OJJDP

Fifteenth Annual

National Juvenile Correctional & Detention Forum

Albuquerque, New Mexico
May 20–23, 2000

ACA

The Fifteenth Annual National Juvenile Corrections and Detention Forum

Mental Health Issues in Juvenile Corrections

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OJJDP

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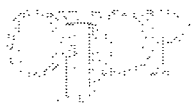

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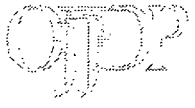

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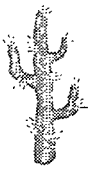

Credits

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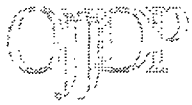

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Introduction

MENTAL HEALTH ISSUES WITH JUVENILES IN CORRECTIONS—According to the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the National Mental Health Association (NMHA), mental health problems in children are real, common, and treatable. However, only one-third of all young people with mental health problems get any treatment and fewer receive appropriate care. Even more troubling, the prevalence of mental health and substance abuse disorders among youth in the juvenile justice system is largely unknown. The statistics that are available estimate between 14 to 20 percent of youth in the juvenile justice system have at least one mental disorder, 32 percent have an alcohol abuse or dependency disorder, and 11 percent have a substance abuse or dependency disorder.

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) and American Correctional Association (ACA) identified the need to address the mental health issues of at-risk juvenile offenders, the quality of services and treatment they receive, and the best ways to prevent their future involvement in the juvenile justice system.

OJJDP and ACA held its Fifteenth Annual Juvenile Corrections and Detention Forum May 20–23, 2000, at the Sheraton Albuquerque Uptown Hotel, Albuquerque, New Mexico. The theme of the 2000 Forum was Mental Health Issues in Juvenile Corrections. Invited were 160 juvenile corrections and detention directors/administrators representing 48 States, the District of Columbia, Puerto Rico, and U.S. Virgin Islands. Also invited were the ACA Executive Committee, OJJDP officials, and other distinguished guests.

In order for this to become a reality, the monograph required the efforts of many people. First and foremost we owe our thanks to the Office of Juvenile Justice and Delinquency Prevention for the funding, which made the conference possible. For the concept, we owe our thanks to Emily Martin, Dennis Barron, Jack Greene, and Bridgette Royster. For the logistics of organizing a national conference, our thanks go to Jack Greene, Bridgette Royster, Carolyn Reynolds, Tonya Brooks, and Marie Hinton. Next, we owe our thanks to the presenters and participants who interacted for three days. The presenters did an excellent job and the participants challenged the presenters, adding to the presentations and sharing examples of real-life situations.

Additionally, we would like to thank Rick Boston, Carla Heath, and Tom Sutty who compiled the initial draft of the monograph and to Bridgette Royster, Diane Geiman, Carla Heath, and Dennis Barron, who formatted and proofed the final draft of the monograph.

And lastly we owe our special thanks to Ty Hannamonn, Superintendent of the Youth Diagnostic & Development Center & Girls' School, and Thomas Swisstack, Director, Bernalillo County Juvenile Detention Center. They opened their facilities and provided transportation for all of the participants who wanted to go for a visit.

Raymond E. Chase, Jr.
Juvenile Grant Administrator
Professional Development Department
American Correctional Association

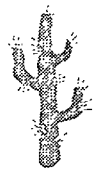
Welcoming Remarks

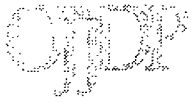
Emily Martin

Director, Training and Technical Assistance Division, OJJDP

It's my pleasure to welcome you on behalf of the Office of Juvenile Justice and Delinquency Prevention to this annual forum of juvenile corrections and detention administrators. It is particularly a pleasure to welcome you to the first forum in this millennium. We finished the last millennium on a very high note, and we're entering this millennium on a very sober note in relation to a problem which is fairly encompassing. The juvenile corrections administrators and juvenile detention administrators have come a very long way in the last 7 to 10 years. When we first started working with this structure fairly intensively through our interagency agreement with the National Institute of Corrections (NIC), and with other granting contractors supporting corrections, we lacked a common vision. We had disparate notions about where we wanted to go with respect to juvenile corrections and detention. Having sat through the Council of Juvenile Correctional Administrators meeting this morning, I know that we're in a different place. A number of years ago I said that leadership is leading and being is becoming and becoming is being. We are well on our way and I'm very pleased to welcome you here. I want to recognize Dennis Barron of my staff who is with us. Dennis is the corrections liaison and manages most of our corrections grants and contracts. I also want to introduce Steve Swisher. Steve is a sidekick and partner. He does a yeoman's job in relation to the correctional leadership program that we support with NIC as well as a series of other projects we've developed under that interagency agreement. I also want to introduce Vince Piceriano who is with the developmental services group, another major contractor. They manage the alliance for the juvenile accountability block grant program. They do a terrific job in organizing and delivering the technical assistance under that project.

I asked Alan Beckelman last week where we were in relation to delivering services under the juvenile accountability block grant program. Were we to the right or to the left? He said we're to the left. When we started this program, technical assistance became critical with respect to assisting states in implementing programs consistent with the philosophy of the purpose of the Juvenile Justice Act. We have done that very effectively because of the





developmental services group and the group of grantees who have worked with them to deliver the services. We're very pleased to have you here.

We have been working fairly intensively with several states and state jurisdictions and we anticipate getting more requests in the coming year. In these forums over the past ten years, we have attempted to focus on issues of major significance. When we first started 15 years ago, we were dealing with a potpourri of topics. Each meeting covered a number of issues. Ten years ago we began identifying themes which were of significance to the field and which would lead to legislative and governmental action in terms of allocations of resources to address issues which were emerging or issues which existed and were of concern to you. Therefore, we started selecting a topic on which to focus all of the discussions within the forum. One topic was conditions of confinement and from that came the performance based standards program, and allocations for that program. Several years ago we focused on legislation at the state level. A grant to the National Association of State Legislatures allowed juvenile justice to communicate with state legislatures about legislative issues of concern to juveniles, especially juvenile justice issues. This forum today, focusing on mental health issues, is timely and of particular significance to the juvenile justice system. It has particular significance to minority youth who are increasingly filling your facilities. Someone said to me a few weeks ago that we're criminalizing mental health. We are translating mental health needs into criminal offenses and therefore moving these young people inappropriately and illegitimately, if you will, into correctional facilities as the only facility of resort. This is criminal within a society with as many resources as ours. Going back 40 years, when I worked in Chicago, mental health services never wanted to work with difficult populations. I remember very distinctly the elimination of whole categories of individuals because they were considered untreatable. They were from dysfunctional families. They weren't good neurotics who would come every week for appointments at an appointed place and spend 60 minutes with a social worker or a psychiatrist. So, they simply wouldn't accept them as patients. I remember the Institute for Juvenile Research in Chicago, a premier treatment facility for adolescents at the time, would not take children who had been referred to the juvenile justice system. They would not take delinquent youth who had been identified by the police and other agencies as having problems in the area of mental health. This is not a new problem. The new problem concerns recent legislation which defines certain offenses and certain offenders as fodder for the juvenile justice system, if you will. There aren't resources to respond to their needs within the community. This meeting today is particularly important and is quite timely in terms of the identification of these young people and to point to the need to develop effective treatment modalities for these young people who have conditions, symptoms, and behaviors which don't fit neatly into the categories that the mental health professionals want. In other words, we're looking for and need innovative approaches to dealing not only with the youngsters, but dealing with them within the context of their communities and within the context of their families. There are some models that do that effectively. We need to research other models and be creative and innovative in developing new models. Then there's the issue of paying for the services once they have been identified in terms of the population and the model. These aren't cheap services. They are expensive and require continuity if they are going to be effective. All of these issues should surface in our discussions over the next two and a half days. I look forward to hearing from you.

Richard Stalder

President, American Correctional Association
Secretary, Louisiana Department of Public Safety and Corrections

I want you to know how honored and excited we are, as an association, to participate with OJJDP in providing these opportunities at the juvenile forums. As a sign of that support, we've had our Spring executive committee meetings in conjunction with the forum. The American Correctional Association's executive committee met today. I want to introduce to you the key leadership of our association: Vice President Reg Wilkinson from Ohio; President-Elect Judge Betty Adams Green from Tennessee; our Vice President, whom all of you know, in the very subdued green coat, Chuck Kehoe from Virginia; our Treasurer, whom we all know and love, Gwen Chunn from North Carolina; our Board of Governors representative to the executive committee, Dave Parrish from Florida; our Board of Governors representative to the executive committee, May McLendon from North Carolina. We also have the staff leadership of our association here. Jeff Washington, our Deputy Executive Director; Deb Seeger, the foundation of our executive office; and Jack, our Director of Professional Development are here. Another of our division directors is here, Bob Verdeyen, Director of Standards and Accreditation. It gives me a great deal of honor to introduce to you one of our distinguished past presidents, Bobby Huskey.

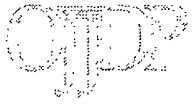
We are committed to helping you. We understand the monumental challenges that we all face in juvenile justice. I hope that through our training efforts like this forum, through our accreditation efforts, through our publications, and through our advocacy, we can help develop strategies and ways to deal with many of these issues. You have tremendous and very broad responsibilities. We need to deliver tools to you to meet those responsibilities. They don't stop with the juveniles who are under your supervision. They include the issues surrounding their mental health that you'll study for the next two and a half days, their criminality, their educational deficits, and safety for them and for the public. These are all critical to us but that's not where our responsibility stops. You have a very significant responsibility to work with and help develop the skills of your peers in adult corrections. Look around the country today. In dramatically increasing numbers, very youthful offenders are showing up in adult prisons and under adult community supervision and, ladies and gentlemen, those people are ill equipped to handle them. You have the expertise and you need to expand your vision. One of the things that I've learned in my friendship with Dr. Barry Glibb is how incredibly effective we can be if we provide training tools to correctional officers and staff in adult prisons who have to work with adolescents to promote the stability and safety of the institutions. It's not just about the child. It's about the environment that the child influences. You have a final responsibility, one that is atypical to juvenile justice. This is a responsibility for all of us in the criminal justice system. We must spread the word about the importance of prevention. You know we will never be as successful changing people's lives after they come to us than we will if we simply stop them from ever entering our custody. And, we want to send a very simple, cost-effective signal to the citizens of our country. The signal is, if you really want to win the war on crime, then invest in programs for children pre-natally and throughout childhood. We know we can do that and it is on our shoulders to communicate this message.

Juvenile Justice Mental Health–Not Making the Same Mistakes as in Adult Corrections

David Pederson

Chairman of the House Judiciary Committee, Albuquerque, NM

The topic of my discussion is the juvenile mental health area. Let's try not to repeat the same mistakes that we make in the adult system. It's certainly misplaced policy to take a system that isn't working on the adult side and try to dovetail it to the juvenile side. Mental health issues are not being appropriately and correctly addressed in the adult correctional system. There is probably no one connected with corrections that would feel we're doing even a passable job. John used the phrase "mangled care" for managed care. My phrase is "rationed care." That's really what it is and that's what we're doing. In New Mexico, and I would suspect in your states, since we have gone to a managed care system, we have seen programs dwindle and evaporate at an astonishing rate because no one will pay for them. The private sector will not create these types of mental health programs. There is simply no money to treat the seriously mentally ill juvenile offender. If there was, I'm sure Bill Gates or Donald Trump or somebody would have invented a program to do that. Dealing with the mentally ill, though, is absolutely necessary in the creation and maintenance of a civilized society. I often talk to police officers, police agencies, and small town government entities. The first thing I ask is, no matter how small the town, where is your local emergency mental health treatment center? Most of the time they say we don't have one. And I say, "Oh no, no, no, no. You all have two: one's your jail, and the other's the emergency room at the closest hospital." That, unfortunately, is what we have been using on a default basis to treat the seriously mentally ill. I fear our juvenile justice facilities will become what our adult facilities have become. They will become, by default, the treatment centers, without the programming, without the resources, and without the staffing to take care of those folks. A warden at the penitentiary estimated that a full 30% of the adult inmates in the New Mexico prison system were seriously mentally ill. Ill to the point they could not function appropriately on the outside, and could not function appropriately in a prison setting. An estimate based on new research of the percentage of children in our country who have serious emotional

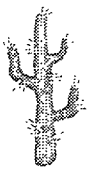


disturbances is between nine and thirteen percent. The old figures were somewhere between one-half and five percent. Most people who have studied juveniles in a correctional setting estimate a full twenty percent of those incarcerated as juveniles have serious mental health issues. If you couple that with the dreadful and overwhelming occurrence of alcohol and other substance abuse, it makes a double problem. The numbers of dual diagnoses, young people who have substance abuse problems and serious mental health problems, is absolutely staggering. My rule of thumb estimate, as a former prosecutor and a defense attorney, is that about 80% of everyone who goes through the adult criminal justice system has a serious alcohol or drug problem. My estimate for children who are going through the juvenile justice program is somewhere between 90 to 95%. The pairing of these two issues offers tremendous challenges to those of you dealing with children who get into serious trouble.

