



Meeting the Mental Health Needs of Youth in Juvenile Justice

Background

One fifth or 20 % of all children and adolescents in America experience a diagnosable mental health disorder before the age of 21 (Roberts, Attkisson, & Rosenblatt, 1998). One in ten children suffers from disease severe enough to impair daily life, but fewer than 20 % who need mental health treatment receive services (U.S. Department of Health and Human Services, 1999). The lack of adequate, appropriate and accessible mental health services for youth and families is a national crisis. Because of this lack of care, adolescent behaviors normally associated with mental illness are more often identified as delinquent with subsequent admission of mentally ill youth to the juvenile justice system (Foster & Connor, 2005). The number of adolescents with undiagnosed mental health disorders committed to the juvenile justice system has exploded. Estimates are that between 50% and 75 % of the youth who are committed to juvenile justice have diagnosable mental health problems (Cocozza & Skowyra, 2000; Shelton, 2001; Teplin, Abram, McClelland, Dulcan & Mericle, 2002).

Diagnosable mental health problems that are discovered after a youth is admitted to the juvenile justice system suggest several gaps in the mental health care delivery system. An initial gap is that the mental illness has never been diagnosed and treated in the youth's community. Second, for those youth who have received some kind of psychiatric care, the mental health system has failed them.

Finally, because of the longstanding stigma surrounding mental illness, psychiatric illnesses of many youth remain undiagnosed and untreated. Youth with

mental health disorders should be served in community settings yet inadequate funding of community mental health systems results in limited capacity and fragmented services (Rosenkranz, 2006). Thus, often due to a lack of psychiatric care in the community and inadequate insurance funding for particular segments of our society, youth with mental health disorders are being committed to the juvenile justice system (Koppelman, 2004), a system that was never designed to provide psychiatric care.

Youth in Juvenile Justice: a vulnerable population receiving inadequate services

Congressional inquiries and media reports as well as the opinions of mental health professionals, correctional authorities and parents all converge on the sad reality that the juvenile justice system has become the avenue of last resort for youth with mental health disorders (Desai et al., 2006). These groups also acknowledge that the juvenile justice system is not designed to address the needs of this vulnerable population. The juvenile justice system is fraught with inconsistencies in screening and diagnosis along with a limited capacity for mental health services (Shelton, 2005; Pajer, Kelleher, Gupta, Rolls, & Gardner, 2007). Further, the primary mission of the juvenile justice system has been the provision of public safety and therefore the system is ill-equipped to be the nation's primary provider of child and adolescent mental health care (Cocozza, Loughran, Denney, & Espinosa, 2005; Thomas, Gourley, & Mele, 2005).

Unfortunately, without appropriate diagnosis and treatment as juveniles, youth in the juvenile justice system continue to demonstrate dysfunctional behavior (Osterlind, Koller, & Morris, 2007).

However, juvenile justice officials note that entrance into adult penal systems is the typical trajectory for these youth (Thomas, Gourley, & Mele, 2005). In one of the

only research studies tracking this, Copeland and others (2007) retrospectively followed a group of children into young adulthood and found that 51.4% of male young adult offenders and 43.6% of female offenders had a child psychiatric history. Early age detention, as well as how detained youth view treatment within the detention center, contribute to lifelong criminality (Arredondo, 2003; Huizinga, Loeber, Thornberry & Cothorn, 2000). Sensitivity to both normal growth and development issues of youth and their criminal trajectories have implications when planning primary, secondary, and tertiary levels of psychiatric mental health (PMH) care to those at risk for involvement or who are already involved in the juvenile justice system.

Screening and assessment issues

The first step in responding to the needs of youth in the juvenile justice system is the provision of screening and assessment. Screening is identification of problems in individuals through procedures that can be applied quickly and inexpensively.

Assessment is development of comprehensive pictures of individuals which yield specific diagnoses with recommendations for diagnosis and treatment (Bailey, Doreleijers, Tarbuck, 2006). Clear recommendations for screening and assessment of juvenile justice youth exist (Penn, Thomas and the Workgroup on Quality, 2005). Penn et al.'s recommendations include:

- all youth should receive screening at the earliest point of contact with the juvenile justice system
- youth who require further evaluation should receive thorough assessments
- care should be taken to identify the most appropriate instruments for screening and assessment

- risk assessment results and needs assessment results should be combined to reflect both the level of risk youth present and youth's need for treatment and services
- There is no one preferred method to provide mental health screening and assessment for juvenile justice youth (OJJDP, 2004).

In 1998, the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration reported approximately 71% of juvenile detention centers provide screening services and 56% provide more extensive assessments (Goldstrom, Henderson, Male, & Manderscheid, 1998). However, advocates for juvenile justice youth state these figures are misleading. Advocates maintain that having someone available to provide mental health screening, assessment and treatment does not necessarily indicate that care is adequate or that all youth needing services receive treatment (Pajer et al, 2007; Coccozza, et al., 2005). Moreover, screening does not diagnose mental illness, nor does it compensate for professional evaluation (Meredith, 2004). Professional evaluation, in turn, is not equivalent to treatment intervention. Thus screening alone will likely fall short of the comprehensive treatment approach this population demands (Shelton, 2004).

Recommendations for treatment include psychological/pharmacological therapies and planning for re-entry into the community (Penn, Thomas and the Work group on Quality, 2005). From a nursing perspective, these youth also need specific interventions to help them restore a sense of meaning and thus a sense of self, a psychological center that likely becomes skewed as they moved through the rigors of the juvenile justice system (Cashin, 2006, 2007). Advanced Practice Psychiatric Nurses' education in medical science, neurobiology of psychiatric disorders, psychopharmacology, systems

theory, assessment/treatment methods and relationship science situates them as ideal clinicians for practice in the juvenile detention systems (American Nurses Association, 2007). In addition nurse-managed programs such as Connecticut's HomeCare Program, a short-term medication management program for youth leaving juvenile detention centers, have demonstrated effectiveness in providing a bridge back to the community and meeting the continuity of care needs of this population (Pearson, McIntyre-Lahner, & Geib, 2005).

A further complication: Funding streams do not favor services in juvenile justice

State and local governments provide most funding of mental health services for juvenile justice youth. However, these government mental health programs are frequently underfunded. Complicating the situation is the fact that youth in the juvenile justice system have no legal entitlement to receive mental health services. Unlike youth in the child welfare system, Medicaid does not pay for mental health care for those in correctional facilities. Juvenile justice officials view lack of access to Medicaid funding as a major barrier to providing an adequate array of mental health services (Cocozza et al., 2005).

Position Statement

Given the issues involved with addressing the needs of this vulnerable population, the

International Society of Psychiatric- Mental Health Nurses takes the position that:

1. Innovations in mental health screening in Juvenile Justice are occurring but these practices need to move into broader dissemination.
2. A quality reporting system should be established monitoring a system's compliance with the Department of Justice's recommendations on screening and treatment.
3. Outcome systems must be developed that track data on the effectiveness and cost-effectiveness of programs which address PMH needs of youth in juvenile justice.

3. Model programs for treatment in Juvenile Justice do exist; they should be replicated with fidelity and the outcomes available for benchmarking.
4. Data on model program effectiveness should be used in lobbying for funding and public attitude change.
5. As services bridge to the community, programs must be built that would provide a continuum of primary mental health care for youth involved in juvenile justice.
6. Intervention programs for youth in juvenile justice must be culturally relevant and trauma informed.
7. Since psychiatric mental health nurses are uniquely suited to work with this population, the PMH Advanced Practice Nursing educational system should recruit and educate a nursing workforce to work with and advocate for the juvenile justice population.

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