systemic focus, utilizing family therapies and placing an emphasis on system collaboration. Building on these considerations, we have worked on the development and evaluation of a new community-based treatment model designed specifically for youth with co-occurring disorders involved in the juvenile justice system. This model is called the Integrated Co-Occurring Treatment (ICT) model (Cleminshaw, Shepler, & Newman, 2005).

The ICT Model

In the Fall of 1999, through the support and guidance of the Ohio Department of Mental Health (ODMH), the Center for Family Studies at the University of Akron convened an eclectic model development group, including youth, families, and professionals representing expertise in the fields of mental health, substance abuse, and juvenile justice (state and local). The group was charged with developing an integrated treatment approach for youth with co-occurring disorders utilizing a home- and community-based service delivery model. The model development group created the ICT treatment approach based on six major components:

1. System of care service philosophy,
2. Home-based service delivery model,
3. Integrated contextual treatment addressing both mental health and substance abuse disorders,
4. Comprehensive service array matched to need,

TABLE 1. KEY DIFFERENCES BETWEEN YOUTH AND ADULTS WITH CO-OCCURRING DISORDERS

	Youth	Adults
Supports	Legally mandated supports—family, school, juvenile court, child welfare	No mandated supports
Family	More family involvement	Less family involvement
Responsibility	Parent/custodian legally responsible for youth; youth is responsible for his or her behaviors	Fully responsible for well-being and behaviors
Life Tasks	School, life skills, working toward independence	Housing, employment, physical and mental health
Self/Social Cognition	Belief in self as invincible; concrete thinking; interdependent	Increased awareness of self’s vulnerability; abstract thinking; independent
Diagnoses	Substance abuse; emotional or behavioral disorders	Substance dependency; serious mental health disorders
Sobriety	Less likely to consider sobriety as an option; earlier stage of substance use	More likely to consider sobriety as an option
Consequences of Substance Use	Fewer negative experiences; consequences have less impact; rewards of use may outweigh costs	Additive effect of consequences over time; more significant and serious consequences; increasing awareness of costs
Life Focus	Gathering experiences	Preserving life

5. Stage-wise treatment and motivational interviewing strategies focusing on adolescent development, and
6. Risk reduction and resilience-building framework.

Treatment using the ICT model is based on the following principles:

Assessment and treatment integration. Treatment for youth with co-occurring conditions should be integrated, with one provider, one assessment, and one treatment plan.

Treatment salience. Services focus on the most salient presenting symptom, concern, and/or need of the youth and family.

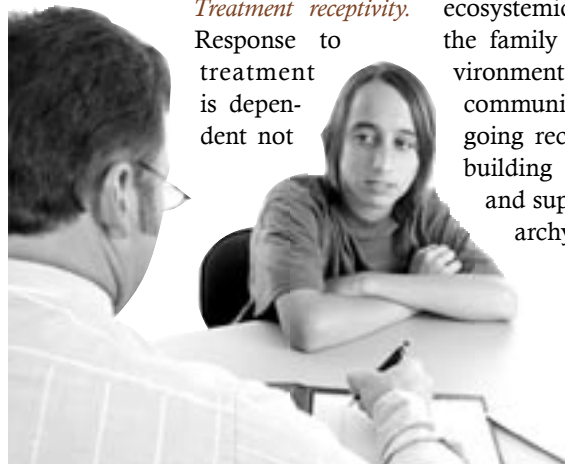
Resource preservation and enhancement. Interventions focus on maintaining the youth's and family's current resources, while building resources and supports where they are needed, with the ultimate goals of individual and family resiliency.

Treatment persistence. Providers are persistent in working with the child and family without giving up on them. When difficulties are encountered, providers are committed to changing the plan rather than rejecting the child and family from services and support.

Family competence. Partnerships are built upon a thoughtful understanding and respect for each family's unique cultural, racial, spiritual, and ethnic traditions, values, and life perspectives.

Cross-system collaboration. ICT providers take a lead role in facilitating the coordination of formal and informal services and supports, as guided by the youth and family.