Another recent problem is the attitude that we have adopted that we must get tough on crime. I don't know any politicians who have ever run for office on the platform that they are soft on crime. My line has always been that tough on crime is easy, smart on crime is hard. The natural inclination of those of us who are elected officials, especially people in legislatures and in Congress who don't have a background in criminal justice, is that we do two things, create new crimes and raise the penalties on old ones. Rarely do legislators decriminalize things or lessen the existing penalties. This creates a built-in inflation factor. More people end up being incarcerated and incarcerated for longer and longer periods of time. One thing we have to do, and the biggest challenge we have, is to get the kind of resources into juvenile justice and do some of the things that John touched upon. Unfortunately, many of us in the smaller towns and outlying areas still don't have these resources. We have to do better screening, have better training, and have personnel who recognize serious mental health issues. We need programs and facilities to treat youth that are diverted away from the juvenile justice system. If we do not do this, we are going to end up with a juvenile justice system in this country that will mirror the adult corrections system. Current figures indicate somewhere over 2 million people in this country are incarcerated. If you add the people that are on probation and parole or pre-trial release supervision, it's 5 million people. If we keep up this trend, ladies and gentlemen, sometime in the not too distant

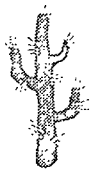
David Pederson was born and raised in Gallup, New Mexico. Graduate from University of New Mexico Law School in 1978; former Chief Deputy District Attorney, McKinley County, New Mexico; and Chief Children's Court Attorney, McKinley County, New Mexico. Mr. Pederson has 22 years legal practice, primarily criminal and juvenile defense; 8 years with New Mexico House of Representatives; 6 years, Chair or Vice-chair, House Judiciary Committee; 5 years, Chair or Vice-chair, Interim Courts, Corrections and Criminal Justice Committee; 4 years, Co-chair, Interim Legislative Ethics Committee; and 5 years, member, DWI Legislative Oversight Task Force.

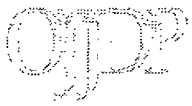
Mr. Pederson prime sponsor: Regional Juvenile Services Act, 85% Truth in Sentencing Violent Offender Act, DWI Penalty Increases and Habitual Felony DWI Offender Acts, Sentencing Standards and Persistent Violent Offender Acts, Revisions to Stalking and Harassment Acts, and over 60 other bills relating to the Adult Criminal Code and Children's Code, and funding support for County Alternatives to Secure Detention. Mr. Pederson is a current candidate for New Mexico State Senate.



future one half of the United States population is going to be in jail and the other half will be guarding them. That's not a good social policy. That is a crazy social policy. We have to do a better job. One of the fundamental aspects of corrections is public safety. Don't get the misapprehension that some of my political opponents have that I am some kind of bleeding heart liberal over this stuff. I think of myself as a pragmatist and someone who is very practical. I want to make sure that our adult correctional facilities are reserved for the violent, predatory offenders who are going out and hurting innocent people in our society. We have no other way to control them. Fortunately, this is not the largest percentage of people who run through the criminal justice system. Another thing we have to do is return to a community based system of justice. It is extremely important for us to encourage cooperation and collaboration among our public schools and healthcare providers. We need to coordinate our public safety obligation by ending what I call the revolving door of juvenile justice, or as may be more accurate, the escalator up. My experience has been that most people who become adult felons had serious delinquency problems. Thank God not every delinquent child becomes an adult felon. We'd have to put a fence around Nevada in order to have a prison big enough to hold those people. A troubling phenomenon we must recognize and deal with is that we have a hugely disproportionate impact on minority youth in our correctional systems, adult and juvenile settings. Institutional racism, ladies and gentlemen, is still alive and well in the 21st century in this country. If you don't believe that, look at the recent to-do about racial profiling by police officers. The most ironic thing that I heard about this study is it showed minority police officers used racial profiling. That's a very interesting phenomenon. In a national news story, a Philadelphia narcotics detective who lived in New Jersey said he always took the back way home from National Guard training weekends because he was tired of being pulled over on the interstate by the New Jersey state troopers. That's a phenomenon we have to acknowledge still exists regardless of the good intentions most people have.

We must not lose sight of the tradition begun at the inception of the separate juvenile justice system as opposed to adult justice, to emphasize rehabilitation and not punishment. I fear that sometime in the not too distant future, we will become so fearful of crime that we will convert what is a correctional system into merely a punishment system. I hope we do not abandon our original philosophical bent because of emotion caused by the latest greatest tragic incident involving youth crime violence. Unfortunately, this is what drives legislatures and Congress. It's the latest worst tragedy, and the question of how young is too young to be held accountable or responsible. We are indeed the only country in the world that executes juveniles who commit murders. That is a telling sort of statistic and something that none of us should be very proud of. We, as professionals, need to counteract some of the popular mythology that has grown up about this issue. "Crime," as Secretary Hart said, "is still a very high profile issue for everyone." If you only read or listen to the popular media you would think crime was out of control, especially youth crime and violence. In polls and surveys the average person will tell you there are huge increases in juvenile violence. Well, there are huge increases in reporting it. The statistics are just the opposite. The juvenile crime rate peaked sometime in 1994. The latest study I saw from 1993 to 1998 shows there was a 37% drop in serious juvenile crime over that five-year period. The homicide rate for juveniles dropped 56% in that same period. We all know that what's drawing





attention nationally and locally is the lethality of youth encounters, probably due to the presence and availability of firearms. What's interesting is that most of the public say half of serious, violent crime is caused by juveniles. The real statistic is 12%. I am very much concerned as a citizen of this country and secondarily as a legislator and minor policymaker, that we are creating a climate of intergenerational fear and mistrust. There is a troubling trend that we are becoming afraid of our own children and grandchildren. People talk about how the family has broken down in America. That might be the most corrosive element of this fear, fear of our own children. New Mexico has developed a unique system. We in New Mexico are very proud of being idiosyncratic. Lew Wallace was one of our territorial governors after the Civil War and author of *Ben Hur.* He wrote it here when he wasn't hunting down Billy the Kid and doing other little things like that. Lew Wallace said that experience garnered elsewhere was absolutely useless in New Mexico. We oftentimes make our own way and our own path. In 1993 we enacted our latest version of the Children's Code which had not been revised since the late 1970s. We've done some minor tinkering with it since then. We created a system that is worth consideration by other states and jurisdictions. We have vested, unlike our adult system, a tremendous amount of discretion in our district judges over when and if juvenile offenders are going to face adult criminal sanctions and/or go through the adult criminal process. We have also vested a huge amount of discretion in our district attorneys and juvenile probation officers. They are extremely influential in making those recommendations and decisions. District attorneys make the initial charging decisions. They also have the discretion to decide whether that child should have a juvenile justice trial or adult criminal trial, and, when the child is found guilty or found to have committed the delinquent act, whether or not that child should face adult sanctions. We've had this system for several years. A few years ago, I carried the bill that lowered the age when someone could be charged as a serious youthful offender. That's a child who is accused of first degree murder. We lowered that age from 16 to 15. We lowered the age for youthful offenders, which is what we call adolescents who commit a laundry list of other very serious criminal offenses, from 15 to 14. I've been very pleased as a practitioner and as a legislator to see that we've had a relatively low number of children tried as serious youthful offenders or as youthful offenders. An even fewer number of them were actually given adult sentences. We have had a relatively small number of young people who have been transferred to the adult department of corrections. This is interesting because they are not separately classified. There are no special programs for them. They are not segregated into special institutions. Although we really don't have much scientific research, we have some anecdotes that we can pass on. One fear, of course, was that some of these young offenders might indeed be preyed upon by hardened older convicts. What ironically turned out to be the case, is that some of the really tough, as we call them *helatos*, ended up taking advantage of the bad check guys, forgers, and car thieves in the institutions. These young men, and they're almost always young men, who have gone into the adult system, are pretty tough cookies for people of such tender age. Only one young lady has ever been convicted as a serious youthful offender. She was convicted of first degree murder.

I hope some of the things that I've said will provoke some discussion and give you some things to think about while you're here. I want to end with a school teacher anecdote. My wife, who is sitting there in the first row, has taught school for as long as I've practiced

law in our home town. Most of the time she was a kindergarten teacher. The top ten percent of high school graduates in my home town are called honor graduates. At the graduation ceremony, they get to pick their favorite teacher to walk with them to get their diploma from the school board. Most of the young people pick high school teachers, because they are almost adults themselves, and they've engaged in adult relationships with their favorite high school teacher or coach or whomever. A few weeks ago, Jamie was in her elementary classroom and a young woman came in and said, "Mrs. Pederson, do you remember me?" "Well, of course I remember you. You were one of my kindergartners." "Well, Mrs. Pederson, I'm going to be an honor graduate at the high school graduation ceremony." "That's wonderful. That's really great." "Well, I'd like you to walk with me." First of all, my wife was very touched. She thought for a second, and said, "Well, you know, usually the kids walk with a high school teacher, or someone like that. Isn't there somebody else?" And this young woman said, "No. You know, you were the first person who ever believed in me." Needless to say, that touched my wife very deeply. What I leave you with is this point: None of us ever knows at what point and in which way we may touch a young person. But I will guarantee you, ladies and gentlemen, that the only way we are ever going to save the world is one child at a time. I encourage you to recall that and remember that. You're in a tough business, but I have found the people in your profession to be intelligent, compassionate, and very caring. I'm very proud to be associated with you in your endeavors. I am very pleased to have been able to address you. I certainly hope that you have a very good time here in New Mexico. Thank you.

Basic Overview and Background on Juveniles in Corrections with Mental Health Issues

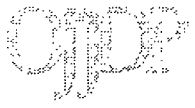
Karen Abram, Ph.D.

Associate Director, Northwestern University Medical School, Chicago, IL

Good morning. I am very happy to be here. I'm a true woman of the millennium. This is probably the most important audience to receive the results of the research we are conducting. Our university research project in Chicago has been studying the mental health needs of offenders for a long time. To have the opportunity to present to policymakers and detention center personnel is vital to the project goals.

Today I'm going to discuss the background and problems faced by that important minority group, juveniles in detention. I'll be presenting data from the Northwestern Juvenile Project, a large scale federally funded study partly funded by OJJDP. We are looking at the mental health needs of juveniles in detention and whether or not their needs are detected and treated. I'm going to focus on their mental health needs with emphasis on what we call co-morbidity disorders—children with more than one disorder. How many young offenders in detention have an alcohol, drug, or mental disorder? How many with an affective disorder? That would be major depression or mania. The most severe disorders are affective. When accompanied by an alcohol or drug use disorder, a new animal is created. Treatment and programs must be modified to address these different needs.

We've been studying the mental health needs of detainees for about 20 years, as well as the issues facing both the criminal justice and the mental health systems. Our work began in the adult jails. We did two very large scale studies of the mental health needs of men and women and whether their needs were detected and treated. Did the emptying out of the psychiatric hospitals in the 1960s and 1970s cause the so-called criminalization of the mentally ill? Are the mentally ill over-represented in the jails? This is what we're finding. We began studying children in detention about four or five years ago, a logical extension of the adult research. We learned from the adults that most problems begin in youth, both psychiatric and criminal. The same problems affecting adults in jail are affecting young people in detention. They're being shuffled into the detention center instead of being treated in the



mental health system. The systems are not isolated. One system affects the other. What changes have been made in mental health services for children? One is welfare reform. Children are now poorer and less able to afford services. There have been reductions in Medicaid. Many juveniles fall in the cracks between systems. Their parents don't have insurance coverage from their jobs or they have too much money to qualify for Medicaid. Even the children who are insured, as many of us know, have inadequate coverage. Due to managed care, the children really have to be at imminent risk to get services. Those services generally do not last long enough to make a real impact, or even develop decent evaluations. Children are probably not receiving the services they need. A critical question is, is the juvenile justice system picking up the slack?

I'm going to present preliminary data on how many youngsters in a typical juvenile detention center have an alcohol, drug, or mental disorder. Why do we study youth in detention as opposed to arrestees? Youth in detention tend to be more impoverished, more over-represented by minorities, and they tend to have greater mental health needs. Children in detention or incarcerated have constitutional rights to services if they have severe disorders. This has to do with the due process laws. You can't be punished until you're convicted. It's important to focus on those in greatest need. Why did we need this study? It seems so obvious that that's where you'd throw all your resources. In fact there were no solid data on the mental health needs of children that could be used to shape public policy. The service system for youngsters was really worse than it was for adults, which I found rather shocking. Our sample is 1,830 juvenile detainees. We camped out in the intake area of a large detention center in Chicago, which we think of as a big city, typical for the midwest and most of the East coast. So our numbers are generalizable to other detention centers. Chicago's a great place to collect data. It has a good Hispanic sample of many different Latino ethnic subgroups. We have fabulous cooperation from the criminal justice system for access to the children and their records. Other large projects are going on there, like the MacArthur-funded Harvard project which has produced some similar data for comparison. We randomly selected young people over a two-and-a-half year period and invited them to be in the project. Parents or guardians gave their permission. Independent interviewers who were master's level and clinically trained conducted 2- to 3-hour structured clinical interviews assessing the mental health needs and other risk factors. One instrument used was the Diagnostic Interview Schedule for Children (DISC). We chose DISC because it's state of the

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Dr. Abram is currently conducting two studies with Linda Teplin. The Northwestern Juvenile Project is the first comprehensive, large-scale, longitudinal study of psychiatric disorders and risky behaviors among 1800 juvenile detainees. The Northwestern Victimization Project is a unique study of criminal victimization patterns among severely mentally ill persons who live in the community. Her research interests also include co-occurring disorders among the severely mentally ill.

50–90% of juveniles in the justice system meet the diagnostic criteria for:

- Behavior disorders, or
- Learning disabilities, or
- Developmental disabilities

(1999, PACER report)

art in diagnostic assessment for epidemiologic research and its relatively reliable. It generates diagnoses, not symptoms. That's important for understanding the data I will be presenting. When I say a child meets criteria for major depression, I'm not talking about somebody who is depressed as a result of being arrested or some recent event. I'm talking about a constellation of symptoms over a specified period of time that have made a difference or change in the ways the children function. Comparative disorder is different from having symptoms. If it was your child or my child exhibiting these symptoms, you would definitely act.

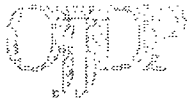
We had a very low parental refusal rate—3.8%. Only 2% of the children refused to be involved. It's a good representative sample of youth who are arrested and detained. In our study, we over-sampled certain groups so we would have enough to say something statistically important about them. These are not the actual demographics of the detention center. Then the data on mental disorders was weighted back so that they do reflect the characteristics of the overall population. Our sample was one-quarter Hispanic youngsters, one-fifth non-Hispanic whites, and half African American. We also over-sampled females. One-third of our sample is female. The female population is so much smaller in number, just like women in jails, and their services tend to be more limited. That's not to underestimate the problems that the males also have. We over-sampled 10 to 13 year olds, because the juveniles coming to detention are getting younger and younger. Finally, although it's not reflected here, we over-sampled youngsters whose cases have been handled in the adult court system, the automatic transfers to understand what's going on there.

We collected a urine sample from most of the juveniles. Two-thirds, 66.6%, of these young people are testing positive for drugs, and most of that is pot. That is not so bad, but it's not encouraging either. We know that this population is using many harder drugs which

Juvenile Offenders with Mental Health Problems

- 75% had significant family problems
- 44% exhibited disruptive behaviors
- 43% demonstrated violence toward others
- 51% appeared to have been abused by their parents

(1998, OJJDP)



tend to lead to heavier drug use. What's interesting is that Hispanic and white youth are much more likely to be using harder drugs than the other groups. The males are slightly more likely to be testing positive than the females, which is ironic. In the adult system, the women are almost twice as likely to test positive for drugs and to have drug use disorders than men. Drug use also increases with age: the older they are the more they use and the drugs they use are harder.

We've been funded to follow these young people longitudinally by re-interviewing them at their 3-year anniversary wherever they're living. We're examining the development of mental disorders over time and how the children fare through the service system at large. The most depressing news we've learned is that 4.5% of our youth have died, most violently. These early deaths cross gender and ethnic lines. However, the Hispanic children are far more likely to be dying violently than others. We think this is due to the unique nature of gang activity in the Latino culture. It may also have to do with the use of harder drugs. We're still looking into this.

In our epidemiologic study, we found that some youth suffer from more than one disorder. Half of these young people have one of these disorders. Two-thirds of the children we interviewed met criteria for at least one of these disorders. Rates of major depression, which is the top line, are very high. One out of every five girls, and a little more than one out of every ten boys, are meeting criteria for major depressive episodes. We need to know this. Also, if you look at any substance use dependence group, you see that half the youth are meeting the criteria. This is beyond just use. These are youngsters whose drug usage definitely affects their lives. Again there is an even split between girls and boys. Even though the boys are using more, the girls are more likely to be using in a way that's more developed. There are three other disorders that we also assessed. One is the psychotic disorders. It's exceedingly difficult to assess psychotic disorders even in a 3-hour interview, even if you're a psychiatrist, even if you meet with this child for a couple of times, because adolescence and psychosis are tough to sort out. We believe the number will be somewhere between 1 and 5%. We'll work hard to get those numbers finalized. The second group that's not here is youngsters with attention deficit disorder (ADD), another difficult disorder to assess. You say, "Do you have trouble sitting still?" The child says, "No," but is climbing the wall around

Prevalence Data of Mental Health Issues Among Juveniles in the Justice System

- ADHD 25–46%
- Affective disorders 32–78%
- Anxiety disorders 6–41%
- History of child abuse 25–31%
- LD and specific developmental disorders 17–53%
- Mental retardation 13%
- Personality disorders 2–46%
- Previous suicide attempts 6–28%
- Prior mental health treatment
  - Hospitalization 12–26%
  - Outpatient 38–66%
- Psychotic disorders 1–6%
- Substance abuse 25–69%

(*Focal Point*, Spring 1997)

150,000 juveniles in the justice system nationwide have at least one diagnosable mental health problem.

(OJJDP, 1998)

you. We have a lot of interviewer notes that we're still analyzing. Finally, we assessed post traumatic stress disorder (PTSD), maybe the most important data of our future. At the time we started the study, the DISC module wasn't ready so we used what was in progress. We added to it and it's taking us a little longer to get that out, but we know the rates for PTSD are very high in the adult population. These children are suffering a great deal of trauma in their lives; the data are coming soon.

Co-morbid disorder, i.e., youngsters who have more than one, we found that 19.3% overall have an affective disorder and 13.3% of youth in detention have both an affective disorder and a substance abuse disorder. That's a large number, more than one out of ten. It's a cause for concern for any program planner or detention center director.

Let's say you want to set up a program for mental health disorders for juveniles either in detention, aftercare, or linkage. How many of those youngsters meeting criteria for mental disorder will also have substance abuse disorder? You need to know these numbers. If you take just the youth with a mental disorder, how many of them also have a substance abuse disorder? We found 68.5% who have drug or alcohol abuse dependence with any affective disorder. This is saying that 68.5%, over two-thirds, of young people with an affective disorder also have a drug or alcohol use disorder. This is huge. You cannot ignore their substance abuse problem when you're trying to treat the mental disorder. In contrast, 30.3% of the youngsters in our study had no psychiatric disorder, but did have a substance abuse disorder, about one-third. That's not to say that the smaller group doesn't need treatment, but when you're looking at the youth with mental disorder, you have to pay attention to this.

I'm not talking about anxiety disorders and disruptive behavior disorders. Anxiety disorders may be a good thing for youngsters because they suggest they're in pain and amenable to treatment. Disruptive behavior disorder suggests you're going to have a little trouble doing that. They're a little tough to engage.

If you were planning to set up a drug or alcohol treatment program you would want to know how many of these children are likely to have a mental health disorder. We noticed that 26.3% of the juveniles with a substance abuse disorder also have attention disorders. So a substance abuse program has to be concerned that one out of four have severe affective disorder. The first implication is reduction of unnecessary incarceration. Many of these children probably don't need to be detained. Many of them are youngsters whose parents didn't show up for hearings. If they do end up in detention, we have to provide adequate services. As I mentioned, detention centers are mandated by law to address severe disorders. This is not easy because there are very few pure types. As a clinical psychologist, I never yet met a child who really matched the textbooks. It's because they have more than one disorder.

The first step in adequate services is proper screening. It is very difficult to sort out what's going on with anyone who has dual disorders. Psychosis or mania, even major depression, can mimic one another and you need at least a 24-hour observation, but 48 hours is better, just to see what you've got. Is somebody coming down, somebody on PCP, somebody in a manic episode or is it some combination thereof? The services themselves need to be tailored for gender differences, and the co-morbidity profile. Here are some examples of what's different about treating a co-morbid youngster. If someone has major depression first, and then develops a substance abuse disorder, you can cure the substance abuse disorder, but you're still faced with major depression. On the other hand, a person with a substance abuse disorder who develops major depression afterwards has a different profile. Depression is a very common co-occurring disorder to all disorders, including medical disorder. You can clear up the substance abuse disorder and depression will often go away. This doesn't mean you can ignore the depression. Among substance abusing people the depression is often more acute, and they often pose a higher risk for suicide than primary depressives. The other issue is medicating children or adults with dual disorders. It is an exceedingly tricky business. You're trying to medicate a disorder without creating another addict or risking death by prescribing something that's mixing with what they're taking on the street. The psychiatric management of these cases is quite challenging. Most important is liaison assistance after release. The systems serving children are very complicated; there's the mental health system, child welfare, the education system, and, of course, the justice system. Transition among these systems must be smooth and must be coordinated in order to be effective. The median length of stay in detention centers is 15 days. This is not a lot of time to get all this together, so the youth are out usually more than they're in.

Again, I want to focus your attention on the fact that while dual disorders is a very important issue, it is the tip of the iceberg with these young people. They are also suffering high degrees of trauma disorders which, if ignored, will simply keep coming back. There can be an enormous sense of loss, and we're also collecting data on that. They also have very poor job skills and very few options for housing. All of these things make an enormous difference in the future of a youth, with or without a mental disorder. It's really exacerbated if you're suffering from a disorder. We hope that providing the data from our study and focusing on improving the service system will begin to make a difference in the lives of these children and re-focus attention on corrections. Thank you.

- Serious and chronic offenders
- Severe, persistent mental health issues
- Dual diagnosis, co-disorders, psychotrophic medications
- Lengthy history of unsuccessful interventions and placements
- Poor adjustment in the community
- Aggressive, violent, destructive, bizarre, and self-injurious behaviors in placement and in the community
- At risk of escape/flight and at imminent risk to public safety

Collie Brown

Assistant Director, National GAINS Center, Delmar, NY

Good morning. I bring greetings to you from the great state of New York. I want to acknowledge ACA and OJJDP particularly. This is a very, very important gathering of juvenile justice administrators, primarily correction detention administrators. Over the years I have enjoyed a very close working relationship with the Council of Juvenile Correctional Administrators (CJCA) and have benefited from this association.

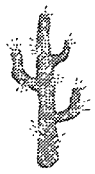
First, I'd like to familiarize you with the GAINS Center. It's a federal partnership of a number of federal agencies, established in September of 1995. We're in our fifth year of operation, establishing partnerships among the Office of Justice Programs, the Office of Juvenile Justice, the National Institute of Corrections, the Center for Mental Health Services, Centers for Substance Abuse Treatment, and Mental Health Services Administration.

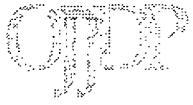
The creation of the GAINS Center is recognition at the federal level of some of the things Karen just discussed. There is a relationship between mental health and substance abuse services at the adult and juvenile levels. There is a need for assistance in collaborating as we address these issues. This federal partnership, as unprecedented as it is, has enjoyed broad support. As we look at the juvenile justice system, we recognize the need for collaboration among all services.

We have seen an increasing reliance on the juvenile justice system to care for youth with mental illness. This has created additional challenges for you as juvenile detention administrators working with limited resources. We've also seen a stark change in the way the juvenile justice system responds to children and youth who have run afoul of the system. We've seen a movement toward adultification of the system. Children are charged as adults and given longer sentences. All of these factors bring additional and bigger challenges that we all have to address. Treatment of youth with mental illness by the juvenile justice system has probably received more attention in the last two years than in the last three decades. This is a fact, at the federal, state, and local levels. We're beginning to see not just an

Collie Brown is the Assistant Director of the National GAINS Center operated by Policy Research Inc., Delmar, NY. He directs the delivery of technical assistance to states and localities to assist them develop or enhance services for adults and juveniles involved with the justice system who exhibit co-occurring mental health and substance use disorders. His work has centered on developing strategies and interventions that recognize the prevalence of co-occurring disorders and the impact on special populations, especially women and female adolescents. He is a spokesperson for the Center on Integrating Behavioral Health and Justice Systems and Services; and also works with federal, state, and local policy makers in developing and implementing policies which improve system responses to this population.

Prior to joining the GAINS Center, he worked as a forensic investigator/health system evaluator with the New York State Commission of Correction, evaluating the medical and mental health care in New York's prisons, jails, and police lockups; managing suicide prevention/crisis intervention programming; and facilitating the development of community partnership with local entities to address the gaps between the behavioral health and justice systems. Mr. Brown is a graduate of Delaware State University.





acknowledgment of these issues but a movement toward establishing specific kinds of responses. We're starting to see legislation at the federal and state levels designed for this population. The state of Washington is drafting legislation to begin addressing a number of these issues. California has made funding available to develop a continuum of services for mentally ill juveniles.

Many of these trends and efforts have begun to force the courts and juvenile corrections institutions to address the problem of youth with mental health disorders. There is a difference between the constitutional requirements for services for these juveniles and those for adults. At the adult level the requirements are clearer. I'm certainly encouraged to learn of the preliminary results from the research that is being done in Chicago. There is a lack of adequate research on the types of mental health disorders among youth in the justice system. Existing research has yielded some general conclusions, which should set the stage for how we move forward. We know that youth in juvenile corrections experience higher rates of mental health disorders than youth in the general population. In most instances, the rates are two to four times higher. The lack of adequate screening and assessment protocols is a real challenge. If you don't know what you have coming in, it's really difficult to develop appropriate responses. In many of your institutions, this may be creating management problems, raising a lot of questions as to what to do with these children.

Concerning the issue around co-occurring mental health and substance abuse disorders, the GAINS Center's efforts and activities have targeted this population specifically, because of the growing awareness of the issues that these youth have. I think that the work we've done over the last four and a half years or so has really moved the field forward, has raised the recognition within the field of the need for systems to begin addressing many of these issues in a collaborative manner. I think as juvenile correctional administrators you need to begin moving out of the traditional role you played in the safety and security of these children. You need to begin moving out of that role, and begin collaborating with community-based providers both before and after the juveniles are in your custody. I think that's the only way we can begin to have any real impact on the services that these young people need. When they come into your institutions, and after they leave, you can play a major role by collaborating with your partners in the community—law enforcement, community-based providers, and the schools. Begin reaching out to them, creating the kind of partnership that is necessary to make a dent in the problem. I've started seeing much more of this happening, more corrections staff taking that leadership role. I think to some extent people have this perception about correction administrators, both adult and juvenile, that their only purpose or their only interest is in security—the custody of youngsters who come into their supervision—and they don't see beyond their door. This is changing. You have recognized that you need to create a partnership among all the providers of services and bring them into your institutions. We're really treading water. Many of these children have multiple service needs, with issues concerning trauma, gender specific services, mental health, and substance abuse. We need to demand a collaborative approach reaching across disciplines. This system, without regard to the discipline or environment, will provide the services that the juveniles need.

The issue is what kind of services do we offer? Sometimes it can be a double-edged sword when you create very elaborate, in-house programs. Suddenly you're looked at as the

only place in your county or state that provides effective, adequate, comprehensive services for youth. The double-edged sword is the danger of children being sent to you because the feeling is that there is nowhere else to send them or that other places may not provide appropriate services. That's one that you really have to begin looking at. We need to question ourselves as to how we go about responding to the needs of these juveniles. Within detention and long-term correction environments we also have some differences in the kinds of services we offer. We ought to make sure that those services match the length of time that people remain in your facility and respond to the kinds of issues they bring to the table. We know female adolescents bring certain needs caused by trauma, sexual abuse, and witnessing violence. These very specific needs are often not addressed by traditional systems. We have to begin raising the level of awareness and the level of response to female adolescents. We need to be sure we do not re-trigger the kinds of trauma that these young women may have experienced. These are some pressing issues that raise the kinds of questions that all of you have. Correction administrators are in a position to encourage and to effect and to support the necessary responses.