Treatment receptivity. Response to treatment is dependent not



only on the consumers' motivation and readiness for change, but also their perceptions of the mandates placed upon them, providers' clinical and cultural credibility and trustworthiness, and the quality of the therapeutic alliance.

Interactive determination and contextual functioning. A youth's behaviors are interactively and multiply determined based on his or her mental health, substance abuse, functional environments, and abilities.

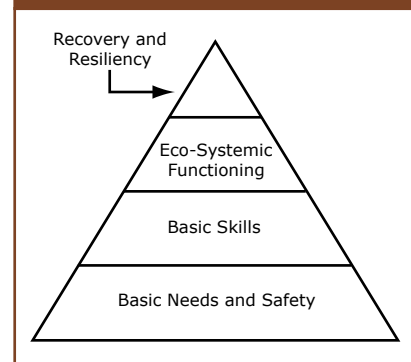
Harm reduction. ICT actively monitors and plans for safety with the goal of reducing harm, risk behaviors, and exposure to risk-generating environments.

Shared responsibility for change. The therapist is accountable for treatment persistence and model fidelity; the youth is responsible for his or her recovery; and the family is responsible for setting the stage for the youth's recovery.

Utilizing a risk and protective factor framework, ICT focuses on reducing risk behaviors and exposure to risk-generating people and environments while simultaneously fostering resilience and building developmental assets. Thus, the main goals of ICT are harm and risk reduction, reasonable functioning in major life domains, symptom reduction, relapse prevention, and ongoing recovery and resilience. To achieve these goals ICT focuses on four main treatment areas: 1) basic needs, safety, and risk factors; 2) individual symptom reduction, recovery, and functioning; 3) ecosystemic functioning, including the family system and recovery environment, school functioning, and community functioning; and 4) ongoing recovery and resiliency, and building community connections and supports. A family need hierarchy (Shepler, 1991; Shepler & Cleminshaw, 1999) is utilized to assess and prioritize the youth's and family's needs (see Figure 1).

Strategies and interventions are matched

FIGURE 1.
FAMILY NEED HIERARCHY



to the most basic need first. Treatment focus progresses to more complex needs once the primary needs are met. A flexible array of individual and family therapies, skill building, crisis stabilization, case management, and wraparound planning are utilized to comprehensively impact family functioning and the youth's mental health and substance abuse needs.

The model has been field-tested in the community with a group of youth with co-occurring disorders who were juvenile court-involved. This pilot study compared 56 adolescents receiving ICT to 29 youth who received usual services in the community. Results indicated that the ICT youth responded more favorably. The recidivism rate for the youth receiving usual services was 72%, while it was only 25% for the ICT youth. In a separate analysis of the youth receiving ICT, functional and behavioral improvements were also noted. While these findings are promising, the results must be interpreted with caution as a true experimental design was not utilized and the number of youth studied was relatively small.

While there is an increased recognition of the prevalence and the need for services for youth involved with the juvenile justice system that have co-occurring disorders, much more research is needed to further our understanding of the special needs of these youth. The ICT model is one promising practice that was developed to address the unique needs of these youth and their families.

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A SHORTAGE OF MENTAL HEALTH SERVICES DRIVES INAPPROPRIATE PLACEMENTS IN JUVENILE DETENTION

Recent reports paint a disturbing picture of youth with mental health difficulties being “warehoused” or “dumped” in juvenile justice detention centers because appropriate treatment is not available. Thousands of young people with mental health needs are held in detention for minor offenses that normally do not warrant detention, and others linger in detention facilities even though they have not been charged with any crime. In some cases, youth become entangled with the juvenile justice system because their parents believe that this is a route to accessing mental health services. Tragically, most of these young people do not receive the treatment that they need. Remedies for these problems are being explored, and often rely on collaboration and creative funding.