One thing we have seen in our work at the GAINS Center is the great need for training in many institutions. I often get calls from adult and juvenile administrators about what kind of training is recommended. We need to shift the way we train our staffs so they can better respond to youth with mental health and/or substance abuse problems. Cross-training is necessary. We must provide training that offers people from different systems the opportunity to learn from other disciplines. At the GAINS Center we have completed a cross-training curriculum. One of the authors, Lisa Boesky, is here and will speak later on today. It's a good document and tool that systems such as yours can utilize to begin the process of cross-training your staff about the kinds of intervention that these children need. The curriculum addresses a wide range of issues; issues about screening, assessment, management, treatment, and collaboration within systems. The curriculum is a very big document. We're looking for ways to offer it to you at no cost. We want you to utilize it in your own jurisdiction to train not only your corrections staff but front line corrections staff or administrators as well. This is a very flexible tool which is designed to bring together staff from different systems under the same roof. Knowing and understanding what colleagues in the other systems are doing will bring the systems together. A cross-trained staff can more effectively address the needs of these young people. This is one area I certainly highlight as a need, and an opportunity exists to bring that system forward.

Another issue that creates a lot of angst for policymakers at the federal, state, and local levels is funding. The needs of these youth cut across all of the disciplines. Funding streams must be devised in such a way that you support these multiple needs. Currently, funding streams discourage the kind of collaboration needed to provide appropriate services. A number of jurisdictions have been very creative in blending funding to insure the delivery of services to different systems. Milwaukee, for example, has a wrap-around system. They recognize the multiple needs these juveniles have and have pulled funding and blended funding in such a way that people are not arguing over is this mental health money or substance abuse money or justice money? Milwaukee recognized this is money used to support all the services the youth need. You have to recognize this is not a justice problem or a mental health problem or a substance abuse problem. This is really a community

problem that impacts all of us. As a community we have to develop the kinds of partnerships that will begin to address the needs that these children have without regard to disciplines. When you order a bowl of chowder soup in a restaurant, you don't inquire as to where the potato came from or where the seafood came from or where the other pieces in the soup came from. You just enjoy the richness of what is there. The idea to apply here is, don't think is this my mental health money or is this my substance abuse money, or is this my justice money? Instead, enjoy the richness of what money is there! It can be done because we're seeing jurisdictions that have done it. Do we as a system have the will to move forward and do things? It can be done and I'm encouraged because I've seen it done. Systems are different but I know these are things that can be done. It certainly requires a commitment, though, and it certainly requires will.

We also need to increase the use of diversion services. Whenever possible, youngsters with mental health disorders should be diverted from corrections and from the juvenile justice system. You, as correction administrators or juvenile correction administrators, agree that you don't want children in your institutions who don't belong there. You'd rather save those beds for people who need to be there. Many of these juveniles present management problems. Can they be served in community-based settings if appropriate? We have to recognize the need for public safety issues. For those youth who pose a public safety risk, institutions sometimes are the best place for them. There are a number of young people in institutions today who can be better served in community-based services. Diversion services should be a critical component of the intervention we provide. Diversion at the contact with law enforcement, diversion at intake, diversion at the point where they're admitted into your institutions, and diversion prior to and after court disposition of cases. Diversion should occur at different points in your system. Administrators ought to play a part in this and encourage diversionary efforts so that you will have youngsters in your institutions that you can effectively manage.

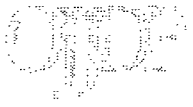
Screening and assessment have been great challenges for our juvenile justice system. We don't have effective, adequate screening instruments. Some very promising models are being developed, but we still have some way to go to have the kinds of screening and assessment tools that are comprehensive and take into account different needs. Screening and assessment tools must be sensitive from a cultural competence standpoint and from a gender specific standpoint. Screening instruments should indicate the necessity for further assessment, and assist in the development of treatment plans. Screening and assessments need to be conducted at various points, be ongoing processes. For example, screening and assessment at pre-placement are really important. This will provide your clinical staff with the opportunity to modify or adapt the treatment approach as necessary.

Another need for this population is transitional services. This is one area in which we're seeing an acknowledgment of the importance of transitioning back into the community. Most of these youth will go back to the community. We need to think about how we, once and for all, can arrest the cycle of going out and coming back. Transitional services should begin at intake. Waiting until the child is about to be released is sometimes too late. You need to begin thinking about transition when the child walks in the front door. Fragmentation of the system poses a challenge to transitional efforts. Systems tend to think of themselves as separate in many ways and not collaborative. It creates challenges because I, as

a corrections administrator, may think my responsibility is only to secure this child while he/she is in my facility. We also must reach out and interact with people and agencies in the community as these youth are moved back. As administrators, you impact, encourage, and support juveniles moving from your institutions back into the community. The community is part of the issues and needs of these children. Unless we begin to address these things we will see them back in the system. So, the earliest point of entry into your facility should be the earliest point of planning for discharge. You need to involve school, community-based providers, and the parents. In many instances, involve the children. The client should be involved in most aspects, sometimes in all aspects, of the treatment you're developing. That fosters buying into the program. That's something we often don't think about. We often think this is the offender. How could they possibly sit in and interact with professionals about what they need?

I mentioned the Milwaukee program. I think it's a very good approach to a system of care that incorporates all of the pieces within the system. It's an emerging model of the best practice for many jurisdictions around the country. In New York state they have regionally-based mobile mental health treatment teams. These teams go into juvenile facilities to provide screening, assessment, training, and other services. Many systems have begun developing and implementing diagnostic settings. When the youth come in the front door you can develop pictures of where these youngsters are and what they need.

These are a few of the issues facing juvenile corrections today. I'm certainly encouraged by the direction in which we are moving. There are a number of supports coming from the federal level to appropriately and effectively address many of these issues. People often ask me about funding. What resources are out there, particularly for this population? A key idea is that funding doesn't always come with the label of juvenile mental health corrections funding. Sometimes the label is youth violence prevention, juvenile violence, or juvenile crime prevention. We have to think about how we can utilize the funding streams to support the efforts we're making. Most of what we're doing is crime and/or violence prevention. You can be creative and innovative when you search for funding, but you can't create the needed partnerships by yourself. Partnerships are necessary with the behavior and school systems. Most funding streams require this now. Move out of your box and out of your system. Reach out to create the needed infrastructure. You will continue to see the kinds of challenges you have now, but I'm encouraged by everything that I'm seeing. We're certainly available to use as a resource. We are hopeful we will receive the funds to continue the GAINS Center. This year we began a series of regional forums at the Center. We look at these as effective opportunities for system change for local jurisdictions. In February, in Tampa, Florida, we had the first forum focused on juveniles. These forums have created an opportunity for people to come in as teams. A requirement of attending the forum is that the teams be multi-disciplinary. For example, a team may include the probation director, the juvenile detention administrator, the director of mental health, and/or the director of substance abuse, if those are separate agencies. What we try to foster is a multi-disciplinary approach to the kinds of services that are offered. Nine of these multi-disciplinary teams from various jurisdictions around the country came together and were presented state of the art information. Specially designed break out sessions gave the teams opportunities to assess the strengths and weaknesses of their environments, and to develop implementation strategies for new programs. I



think where these regional forums are different, is that following the forums we pledge our support and technical assistance when these teams to go back home. We are trying to transport the principles of these regional forums to statewide systems. Last year in Missouri, we actually conducted a state juvenile justice forum. A number of the court circuits in Missouri were able to come together and do the same thing. I offer that to you; again, as administrators, this can be a resource for you. If you are interested in this kind of effort, we are in a position to offer you the technology and assistance whether you are at the state or local level. The goal is to begin the process of creating real change at the local level by including all the different players in your jurisdiction. We'll offer you all the resources that we have available to analyze your system and create interventions that will change the way business is done.

Identifying Mentally Ill Juveniles

Lisa Boesky, Ph.D.

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What I'm going to talk about today is identifying mentally ill juveniles. What you're going to hear about for the next two and a half days is screening and assessment, the importance of treatment, transition, and all that stuff about mentally ill juveniles in your facilities. Which youth are we actually talking about? It varies from state to state. Some states say we don't have any mentally ill juveniles in our facilities. I go to other states and they say every child in my facility is a mental health child, but I can't get services to everybody. That's the reality, all of our youth have mental health problems, or the majority of our youth have some kind of mental health issue and could benefit from some kind of treatment. You don't have the money to do that for every single solitary child. Our goal is really to find which juveniles need your resources the most. Here are two quick video clips. This first one is a young man who may look familiar to you. Take a look and see what kind of thoughts come to your mind, particularly in the area of mental health.

JUVENILE: I didn't get caught for anything. I was doing little crimes. I never got caught. And then it just progressed and . . .

INTERVIEWER: Little crimes being?

JUVENILE: Little crimes, started with shoplifting, you know, and then maybe stealing a bike or another car. You know, going on a joy ride. Robbing somebody and I never got caught. Never got caught for any of the crimes that I was doing until this, the one that I'm locked up for now, and that's murder.

INTERVIEWER: Murder?

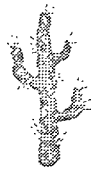
JUVENILE: Yes, murder.

INTERVIEWER: How'd that happen?

JUVENILE: It's a real long story.

INTERVIEWER: In essence I mean.

JUVENILE: The essence: I was in a real bad mood that day and someone was in the wrong place at the wrong time. It could have been anyone at the



time. Someone just said something to me. I have no idea what the person said. I just unleashed all the anger I had inside of me.

INTERVIEWER: Did you have a gun?

JUVENILE: No.

INTERVIEWER: How'd you do it?

JUVENILE: With a piece of wood.

INTERVIEWER: Did you know the guy?

JUVENILE: No, I didn't know who he was.

INTERVIEWER: Had you been drinking?

JUVENILE: No, I was sober.

INTERVIEWER: Were you on drugs?

JUVENILE: No.

INTERVIEWER: But there was a fight?

JUVENILE: Nope. I was just in a bad mood. It was years of violence; years of being violent. It just built up, the anger, resentment. Just aggression.

INTERVIEWER: What were you mad at?

JUVENILE: The world. Everything. It started when I was a little kid when my parents got divorced and then the choices I made.

INTERVIEWER: How old were you?

JUVENILE: I was 11 when my parents got divorced.

INTERVIEWER: What did you think about that at the time?

JUVENILE: I thought that my whole world had just gone to hell. Everything fell apart because before my parents got divorced I thought we had the perfect family. You know, I had everything I wanted. And I was real happy. But they got divorced and it was like somebody dropped a bomb.

So how many of you think that this youth is mentally ill or has a mental health disorder? How many of you would say, "No, this youth does not have a mental health disorder"? Raise your hands. How many of you say, "I have no clue whether this youth has a mental health disorder or not"?

I'm going to show you one more clip. This is a young woman from Seattle, currently on probation.

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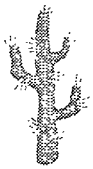
Dr. Boesky has designed a mental health training program for correctional staff and trains juvenile justice staff regionally and nationally. Dr. Boesky also serves as a consultant on mental health policy and programming to various juvenile correctional facilities throughout the state of Washington.



INTERVIEWER: What charge were you brought here for?

JUVENILE: Residential burglary. I was an accomplice in a residential burglary.

INTERVIEWER: And how many times have you been arrested?

JUVENILE: Four.

INTERVIEWER: And you've been locked up in detention before?

JUVENILE: Yeah.

INTERVIEWER: Have you ever seen a counselor before?

JUVENILE: Yeah, only school counselors though. They always tried to get me counseling outside of the school but, you know, I mean I was either too busy or I was being a bad kid. . . . I had like, my friends had a lot of problems and I always wanted to help my friends. Had to be there for them.

INTERVIEWER: So you saw a school counselor, and what were some of the reasons that you went and saw the school counselors?

JUVENILE: Actually they would make me go see the school counselor because they thought I was suicidal. I was weird because of, like, the way I dressed and the way I looked. They automatically considered me, like, you're going to kill yourself, you're Satanic, you know. Like, you're weird, you wear black lipstick.

INTERVIEWER: Okay, and during these times were you ever suicidal?

JUVENILE: Um, before, yeah. I had, but I mean, that's because I was on drugs and bad drugs and stuff like that and my life was just falling apart. I didn't really care. I didn't want to deal with it.

INTERVIEWER: So how long ago was it that you were feeling suicidal?

JUVENILE: A year and a half.

INTERVIEWER: And do you remember what was going on at that time?

JUVENILE: I was on heroin and, I mean I had gotten really bad into it, and I mean everyone around me was just dying, but I just kept doing it and I was just hanging out on the streets, living on the streets, didn't want to go home, didn't want to go to school, just wanted to, you know, mess around and do drugs.

INTERVIEWER: And how old were you back then?

JUVENILE: I was 13.

INTERVIEWER: 13? Okay. And you tell me that you felt suicidal, did you actually make a suicide attempt?

JUVENILE: I had four times.

INTERVIEWER: In what ways did you try to kill yourself?

JUVENILE: I purposely got alcohol poisoning. Had to go to the hospital for that. I had OD'ed twice and I tried to cut myself.

INTERVIEWER: Okay. And how about not trying to kill yourself. Have you cut on yourself, burned yourself, things like that?

JUVENILE: Yeah.

INTERVIEWER: What kinds of things have you done?

JUVENILE: Put cigarettes out on my arms, cigars. Slashed myself. Yeah, I mean, I used to think that, like, you know, it helped. I didn't want to hurt other people. It helped me to hurt myself instead.

INTERVIEWER: So, were you feeling, you didn't want to hurt other people? Were you feeling like you wanted to hurt other people? Can you describe what that was like for you?

JUVENILE: It was, I mean, I'm not a mean person. You know, I mean I don't like the fact that, you know, I want to hurt someone. It made me feel like, you know, bad. So I thought I should be punished for that.

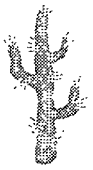
INTERVIEWER: And how did you end up on the street versus going to, say, a family member's house or going into foster care or something like that?

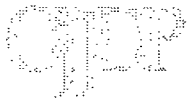
JUVENILE: I started going up there and meeting the people, and there was, you know, they really are good people, good kids. It felt like a family to me. I felt like I belonged.

Okay, so how many of you would say that this young girl has a mental health disorder? How many of you would say no? How many of you would say you don't know? One of the things I want to point out is it's very difficult to tell who has a mental health disorder and who doesn't. Think about the kinds of questions that were asked. I would agree with you if I had to say the first young man probably does not. As a clinical psychologist, I'd do a full assessment and evaluation. What if we had asked him, "have you ever made a suicide attempt"? What if we had asked him if he had ever been on psych meds? What if we had asked him if he ever self-mutilated? He very likely could have made more suicide attempts, cut himself more, been on meds the last ten years, and been in treatment since the age of seven. We don't know because we didn't ask. For a lot of years, that's the way juvenile justice was, focusing on one area. Now we're changing the questions we're asking. The differences we're finding today are because of the questions we're asking. You never want to jump to too many conclusions immediately when a child comes in. The kinds of questions you ask will tell you if the child is or is not a mental health child. I agree that most likely the first youth does not have a mental health disorder, the second youth obviously does.

I want to quickly let you know what my bias is. You're going to be hearing from a lot of speakers and we all come with our different biases depending on the system we come from, what our training was like, and what our experiences are. I want to tell you up front what my bias is. If you don't buy into my bias you're not going to buy into what I'm saying for the rest of my time, which is fine, too.

I imagine that youth in juvenile justice follows a normal curve, not a very good one, but a normal curve of how things occur in juvenile justice. Just like any other normal curve, say intelligence, a majority of the people have average intelligence with a small subset that are on a genius level and a small subset that are well below average or mentally retarded. The same thing applies to height. We have an average height, some are basketball players who are really tall, some are really small. In juvenile justice, it's the same thing. We've got a small subset of psychopaths or sociopaths. These are hardcore juveniles who knew exactly what they were doing when they did it. No amount of treatment or rehabilitation will touch this youth. They're going to come out, they're going to do it again, and they'll end up in the





adult system. This is the kind of child with really no conscience, no empathy, nothing. This is a very small subset of children that we work with. The media thinks it's this big [indicates a large amount], but I think it's really this big [indicates a small amount]. We're still doing a lot of research. There's another subset of youth, a very small one, who are so severely and profoundly mentally ill they should not be in our system. These children belong in a mental hospital. They would have been there years ago, but somehow they had a bad attorney or for some reason the judge decided there was no place for these youth so they were sent to our system. They have no reason to be there. We can't handle them. We don't have the resources. The majority of the people we work with have both of these things. They have some level of mental illness, not necessarily psychotic and hearing voices—It could be attention deficit/hyperactivity disorder (ADHD), could be a learning disability. They also knew that they were stealing that car and that it was wrong. They also knew they shouldn't be dealing drugs. They also knew they shouldn't have been involved with that person. Both of those things are occurring at the same time. Does that mean the ADHD caused them to kick someone or to steal the car or to sell the drugs? No. What that means is, you need to treat both of those things. Your systems are very good at the criminal stuff. You're good with behavior management. You're starting to get better at bringing in the mental health issues. Unless you address both of those and the way that they interact you're going to have that child coming back

In my bias, the youth needs to be held accountable, whether they've got bipolar disorder or ADHD. Some people are talking about diverging mental health youths from your system. I don't necessarily agree with that. If you steal a car, there are consequences for stealing a car, regardless of whether you're bipolar or not. Does that make sense? That's the bias I'm coming from. Just because this youth has this problem you do not need to take it easy. Keep in mind, if the child has ADHD, you are going to have to change your programming. You're going to have to give more reminders. You may have to post some rules. You may have to do some modifications to what you do, but that doesn't mean that they get any fewer sanctions than any other youth.

Rates of Mental Health Disorders

	General Population	*Juvenile Justice*
Mood disorders	2–8%	32–78%
Attention deficit/hyperactivity disorder	2–10%	19–46%
Learning disorders	5%	36–53%
Posttraumatic stress disorder	1–14%	41%
Conduct disorder	2–9%	50–90%
Psychotic disorders	.05–1%	1–6%
Borderline personality disorder	2%	44%
Substance abuse/dependence	1–15%	25–63%
Co-occurring disorders (if have mental health disorder, have a substance abuse disorder as well)	16%	70–73%

Studies of Incarcerated Youth (Short Term)

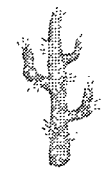
Out of 6,200 admissions to the county juvenile detention facility (representing about 3,200 youth) in 1995:

- 35% of the youth were involved with Community Mental Health Centers
- 70% of the youth were involved with a medical doctor or counselor
- 20% of the youth had prior inpatient hospitalization for acute mental health reasons

Here is a very quick study we did in King County, Seattle. It's an urban environment. We have 300 juveniles in our detention facility. We asked the youngsters as they were coming in about mental health things. I want to point out the kind of services that these youth have had because often people say, is this a mental health child? They look at the file and say, has this child been in mental health treatment? From our study, 35% of youth coming in were involved in some kind of community mental health center, 70% were involved with a medical doctor or a counselor, and 20% of these had prior inpatient hospitalization. That's a very high number. In order to be admitted to a psychiatric hospital, you've got to be a danger to yourself, a danger to others, or severely gravely disabled and unable to take care of yourself. Twenty percent had been in inpatient hospitals. So, you think, that's how we can tell how many of these juveniles are mentally ill because we can look at their services. But if you really look at the data, less than 2% of our youth have received treatment for six consecutive months. When you ask the child if they've ever been in treatment, almost all of them say yes. "Oh man, I've been in treatment. I saw a psychologist, wasn't helpful at all." "Did you go to more than the first session? Did you ever tell him anything that was going on?" "No."

You can't really believe their view of what treatment is. Some of them will say, "I've been in hardcore psychiatric treatment," and it was a six-week anger management class. You've got other juveniles who have been in serious psychiatric treatment and have been on anti-psychotic medications and they say, "Yeah, I did some anger management things and they gave me something to help me control my anger." So children aren't necessarily the best reporters of the kinds of treatment that they've had, and neither are the mental health professionals or the juvenile justice staff that are transferring it from file to file to file to file. The youth may have been signed up to go to treatment. Whether they went more than once, we don't know. Also, we've got youngsters who have gone for two years, once a week, showed up every time. When you ask if they told their psychologist everything: "No, she was a witch, I never told her a thing. I just sat there and kind of talked about the kind of things I did. We just chatted and that was it." That is not therapy, that is not treatment. For that child to say the treatment doesn't work or for us to say the treatment doesn't work isn't really accurate, because that's not really treatment.

The same thing occurs with meds. You cannot use a youth's medication history to determine the mental health state. Medication is prescribed in a variety of places for a



variety of reasons. The person who's doing the prescribing may have more influence than the child's symptoms. You have to be careful with this. A lot of our youth say, "I've been on Prozac. It doesn't work." "Well, were you smoking pot while you were taken it?" "Oh yeah, I was doing acid, too." Maybe that's why it didn't work. Other juveniles say, "I've been taking this Thorazine for two days. I don't notice a difference," or things like that. This happens with meds that take about four to six weeks to kick in, they'll say, "I took it for two days, didn't work, so I went back to doing my drug. It seems to help me a lot more." For the self-medicating youth their drugs seem to work fairly well. I'm not advocating that, but we're saying "don't take your drug, take my drug." Sometimes our drugs have a lot more side effects. Their own judgment is not so bad: this stuff helps me pay attention and has fewer side effects. It makes me feel good. So anyway, get off the other stuff.

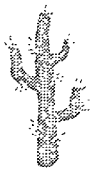
Again, be careful how you identify juveniles. You don't want to do it just based on whether they've been in treatment. It is helpful to know if they've had meds. You need to ask more than just these question, you need the qualitative data.

What I'm going to be talking about today regarding diagnosis is coming from the Diagnostic Statistical Manual of mental disorders, the fourth edition (DSM IV), which is the diagnosis bible for the psychologists and psychiatrists. When I say a child has major depression everyone knows what I'm talking about. The DSM IV has a laundry list of symptoms to diagnose a disorder. A term often applied to our youth is oppositional defiant disorder (ODD). That means it's the kind of youth who argues with adults, may defy rules, lie, blame others, be angry and resentful, and easily annoyed by others. How many of you have teenagers at home? How many of them would fit this category? You have to have a pattern that has existed for a long period of time, and it has to be interfering with their functioning. There are not a lot of good research data on ODD that describes where normal adolescence goes into being dysfunctional. It's really not clear cut. I do not find ODD a particularly helpful diagnosis with our kind of youth. If someone tells you the child has ODD, tell me something I don't know. Interact with that child for five minutes and you could have figured that out for yourself. What you'll see more often is conduct disorder. There's a lot more data on conduct disorder. It's probably the most common disorder that you will see in the files of your juveniles. Does that necessarily mean they all have conduct disorder? No. Conduct disorder means a youngster has violated the basic rights of others by showing aggression to people and animals. Some of our youth do that. Destruction of property; some of our juveniles do that. Deceitfulness, serious violations of rules, or theft; Some of our youth do that.

Oppositional Defiant Disorder

Pattern of negativistic, hostile, defiant behavior—

- Loses temper
- Argues with adults
- Defies rules
- Deliberately annoys others
- Blames others
- Easily annoyed by others
- Angry and resentful
- Spiteful and vindictive



Conduct Disorder

"Basic rights of others or age-appropriate societal norms/rules are violated"

- Aggression to people and animals
- Destruction of property
- Deceitfulness or theft
- Serious violations of rules

And serious violations of rules. They're breaking the law, they're getting locked up. You would say, this is like every kind of youngster I work with. They all have conduct disorder. This is not necessarily true. In order to make the diagnosis, we have to have a syndrome or pattern that has existed for a long period of time. The thefts that they commit are more serious. There should be assaults and/or aggression. This happens over a *long* period of time. It's not just one or two little things. How many of you work with young people like that? Many of the youth we work with have done these things and fit this category. Often people confuse delinquency with conduct disorder. The community mental health workers see juveniles committing crime and getting in trouble. "Oh my gosh, he's been aggressive. Conduct disorder. Conduct disorder. Conduct disorder." They stop there. Number one, they've got to look to see if it *really* is conduct disorder, a syndrome that's been going on for a long period of time. Number two, be sure a good comprehensive evaluation was done. If they come back with conduct disorder and just conduct disorder, send the evaluation back and say, "What else is going on?"

Ask this question whenever you see this term. The juvenile is incarcerated. You know that laws and rules have been broken. You need to know what else is going on. And I guarantee you with a lot of our youth, there's something else going on. If they come back and they say, "Really, there *is* nothing else going on. There is no mental health disorder. There's just conduct disorder." Then what you want to ask is, "So what do I do? What's motivating this child? Is this child amenable to treatment? What reinforces this child? What's the appropriate way that we should be treating this child?" A repeat of this diagnosis is not helpful to you. Again, spend ten minutes with the child, letting him tell you about the criminal history and you can diagnose it for yourself.

You also want to be careful, because a conduct disorder diagnosis does a disservice to youth that we work with when we call it a psychiatric disorder. Research tells us delin-

In "Conduct Disorder" the Problematic Behaviors Tend to be More:

- Frequent
- Intense
- Chronic
- Reflective of a syndrome vs. symptom

quency is caused by a multitude of factors in the environment: the way they were raised, the total family environment, their peers, and whether they use substances or not. To say, "You are a bad child, and you need to come to treatment because of your conduct disorder," does a disservice to the child. We know that in order to *really* help someone with conduct disorder you've got to bring in the family, work on the substance abuse and what friends they have, and get them back into school or find a job. Be careful if the file says, "Youth has conduct and refer for outpatient therapy."

Let's go over some of the more meaningful diagnoses. ADHD is one of the most common you will see in your facilities. The DSM IV is the latest edition. In the last edition it was called attention deficit disorder with hyperactivity, and without hyperactivity. They are the same. This is just a new name. In the next edition ADHD may be called something different. How many of you think ADHD is over-diagnosed in your population of juveniles? How many of you would say, "Trust me, I've got youth that meet the criteria, that should have the diagnosis, but don't"? How many of you would say, "Ritalin is over-prescribed"? How many of you would say, "I've got youngsters that need to be on Ritalin and I wish somebody would do this"? Actually all of you are right; this is a very difficult diagnosis to get when done correctly. You must have more than one or two of these criteria: difficulty paying attention; not listening; losing things; easily distracted. How many of you meet these criteria half the time? Exactly. Do you all have ADHD? No. Since many of our young people are living in stressful circumstances, they answer "Yeah" to these things. In order to get the diagnosis, you need to have these problems for six months or more. They must appear in two settings, also. If you're seeing all of these problems in the unit, but in the school area they're doing fine, it's probably not ADHD. If they're having the problems in school, but back on the pod and in their unit they're doing fine, it's probably not ADHD. If the family says they never saw this in the home, but only in school, it's not ADHD. You need it in two settings. Plus, you have to start seeing it before the age of seven. If a 13-year-old kid comes

Characteristics of Youth with Attention Deficit/Hyperactivity Disorder (ADHD)

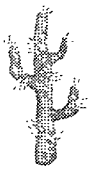
"Inattention" (6 or more/6 months/Maladaptive)

- Difficulty with details
- Difficulty sustaining attention
- Not seem to listen
- Not follow through on instructions/fails to finish schoolwork or chores
- Difficulty organizing tasks and activities
- Avoids tasks requiring sustained mental effort
- Loses things
- Easily distracted
- Forgetful

to your setting and all of a sudden starts to exhibit all of these difficulties, it's probably not ADHD. There must be symptoms before the age of seven. Also, it needs to interfering with their ability to do things. I, too, have many of these things, but I'm able to get my job done, it's not interfering with my life. This disorder has to be causing significant problems in their ability to function.