Optimally, most of the children with mental health needs who are currently in detention would instead receive community-based treatment, while some others would be placed in residential treatment facilities. However, appropriately intensive care is often not covered by private health insurance. Even under mental health parity legislation, which prohibits insurance companies from covering mental health problems differently than other health issues, loopholes limit days of care, treatment episodes, or diagnoses covered. For instance, serious emotional disorders, personality



disorders, and child substance abuse are typically not covered at all, thus precluding access to intensive community-based outpatient treatment and residential treatment (National Mental Health Association, 2005).

When insurance does not cover intensive treatment, families are often unable to pay the high costs of private care (up to \$250,000 for residential mental health programs), and some families turn to law enforcement agencies for help. Parents who cannot access community-based supports or services may become overwhelmed by their children’s troubling or aggressive behaviors. With nowhere else to turn, they may call police to the home

to help manage an argument, outburst, or crisis. Police may encourage families to place charges so that children can get access to mental health services within the juvenile justice system. Sometimes, police and other agency officials do not have accurate knowledge about services available through the juvenile justice system, and they can lead families to believe that their child will receive services that are actually unavailable. In total, more than 9,000 children per year are placed in juvenile justice systems just so that they can receive mental health care (US GAO, 2003).

Juvenile justice detention facilities are also increasingly holding youth with mental health difficulties who have committed only minor offenses (US House, 2004). “Zero tolerance” policies in schools are an

important contributor to this phenomenon. Such policies are extremely rigid, and can require law enforcement involvement even for minor incidents. Documented incidents include a child disciplined under zero-tolerance policy for accidentally hitting a teacher during an epileptic seizure, and a five-year-old handcuffed by police for having a temper tantrum (NAACP, 2006). In Florida alone, a one-year review found that 76% of the 30,000 law enforcement referrals were for incidents such as trespassing and disorderly conduct, which are often labels given to school-yard fights (NAACP, 2006). For children with emotional and be-

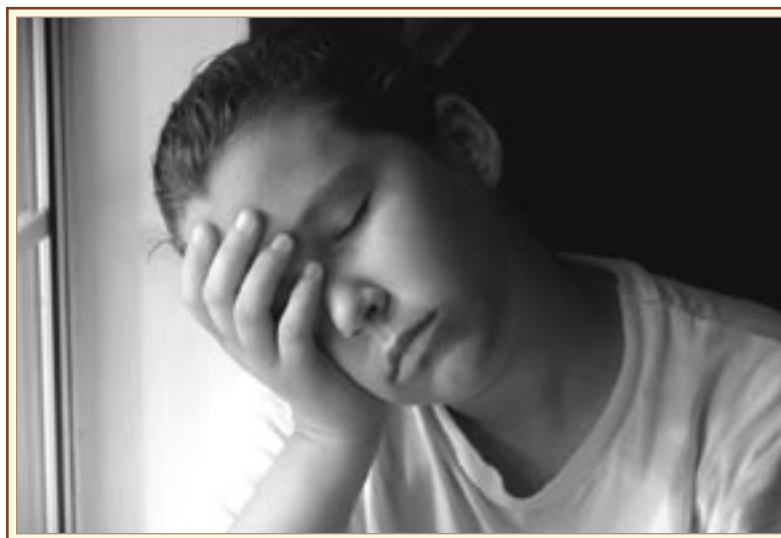
havioral disorders, zero tolerance policies require the juvenile justice system to become involved in incidents that would previously have been handled by school administrators.

When services are scarce, children may be placed in detention facilities even when they have committed no crime at all. Waiting lists for care are often long, due in part to the low reimbursement rates that Medicaid offers to mental health professionals and facilities. State officials report long waiting times for youth mental health residential treatment beds, as well as a lack of age-appropriate placements to serve children with mental health needs (US GAO, 2003). Some children who have committed no crime at all are placed in detention facilities because they are depressed or suicidal, and there are no beds available in mental health facilities. Two-thirds of juvenile detention facilities report holding children, sometimes as young as seven, who are awaiting

mental health placements. Overall, about 7% of youth in detention facilities are awaiting mental health placement (US House, 2004).