All of these things make ADHD a very difficult diagnosis. And you have to talk to teachers, parents, and the child. You have to know if it started when they were younger. It takes a very comprehensive evaluation. How many of our youth who have an ADHD diagnosis have had that kind of evaluation? Not many. What often happens, particularly in the last five or six years, is a parent will say to the family medical doctor, "My child's having difficulty paying attention. He's bouncing off the walls. He's starting to steal things." The parents put the child down: "You do seem kind of fidgety. You seem like you're having problems in school." "Yeah, I can't concentrate." "I think you have ADHD. Here's some Ritalin." This is not the appropriate way to diagnose ADHD, but it's the way a lot of our young people are diagnosed. The diagnosis gets passed on from file to file to facility to facility. Does anybody reassess these children? Not all the time. They may have been diagnosed at eight or nine years old. When they get to you they're 14 and 15. Maybe they still have it, maybe they don't. But the disorder and the Ritalin continue, so we never see what they're like off the medication. I have seen many youth come off of their Ritalin, or at least have a lower dose, when you lock them up. We've got the most structure. We've got the most consistency, with clear expectations, and clear consequences. That's the best treatment for juveniles who have ADHD. It's a structured, consistent environment. It's the best time to try them on a lower dose of medication. If you have a child who has ADHD and their behavior gets worse, it's very short-lived. If you take them off the Ritalin, and they start to bounce off the walls again or aren't paying attention, put them back on. It's not that difficult to do. There are not a lot of side effects when you do this. Give the child a chance to be monitored. You're right, ADHD is over-diagnosed. But there are youth in our system that need the diagnosis and need the Ritalin, whose parents couldn't afford to take them to a doctor. They didn't think anything about it. They thought, "This is a rambunctious child." Or, in my culture, he just seemed kind of independent, so we didn't pay much attention to it. There are some young people who do need to be evaluated for ADHD. If you have these criteria, you have ADHD, inattentive type.

You can also have the hyperactive type. Here is how I see these juveniles. They are always in your hip pocket. They are the most challenging to staff. The child's always saying, "When can I call my mom, when can I call my mom?" "You can call your mother after lunch." "When's lunch? When's lunch? When's lunch? When can I do it?" "Didn't I just tell you? Go in your room, make your bed, brush your teeth, take time out, and then you can go play basketball." They go in their room, they start reading a magazine and they never come out. When they come out two hours later they say, "Can I go to play basketball?" "Well, I told you, you need to brush your teeth, make your bed. . . ." "Well, I forgot." Staff thinks they're being oppositional and says, "You don't get to play basketball today." Then the child throws a tantrum. "You *never* let me play basketball. . . ." To avoid this struggle with ADHD children you've got to tell them one thing at a time. These are also the youngsters who are moving around. They're yelling things in group. They're interrupting. They're poking other



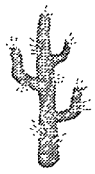
kids. You tell them, "You've got to sit down in group." "Okay, okay." "No really, you have to sit down in group. I'll remove you from group if you don't sit down." "Okay, okay, okay." They sit there, and bam, they're up in two seconds. Of course the staff thinks they're being oppositional. "That's it. You're out of the group." A lot of these children cannot help it. If you have worked with a classic, true ADHD child, and you've seen them on Ritalin or Dexedrine or any of the other medications, you've seen a profound, profound difference. Do meds cure it? No. Meds help the child pay attention long enough to participate in groups. They're not so annoying to peers and people actually want to hang out with them, the staff actually want to interact with them. That's what we're trying to do, just slow them down or help them pay attention.

You can have ADHD inattentive type, ADHD hyperactive type or, if you've got symptoms of both, you have ADHD combined type. If you have a child who appears to have these symptoms and you put them on Ritalin and they tend to get worse, consider an anxiety disorder. Anxiety can look a lot like ADHD. You can't pay attention, you're moving around all the time. Anxiety is very often confused with ADHD. The first thing out of people's mouths is ADHD, and they tend not to dig a little bit further. The impulsivity, hyperactivity and inattentiveness make these juveniles very difficult to manage and it's why they get into delinquency. They have a lot of other traits that go along with these. People think these aren't smart children. Often, children with ADHD are very bright, but have poor social skills. They have a lot of temper outbursts, a very low frustration tolerance, and their moods are up and down. An ADHD diagnosis can range from mild to severe. Ritalin can help them pay attention and slow them down, but this is where your job comes in. They need help learning new social skills, getting school skills, and managing their emotions.

Characteristics of Youth with Attention Deficit/Hyperactivity Disorder (ADHD)

"Hyperactivity-Impulsivity" (6 or more/6 months/Maladaptive)

- HYPERACTIVITY
  - — Fidgets with hands/feet or squirms in seat
  - — Difficulty remaining seated
  - — Runs/climbs excessively/feels restless
  - — Difficulty playing quietly
  - — "On the go"/"driven by a motor"
  - — Talks excessively
- IMPULSIVITY
  - — Blurts out answers
  - — Difficulty waiting for their turn
  - — Interrupts or intrudes on others



Major Depression

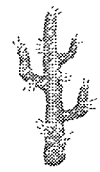
(2 Weeks/5 or more)

- Depressed/irritable mood
- Diminished interest or pleasure in all, or almost all, activities
- Significant weight loss or weight gain or significant increase/decrease in appetite
- Insomnia, excessive sleeping or other sleep problems
- Physical restlessness or slowed body movements
- Fatigue or loss of energy
- Feelings of worthlessness, excessive or inappropriate guilt
- Diminished ability to think, concentrate or make decisions
- Recurrent thoughts of death or suicide, or a suicide plan or attempt

I could spend a day on each diagnosis, but I'm just going to give you a brief review of them. Major depression is one of the most under-diagnosed, or misidentified diagnosis in our system. Some of you may have been depressed at some time in your lives. You may have had friends and family members who were depressed. You've seen people on TV who have major depression. What are the kinds of symptoms these people have? "Lifeless." "Hopelessness." "Isolation." What's their mood like? "Sad." What's going on with their sleep? Are they sleeping more or sleeping less? Actually it's both. They're sad all the time, crying. They have diminished interest or pleasure in all or almost all activities. Anybody know what the fancy word for that is? Any mental health specialists? Anhedonia. Yes, you can use that term and impress your friends. Anhedonia. "How you doing this week?" "Oh, feeling pretty anhedonic." Blows 'em away! Young people, you know, who are interested in playing basketball or hanging with the other girls, braiding each other's hair, will suddenly stop doing their favorite things—playing basketball, hanging out with the other girls, etc.

A depressed mood is a common symptom in adults. In adolescents, particularly male adolescents, and the adolescents we work with, it's not usually about a sad mood, it's irritability. You are more likely to see a depressed/irritable state. Depressed adolescents, particularly in juvenile justice, are not in the corner crying. They're hitting, they're kicking, they're biting, they're yelling, they're cursing, they're stealing, they're very irritable. Recall, we're talking about a change from how they normally are. They have to exhibit this for two weeks or more. The youth is an average child doing whatever he does in our system, and suddenly changes to *really* irritable, really angry all the time, explosive, fighting with staff and other juveniles. When you notice that irritability and that anger, that's when you want to consider depression.

Weight loss or weight gain works with adults as a good signal of depression. When you're working with our adolescents, other than depression, what are some of the reasons a child might eat a little bit more when they get locked up? Getting better food, some say. It



may be boredom, or immediate gratification. Some of these youth are coming in off the streets and haven't eaten in days, after they come off their drugs. They've got this ravenous appetite. This usually doesn't mean they're depressed, but it can look that way. Why would a child eat less? Why would they have a decrease in the amount that they're eating, other than depression? They don't like the food. Or they work in the kitchen or know young people who work in the kitchen and hear people are spitting in the food, or there are rats in the food. All those kinds of rumors go around. Some institutions have better food than others, and children will not eat as much if they don't like it. Does that mean they're depressed? No. You have to be careful. When people talk about mental health disorders and how juveniles seem to be depressed or have ADHD, it's important to understand that our population is different. Our youth don't fit with criteria the way they do in the community. Even in the community it's hard to diagnose adolescents. But for our young people there's a variety of external situations and circumstances that make diagnosis very complex.

The same thing applies with sleeping. Why would the child sleep more than normal? Being in a safe environment. Coming off drugs. If they are bored, sleeping makes the time pass quicker. Why *wouldn't* they sleep as much? They could be scared. It could be the first time they've ever been locked up. Some youth had traumatic experiences in the past or could be claustrophobic. It is very difficult to diagnose from appetite/sleep disturbances. It is important to ask. With these children, you've got to ask more detailed questions than just, "Are you eating more than normal? Are you having trouble sleeping?" You've got to go beyond yes or no questions.

You want to pay attention to physical restlessness or slowed body movements. The juveniles move very fast, are fidgety, can't sit still. What else could that be? Looks very similar to ADHD. Slowed body movements are exhibited by the child at the back of the line who is always dragging. Speech can become slower. Again, it's a change from how they normally are that you're looking for. It has to last two weeks or more.

Fatigue, or loss of energy, and excessive or inappropriate guilt are also symptoms. This is not somebody who has been locked up for murder or rape or serious assault. You want them to have a little bit of guilt, you want them to feel bad about what they've done. The youth who comes in for a very minor crime, and feels his entire life is ruined, his family's destroyed, is showing guilt excessive to the situation.

Some may not be able to think or concentrate as they used to. Making decisions is difficult. Again, this can look like ADHD, so they tend to get confused during diagnosis.

Recurrent thoughts of death, suicide plans, or suicide attempts also signal depression. Things they're writing, and/or pictures have death themes. A suicide attempt is an obvious sign. Children will say, "Oh I think about suicide, all kids do." Many adolescents in juvenile justice think about what it would be like to be dead. Many youngsters in juvenile justice think, "Wow, I wonder if I should, you know, if I should kill myself." Not many of them think about it in enough detail to plan how they'd do it. Even fewer have actually done it. This is not a part of normal adolescence. Planning and making a suicide attempt should never be thought of as a normal part of adolescence. Some people say, "I know he's just doing it for attention." There are plenty of ways to get attention in an incarcerated facility other than trying to hang yourself or cut yourself. Even if the child *is* trying to get your attention, you still need to know what else is going on. When they try to gain your attention

in this manner, you need to follow it up. You'll take precautions and monitor as you always would, but you need to find out what's going on and not just dismiss it as a fake or bid for attention. You want to go beyond. When you walk away from today, I want you to always ask, "What else is going on? What else is going on?"

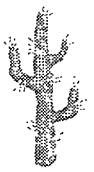
I want to really emphasize that it's a change from how things normally are that's key. This change must cause significant impairment in functioning, interfering with their ability to get things done.

How many of you have heard of dysthymia or dysthymic disorder? How many of you have never heard of that before? This is something you want to become familiar with, as it is probably more common than depression among the kind of juveniles we work with. This is low-level depression. Most of us have good days and bad days, but we keep within bounds. People who are depressed also go up and down, but often they go down, down, down until they become suicidal. Adults and young people who have dysthymic disorder or dysthymia are not totally depressed, but they're lower than the rest of us. It's chronic, lasting for a year in young people or two years or more in adults. This is low-level chronic depression. In adolescence it may appear as irritability. I call these children "prickly." No matter what you say, no matter what you do, you make them mad, you piss them off, and nothing makes them happy. No matter what you tell them, the answer is, "Don't tell me what to do." They're always like that, and they've always been like that. Not because they're tired or coming off drugs, they're just like that. That's the kind of child I'm talking about. If you ask them how long have they had a short fuse or how long people have been getting on their nerves, they'll say, "As long as I can remember. Even when I was in first grade people were getting on my nerves." That's the kind of child we're talking about. Depression often has genetic components. If you have a family member who has depression you are more likely to have depression. We're finding dysthymia is related to having an environment of poverty, stress, abuse, and neglect. This is very similar to the kind of environment most of our juveniles come from. An anti-depressant might be helpful for depressed youth. Medication doesn't work so well with dysthymic children. Here you need a lot of behavioral strategies. The indicators are sleeping and eating habits, low energy, low self-esteem, poor concentration, hopelessness, and irritability or low-level depression.

Dysthymia

Depressed/irritable mood most of the day, more days than not, for at least 1 year (2 years in adults) PLUS 2 of the following:

- Poor appetite/overeating
- Insomnia/excessive sleeping
- Low energy/fatigue
- Low self-esteem
- Poor concentration/difficulty making decisions
- Hopelessness



Bipolar Disorder

(1 Week or Hospitalization)
"Period of abnormally and persistenly elevated, expansive or irritable mood"
with 3 of the following:

- Inflated self-esteem/grandiosity
- Decreased need for sleep
- More talkative than usual or pressured speech
- Jumping from one subject to another without obvious connections (flight of ideas) or feel like thoughts are racing too fast
- Distractibility
- Increased ability at work, school, socially
- Involvement in impulsive behavior with potential for painful consequences

Bipolar disorder is the third of the mood disorders. Depression is way down here, and dysthymia is higher. Bipolar is what used to be known as manic depression. These juveniles have low, low depression and then they go way, way, way, way, way high in the manic phase. The manic phase for adults is an abnormal, persistent, elevated, and expansive mood. They're just so happy, they're on top of the world. They come up with these great ideas. They go out and buy cars or make investments in the stock market or decide how they're going to create a whole new business. Our children, lucky us, often become extremely irritable. Often you'll see an adolescent who doesn't get extremely happy. Some of them do, but more often you'll see a change to incredibly explosive irritability. This is the manic phase. What makes this different from ADHD or depression is they often feel great about themselves. It's a grandiose attitude of, "The rules don't apply to me. Well, I know those *other* guys have to go to bed at 8 o'clock, but *I* can stay up, can't I?" "I know that we're not allowed to play basketball at 2 o'clock because we need to be in our rooms, but *I* can play basketball. How dare you?" "How dare *you* even though I'm locked up and you're a correctional officer. How dare *you* tell me what to do?" They see absolutely nothing absurd. There are clues to the mania thing. You may see a decreased need for sleep. Three or four days may go by without sleeping a wink. We'd be dragging, but they've got tons of energy. They just go and go and go and go. Suddenly they talk a lot. They want to tell you everything. They want to ask you everything. They just talk, talk, talk, talk, talk, which is called "pressured speech." This is very similar to how I'm talking right now. It's very difficult to interrupt me, as I'm going very quickly, trying to get the words out. That's what they start sounding like. When you ask them, they say that the thoughts in their head are going so fast they can't get it out quickly enough. They may jump from one subject to another. We call this a flood of ideas without connection. A girl hangs up the phone, "Damn!" You say, "What's going on?" "Well, I just hung up with my boyfriend, and he says he's dating LaWanda, and I don't know, we're going to have macaroni and cheese for lunch today, but we had that last week and I don't know when she's going to braid my hair because my mom

says that I'm going to get a new comb, I'm going to go, and then, do you think LaWanda's pregnant? Because if LaWanda's pregnant, then, are we having hot dogs with that macaroni and cheese or not?" You can follow them, and tell that there's something more than not paying attention. It's really what's going on in their heads. They have all these thoughts coming so quickly and they don't realize they're not making a whole lot of sense. This can be very confusing to the listener.

Distractability by anything that's going on, any sound, any movement, anything, is another clue. Mania can look very similar to ADHD. The energetic, distractible, behaviors of the manic stage are often confused with ADHD. I have yet to see any of our youth in a manic phase say, "I can't wait to go to school. I can't wait to go to work." Typically, they increase their involvement in a current activity. If they are engaged in theft, they steal a lot more. If they're aggressive or assaultive they become more aggressive and assaultive. They do become more social. Girls become much more sexually promiscuous. Boys and girls tend to get involved with older people. They interact with people they never would have before. Gang members suddenly start walking over to other gang members, "Hey buddy, what's going on?" Their judgment seems to go out the window. They just want to get to know everybody and talk to everybody. They're just *so* friendly. It can often get them in a lot of trouble. This is impulsive behavior with the potential for painful consequences. Some of the youth that are locked up right now got into trouble while they were in a manic phase. They walked into a Wal-Mart, saw a boom box they wanted, and walked right out with it and a couple of CDs. When law enforcement said, "Excuse me, you're under arrest." "What do you mean? What if I wanted it?" It's that grandiose notion that rules apply to everyone else but they don't apply to me. Some may take extreme risks and not think about the consequences. Again, this is very similar to ADHD.

Post traumatic stress disorder (PTSD) was discussed earlier today when we looked at the traumas our young people experience. There can be major traumas, such as seeing your best friend shot, having them die in your arms, watching your parents overdose, or watching years of domestic violence. It can be moving from 12 foster homes before the age of 12. It can be being raped, abused, or neglected. Does that mean that all of the juveniles who have suffered from trauma suffer from PTSD? No. Often in mental health we say, "Oh, my God, there's been a trauma. This person has PTSD." This is not necessarily true. You have to meet diagnostic criteria. Does that mean you shouldn't do trauma-focused work? You should do trauma-focused work, if that's what will be helpful for that youth. Do a lot of these young people need to go through that kind of work? Yes, some of them do. Do all of them? No, not necessarily. When we know a child has PTSD, obviously they have had a trauma, and they're re-experiencing it. They're having intruding thoughts. They're having nightmares. They're having flashbacks. This happens a lot of times during take downs. When a child has been assaulted or abused in the past, instead of not resisting with four guys around, these juveniles get a lot worse. They start screaming and yelling and become out of control. These youth are seeing the correction officers as the perpetrators. They have totally lost contact with where they are and are re-enacting what happened before. Not all of our youth have flashbacks or nightmares. For some reason juveniles have had terrible things happen to them and they come up with coping mechanisms. Some of our children have learned to dissociate. This is particularly true for girls who've been sexually abused. You'll see them just spacing

Posttraumatic Stress Disorder (PTSD)

(Symptoms for 1 month or more)

Exposure to extreme traumatic stress (fear, helplessness, horror, disorganized or agitated behavior)

- RE-EXPERIENCE THE TRAUMA
  - — Intruding thoughts
  - — Distressing dreams about event
  - — Flashbacks (sober and/or intoxicated)
  - — Some youth may "dissociate" and lose touch with reality
- AVOIDANCE OF STIMULI THAT REMINDS THEM OF TRAUMATIC EVENT
  - — Avoid thoughts, feelings, conversations about trauma
  - — Avoid activities, place, people that remind them of trauma
  - — Unable to recall certain aspects of trauma
  - — Markedly diminished interest or participation in significant activities
  - — Feeling of detachment or estrangement of others
  - — Restricted range of feelings
  - — Sense of a foreshortened future
- PERSISTENT INCREASED AROUSAL
  - — Difficulty falling or staying asleep
  - — Irritability or outbursts of anger
  - — Hypervigilance
  - — Exaggerated startle response

out and losing track of time. Often that's a sign of PTSD. They also avoid things that remind them of the event. They don't want to talk about it, or go near anything that has anything to do with it. These youth feel they're different from others. They feel very separate from others. They also have a restricted range of feeling, so they don't really get happy, and they don't really get sad. They have this monotone feeling, without a lot of hope for the future. Again, this has to be interfering with the ability to function. Some people would say, "The child is incarcerated. They're obviously not functioning very well." We have to broaden it, young people who may have been locked up are doing really well in school, and have friends. You don't want to automatically assume an inability to function. Increased arousal, having a hard time falling or staying asleep, irritability, and outbursts of anger may be signs of hyper-vigilance, or, always knowing who's doing what. "Why are you doing that? Why did you move you pen? Why are you wearing that tie today? Didn't you say you didn't like that tie? Hey, you came in ten minutes late today." A lot of our abused children are hyper-vigilant. As they grew up they learned, "Uh oh, Dad's got alcohol on his breath. Uh oh, got to be careful. Uh oh, don't go near that." They're very good at checking out their surroundings. Often what we say to them isn't half as important as our tone or body movements,

because that's what they're paying attention to. There may be exaggerated startle responses. As you go up to them they kind of shake.

Research is showing that there are a lot of young people we should leave alone. This may conflict with some of your programs. If a child is not actively experiencing flashbacks, is not actively having problems due to the trauma, can move on and get job skills, education skills, and social skills, they don't need to relive the trauma. They don't need to go back to it. Juveniles will tell you, "I don't need that. I don't want that." And if they say that, you should listen. It's much more traumatizing to force someone by saying, "No, but you were abused and you need to talk about it and you need to get into it and you're in denial." We know this does not work for these youth. Research is finally showing that. If PTSD is interfering with the ability to function absolutely, there are now prescribed ways you can use to move the child into an empowering state and help develop the needed skills.

Self-mutilation is probably what you'll see the most when you have PTSD kids. Suicide is more often associated with depression. PTSD is an anxiety disorder. These kids are often very anxious and self-mutilation is typically a tension release. When kids are anxious they cut themselves, they burn themselves. It helps them relax. It helps them ground themselves. For us it would hurt, for them it actually feels good and really does relax them.

Now, for a quick look at learning disabilities. Test someone's IQ. Regardless of what their IQ is, if achievement tests in reading, writing, and/or arithmetic are a lot lower than what you would expect given their IQ, that would indicate a learning disability. With a genius IQ, you'd expect them to be doing genius work. If they're scoring significantly lower than that level, they have a learning disability in that area. They could have a below average IQ, so you would assume below average scores in math or reading or writing. If achievement is significantly below average there is a learning disability. You can have a learning disability at any range of intelligence. The most common is a reading disability. The most famous name for that is dyslexia. Learning disorders are very common among our population of youth. We know this is a significant risk factor. If a child has good academic skills, it's one of the places we can make the hugest difference in the lives of these youth. Young people

Learning Disorders

A learning disorder is diagnosed when the individual achievement on individually administered, standardized tests in reading, mathematics, or written expression is substantially below that expected age, schooling, and level of intelligence.

The learning problems significantly interfere with academic achievement or activities of daily living that require reading, mathematical, or writing skills.

- Reading disorder
- Mathematics disorder
- Disorder of written expression
- Learning disorder not otherwise specified

Mental Retardation

- Significantly sub-average intellectual functioning (IQ approximately 70 or less)
- Concurrent impairments in present adaptive functioning (self-care, social/interpersonal, communication, self-direction, safety, etc.)

who never would have gone back to school after 6th or 7th grade are coming out with GEDs and diplomas and actually wanting to go further. It's just amazing to me.

Hopefully you aren't seeing a lot of mental retardation juveniles. They should be diverted early on. Many of them are slipping through the cracks because services are going away in the community and there's no place to put them. This is the child who has a sub-average IQ, 70 or less. People forget there is also an impairment in functioning. A child who has an IQ of 68, is able to take care of himself, has decent social skills, and is able to function, is not mentally retarded. You need to show there's a low IQ *and* problems functioning. The problem comes with a child who has a 71 IQ and cannot function. People say, "Sorry, no services, you're above the cutoff." Those are the children who worry me the most because there are no services for them. Most of the juveniles you see are probably in the mild range, and a few in the moderate range. The severe and profoundly retarded should be completely out of your system because they should never have been found competent to stand trial. It's amazing to me how many adolescents get in our system who prompt you to say, "How were they competent to stand trial? I cannot even imagine how they got into our system."

Fetal alcohol syndrome (FAS) has become more well known in the last few years. It's misunderstood and we don't have a lot of time to go into the details. When someone is diagnosed with fetal alcohol syndrome, they look at a variety of things. One is the brain, so a PET or CAT scan is given. We know there are structural differences in the brain and some areas of the brain do not have as much blood flow. An organic disorder, FAS is brain damage which has happened *in utero*. Once the brain is damaged, it's not going to get undamaged, no matter what you do. Neurological exams show structural differences. Behaviorally, you see the effects: impulsivity, mood swings, ups and downs, oppositional behavior, and very rigid thinking. A lot of these children look like they have ADHD and many do have concurrent ADHD. Also there is a typical FAS face. It's a flat face and the area above the lip is very

Mental Retardation

MILD mental retardation	IQ 50–55 to approximately 70
MODERATE mental retardation	IQ 35–40 to 50–55
SEVERE mental retardation	IQ 20–25 to 35–40
PROFOUND mental retardation	IQ below 20 or 25

flat. The eyes tend to be smaller and are often very close together or very, very far apart. Once adolescence is reached, facial abnormalities do not to show up as much. You really need to look at earlier pictures. This is very important. These youth are often smaller than usual when they're younger. You also have to rule out other diagnoses. We have a lot of drug-affected juveniles in our system which is very different from FAS. Drug-affected youth have a different kind of brain damage.

There are also children who have fetal alcohol effects (FAE). They don't have full-blown FAS, but they were affected by the alcohol their mothers drank. How much did the Mom drink? This depends on Mom's metabolism, and the child's metabolism. These are some of the most frustrating young people to manage. Most children function in the average range, and there's another level where they function so low they get services. Youth with FAS tend to have skills that are lower than most, but not low enough to qualify for services. They are low across the board. Even a child who can't function, they've never received any services. Everybody thinks the child's faking it because they can't figure out why he can't function. The problem is the brain damage. You never know how that child's going to behave. One day he can do it, the next day he can't. It's not because he's choosing this. Sometimes the brain's working and sometimes it's not. These juveniles need the most structure. Other children can finally internalize things, if you go over it with them enough times. But brain damage is brain damage. Even if you can go over it and over it and over it, the minute you take that structure away, they will forget and fall apart. This is why they tend to do fairly well when incarcerated, but when released into the community they can't function. We can't give them enough structure on the outside. FAS is probably one of the most frustrating, most misunderstood, and most confusing syndromes for the staff. These youth tend to get a lot of room confinement and a lot of sanctions and not really understand why. Nobody can figure out what's going on with them.

Psychotic symptoms may be observed. Very few of you will work with youth who have actual schizophrenia. Schizophrenia tends to happen in late adolescence or the early 20s. Young people will probably have their first psychotic period when they get into the adult system. What you will see is children who have hallucinations; hearing things or

Fetal Alcohol Syndrome (FAS)

The Diagnosis of FAS

I. The Brain
   A. Structural
   B. Neurologic
   C. Behavior
II. The Face
III. Somatic Growth
IV. Ruling Out Other Diagnoses
V. Alcohol Exposure

"He Can't" vs. "He Won't"

Psychotic Symptoms

- HALLUCINATIONS—false sensory perceptions not associated with real external stimuli (can involve any of the five senses)
- DELUSIONS—false personal beliefs, not consistent with a person's intelligence or cultural background. The individual continues to have the belief in spite of obvious proof that it is false and/or irrational
- DISORGANIZED BEHAVIOR—disheveled appearance, restless/agitated, bizarre movements/posturing, pacing, rocking, etc.
- DISORGANIZED THINKING/SPEECH—talking in sentences that do not make sense or are only loosely related, using words in sentences that make no sense, parroting back what others have said, talking in rhymes, etc.
- NEGATIVE SYMPTOMS—flat affect, inappropriate affect, poor eye contact, unchanging facial expression, no interest in work or social activities, isolation, decreased amount of speech and content of speech, etc.

seeing things will be the most common. They may hear voices telling them they're bad; they're stupid; kill yourself; kill your staff. You always want to pay attention to stuff like this. You really, really do. Hearing voices is much more common than seeing things. Seeing things is typically associated but obviously you want to pay attention to both. Not all of our juveniles who experience hallucinations are psychotic. Many adolescent with PTSD caused by profound trauma may hear voices later on in life when they're with us or under stress. They know the voices aren't real and this doesn't interfere with their functioning. That's very different from the child who's psychotic and thinks these voices are real. Determining who's hearing voices, who's not, when they're real, when they're not, when you should worry, when you shouldn't, is very difficult to do, especially for our population. You'll have one child hearing voices and suddenly everybody's hearing voices, but they're all hearing the same thing. You need to be aware of this contagion factor.