Unfortunately, once children with mental health needs enter a detention facility, they are unlikely to receive necessary care. In 2003, a study of the California Juvenile Justice system conducted by the National Council on Crime and Delinquency (Hartney, McKinney, Eidlitz & Craine, 2003) found that 67% of California youth detention facilities reported not having appropriate means to meet the needs of children with mental health problems, and over half of the detention centers reported that no individual therapy is available to youth in detention. The juvenile justice ad-

ministrators who participated in this research reported that children with mental health problems receive inappropriate placements, spend more time than necessary in detention, enter into placement further from home, face increased family problems due to inappropriate placement and services, receive poor follow-up after release from detention, and are poorly prepared for aging out of the system. Higher rates of recidivism and violent behavior while in custody are other problems associated with these children. Another disadvantage that many children experience is the discontinu-



ation of their Medicaid while they are in detention; often they must wait 1-3 months for its reinstatement upon their release (Hartney et al., 2003).

Federal law does not require, but “strongly suggests” that detention facilities provide mental health treatment. Juvenile justice facilities are generally not eligible for Medicare or other state insurance programs because of federal eligibility criteria; thus, resources for mental health treatment come from general operating funds (Hartney et al., 2003). The expenses of mental health care are particularly burdensome for small detention centers. Some detention centers have creatively used grants to cover mental health costs. Other centers have collaborated with schools or

other agencies that can receive federal reimbursement to create intensive day treatment programs. Some county detention facilities have interpreted the policy that discontinues Medicare funding to youth in the juvenile justice system to mean that a youth’s Medicare coverage is not discontinued until formal sentencing, thereby extending the timeline of Medicare eligibility. In Massachusetts, the state Medicaid agency continues to cover children in detention, reimbursing the juvenile justice system for the portion of funds that the federal dollars will not cover in order to provide better mental health access (US GAO, 2003).

States have a variety of options for promoting appropriate community-based mental health care or appropriate residential settings for youth in lieu of placing them in detention centers. Some strategies to make community-based care more accessible focus on families who are too well off to receive Medicaid, but whose private insurance does not cover

intensive treatment. For instance, children who meet disability criteria can receive additional care in states that exercise the “Kate Beckett” rule (although only ten states are currently exercising this option). This rule allows states to use federal Medicaid funding to cover home-based treatment in lieu of institutional care, and does not require that families have limited income. States are also expanding their State Children’s Health Insurance Programs (SCHIP) to offer eligibility to those families whose earnings are too high to receive Medicaid. Benefits of SCHIP programs include early mental health screening and treatment. States can also exercise the Medicaid Home- and Community-Based Services waiver to pro-

vide services to targeted groups who would otherwise require placement in a hospital, nursing facility, or intermediate care home, as long as they substantiate that the services are provided at a cost-savings over institutionalized care that Medicaid would otherwise provide (US GAO, 2003).

health services in schools to provide enhanced screening and services. Other communities have implemented services such as mobile crisis-intervention programs, transitional service programs for youth leaving mental health residential care, therapeutic summer camps, respite care, and pro-

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When more community-based resources are available, parents are less likely to turn to public institutionalized care (US GAO, 2003). In 2004, Congress passed the Mentally Ill Offender and Treatment Crime Reduction Act, which offered \$50 million to states for pre-and-post-booking services. Some communities have tapped into these funds to create mental health court diversion programs. Other creative partnering and funding techniques have included establishing coalitions to blend their funds and offer services to children, comprehensive screening, and tapping into states' flexible funds to pay for nontraditional services. Some counties have brought together multiple services under one roof to provide easier access and collaboration, or have co-located mental

grams that target parent involvement in mental health planning.

It is clear that jailing children or turning them over to authorities is not an adequate remedy for the widespread lack of access to appropriate mental health care. Recent efforts have demonstrated that it is possible for state and federal governments, juvenile justice systems, mental health providers, and families to creatively work together to reduce inappropriate placements of young people in detention, and to promote more suitable mental health treatment.

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
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