We have these youth who have these delusions or beliefs, which don't make any sense. Even given evidence, they still cling to their delusions. Adults believe that the FBI and CIA are after them. Our juveniles think that there's computer chips implanted in their heads, that everybody in the facility; particularly all the gang members, are out to get them, people are sticking notes under their doors at night, but the notes disappear because they are on strings. We had one youngster who would not go out and play soccer. We couldn't understand why. Finally he shared with us that he had a uterus growing in his calf and he didn't want to hurt the baby. Very odd. He was taken for medical exams and was shown there was no baby there. He still clung to his belief. We were the ones who didn't understand. We were part of the conspiracy that didn't want men to have babies. Even though I make jokes like that, I take mental health and our children very seriously. This is not a light topic. When you spend many years in the system, particularly working with mentally ill juvenile offenders, if you don't laugh you may become ill or else take medication. It's very, very stressful.

Schizophrenic behavior is a kind of rocking or restless pacing, up and down. Adult schizophrenics have more of these behaviors. You may see weird kinds of facial movements and tics. Typically, this is a side effect of the medication. That's why we're conservative about anti-psychotic meds. When you have a juvenile who's out of control, a lot of times you'll be tempted to say, "Just give him some Thorazine. Get this child under control." The side effects are so strong and serious that we try not to use anti-psychotics.

Talking in sentences that don't make sense is a symptom of disorganized thinking. Some may talk in rhyme. "Yeah, me and Jamal are going to the mall. Is my boyfriend going to call?" When you hear these kinds of things, you want to start worrying.

Negative symptoms are the opposite of hallucinations and delusions. Their emotions are very flat and don't fit with anything. They just kind of sit there, very isolated, and don't talk a lot. Anti-psychotics tend to help with the positive symptoms, such as the hallucinations and delusions, but don't affect negative ones.

In your system, you may see the prodromal phase of schizophrenia. The prodromal phase of mental illness, particularly schizophrenia, often looks like delinquency. I worked with an average 14-year-old boy. He suddenly started having problems in school, stopped going to class, started smoking some pot, and hanging out with deviant peers. His parents were worried, and referred him for treatment three different times. Each time, the parents were told, "The child's a normal adolescent boy who's going to go through it. Leave it alone." They were still worried and concerned. Finally, as the boy got worse and worse, he broke a bottle and threatened his parents, "You can't tell me what to do." He was sent to detention. Detention realized there was something going on with this boy, and referred him to me for a competency evaluation. When I interviewed him, he seemed like an average boy, with a normal delinquency pattern. I told the parents, "Well, obviously you were concerned about something. Is there anything else you're not telling me?" They said, "Well, the thing we're worried about is that every night at midnight we could hear him rearranging his furniture." And I said, "Anything else you noticed?" "Well, to be honest, every time that we come home from work he's unscrewed all the light bulbs from all of the fixtures around the house saying that light sockets are talking to him." And I said, "Did you tell this to anybody?" They said, "No, we were kind of embarrassed." I said, "Well, this is something we want to look into." After more questioning, I found this boy was an adopted child, whose mother was schizophrenic. She gave up her child when she was hospitalized with schizophrenia at 19 years old. This boy was with me for four weeks. I was an intern at the time. In an assessment session he literally, in the middle of the interview, was constantly turning around and clearly responding to voices. I thought, "This kid has got to be faking it." He would laugh at very bizarre times, as if someone was talking to him. I would say, "Are you hearing voices?" "Oh no, no, I'm not hearing voices." We were doing MMPI. He couldn't read it because he was so distracted with these voices, so I'd read to him. The MMPI is a great instrument but it does have strange questions. "Do you prefer your vegetables raw or cooked?" He said nothing for two minutes, and then he said, "Raw." "Do you feel as if there's a tight band around your head, yes or no?" Two minutes would go by, "Yes." It was clear he was hearing these voices. The next day he wouldn't answer any questions. I took him to the dentist, because he was convinced that his teeth were rotting and falling out. "Look at my teeth! Look at my teeth!" He became paranoid. He wouldn't eat any food. He thought everybody was out to poison

him. As an intern I thought, "he's faking it. This boy is faking it." My way of checking to see if a child is faking is to spy on them. I don't advocate spying, but I find it helpful. When a psychologist comes around, and suddenly all of these symptoms start appearing, you begin to wonder. So, I stood outside of his room. I heard him talking to himself for a half hour to 45 minutes. There was nobody in that room. He was laughing, and having a great time. I walked in and he was literally having a conversation. When they'd force him to come out to the day room, he sat catatonic on the couch. As everyone else was engaging in things, he would space out for hours at a time. When my internship was over and I went to the legal offender unit in the adult state hospital on the same campus, I came back to visit six months later. This boy was completely different. They put him on a lot of meds, so he was really zoned out, but still hearing voices. He had lost weight, and was just like a shell of a boy. What was so sad is that he was a very attractive boy. All of the girls had crushes on him. He was very smart, initially. The first psychotic break can do a tremendous amount of damage. This youth will probably never go back to the way he was. He was on so many meds, he was zonked out. He was so paranoid he couldn't eat, he couldn't function, he heard voices all the time. That's what psychosis can look like, and you usually see the first stages, where it often looks like the oppositional prodromal phase. Any time your staff get a feeling of, "There's something going on with this child," refer that child. Let the mental health professionals weed it out. Oftentimes it's just this oddness, this strangeness that they can't put into words.

We talked about co-morbidity this morning. Very few of our youth will have only one of the diagnoses that I've discussed. They will have two, three, four. It is not uncommon to have major depression, a learning disability, conduct disorder, substance abuse, and some anxiety thrown in with even a little PTSD. It's very difficult to treat. The term you will be hearing for the next five years is co-occurring disorders: mental health issues and substance abuse. Collie talked about that this morning. He said how difficult it is when you're talking about mental health and substance abuse, and to work with how they interrelate. We know they mimic each other. Intoxication and withdrawal may look like mental illness. Put drugs on top of mental illness, and things look a lot worse. How do you treat it? You need to integrate treatment and assessment. I'm predicting my talk today will not be relevant in five to ten years. My belief, and there's no research that I'm aware of, is that we're going to find

Protective Factors/Resilience

- High IQ
- Easy temperament
- Ability to relate well to others
- Good work habits at school
- Areas of competence outside of school
- Pro-social peers
- Good relationship with one parent/important adult

the youth that we're working with today don't fit into these categories. This won't be the best way to look at them.

From my experience in the juvenile justice system I find that a lot of these adolescents have low level brain damage, from not enough oxygen, bad pre-natal care, and/or drugs and alcohol used in pregnancy. These youth don't have mental retardation, but their frontal lobes were affected. They're impulsive; they're not problem solvers; they don't think. When you ask them, "What else could you have done besides hit him?" "I don't know." They really don't know. The mood swings and the temper outbursts cannot be explained purely by environment. There's something going on. It's that the nervous systems of the youth you work with are different. No matter what you do with these young people, nothing seems to work. Every area of their life is so profoundly affected. And there are some children who don't fit any of these diagnostic categories. They're just functionally impaired. You might have a feces-smearing, out of control child, that the psychologists and psychiatrists have all looked at and said, "Doesn't fit any of the diagnoses I know. Just an out of control child." We've got to figure a way to help and treat this kind of child, even though insurance won't pay for it because they don't have an Axis I diagnosis. So I think it's really important for more research over the next few years. We need to understand what's going on with our youth.

I want to show you a study, then I'll wrap up. This is a great, great study of the adult system. It fits the juvenile system as well. When asked, "Would you like to have more training to deal with mentally ill offenders?," 97% of correctional workers said, "Yes, we want more training." Ninety percent said working with the mentally disordered adds to the stress of the job. Approximately 90% said mentally disordered prisoners should be kept in separate facilities. You can imagine the corrections workers saying, "Oh yeah! Get 'em outta here!" Many administrators say that, too. Again, almost 90% said, "My training for this job

Correctional Officers' Response to Statements about Working with Mentally Ill Offenders

Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
Would like to have more training to deal with mentally ill offenders	3%	0%	26%	69%
Working with the mentally disordered adds to the stress of the job	4%	6%	32%	58%
Mentally disordered prisoners should be kept in separate facilities	1%	5%	33%	56%
My training for this job did not prepare me to work with mentally disordered offenders	6%	8%	32%	54%

did not prepare me to work with mentally disordered offenders." That's even more true with juveniles because our staff are working directly with the children, not just monitoring them from behind glass. These youth are more impulsive, are very difficult to treat, and our staff are being asked to manage them with very little training. This is not something they've signed up to do. It's important that we talk about identifying mentally ill juveniles because you're the ones making policy and programming decisions. You're the ones deciding where the money goes and what programs you're going to have. It's also important for your staff to know. They're the ones with the juveniles 24 hours a day, seven days a week.

A shift in attitude is what's going to make a difference in the treatment of these young people. Staff often think mental health youth are trying to make their lives miserable, are trying to be oppositional, and are doing this just because they're buttheads. Burnout and turnover of staff come from a feeling of ineffectiveness. It's hard for juvenile justice staff to feel effective with these kinds of adolescents. These people went into juvenile justice corrections, not adult corrections, because they want to work with children. When staff start to understand this stuff, they feel good when they understand and can help a child. We must help them identify these young people. They need to tell the psychiatrist or psychologist what's going on. If a child gets put on meds and is getting better or worse, it's our line staff that see the change and should report it. They are active team members in the treatment of these children. Even if you call them security staff, when the child hangs up the phone and has an outburst, they should be talking to the staff about the incident. These staff know more than the psychologists and the psychiatrists. Fifty minutes with me is not half as valuable as every interaction that your line staff have with your juveniles. Everything they do, *everything* that they do can reinforce appropriate behavior or reinforce inappropriate behavior. If you can help them identify these youth as well, they will feel more effective. I want to extend my profound thanks to ACA and OJJDP for devoting these next two and a half days to mental health. That so many people are here really shows a commitment to one of the biggest issues and challenges facing juvenile justice today. Thank you.

Risk Assessment and the Screening Process

Daniel Seagrave, Psy.D.
Forensic Psychologist, University of Massachusetts Medical School, Worcester, MA

Risk assessment is a very broad topic. I have tried very hard to pull some things together that will meet your clinical educational needs, and/or administrative needs. I'm a forensic psychologist and the previous presenter was talking about her bias. My bias is I'm kid-friendly. I like kids. I like adolescents. I think there are savable youth out there. I'm also interested in public safety, and I know that there are dangerous youth out there. I know that there are dangerous juveniles that you all have to manage.

So I have tried to blend those two things together. I also have an administrative background as I ran a forensic hospital only about 120 miles from here in Las Vegas, Nevada. I have an understanding or an appreciation for what some of you feel and how difficult it is managing these adolescents day to day. They exhibit violent behaviors toward others as well as toward themselves. Today, I'm going to focus on violence toward others. I will run through a brief survey of how violence risk methods have worked. I want to talk about some of the risk factors that have been shown in the literature to be related to future violence or violent recidivism in youth. There is a fair amount of research with adults and violence. Over the last ten years more attention has been paid to the risk factors of youth violence. I want to review some of those factors. I also want to present to you a different kind of model for approaching young people by looking at a variety of different kinds of risk factors. Some factors are related to offense characteristics, some have delinquency histories. Other things blend into the mental health area and are very much related to violence risks and violence recidivism. Finally I want to conclude with cases that exemplify some of these issues and show how complicated risk is. Adolescents are risky, or high risk, for different reasons. I wish I could give you a very simple model and when you leave here you will feel you have a good tool to work with. I know you have a lot of experience with these young people, but this isn't what you've been dealing with over the last ten years. Forensic psychology is a blending of different fields from sociology to criminology.

Over the past 20 years there have been two primary trends in how violence has been approached. First, there's a movement away from violence prediction to a model of risk assessment and risk management. Violence prediction implied that violence was a black and

white issue: either the child was dangerous or the child wasn't dangerous. Their dangerousness was also seen primarily as the result of dispositional characteristics, or that it resided within the individual. Therefore, violence risk or the degree of danger posed was a static variable and not subject to much change. One big problem with this approach was that clinicians' predictions of violence were more often wrong than right. Research in the 80s showed that about two out of three predictions missed the mark on violence, with the most common errors being false positives, or predicting that an individual would be violent when actually it did not occur. In contrast, the risk assessment approach used violence risk or dangerousness as a contextual variable. It can vary along a continuum from low to moderate to high, for example. It's very dependent on situations and settings, as well as being influenced by dispositional or individual characteristics. So there's really an interaction among these variables. The propensity for violence is influenced by a variety of risk factors, some of which are static and unchangeable, and others that are very much dynamic, or changeable. Therefore, the objectives of the violence risk assessment are shifted away from questions such as, "Is this individual dangerous to others?" to "What's the nature and the degree of violence risk in light of anticipated conditions and settings?" Again, you can't take individuals or children out of their context.

The second major shift in violence assessment research over the past 20 years has to do with the debate over the superiority of actual approaches of prediction versus clinical assessment. Some proponents of actuarial methods claim that a statistical formula is the preferred method for making decisions involving the likelihood of future violence. In essence, you plug a few variables, for example, age, gender (male, of course, would be a higher risk), and the individual's history of anti-social conduct into a formula, and out comes the probability of recidivism. For example, the probability that this youngster is likely to commit a violent offense over the next five years is 42%. While this construct can be powerful and has some value, it also has its serious limitations. Would knowing the probability of violent behavior help a judge or a classification panel decide how best to manage that risk? It doesn't provide any information for management. The actuarial approach also disregards patterns or situations involving violent behavior. It doesn't inform you under what circumstances, in what places, or with whom the violent behavior is most likely to occur. Finally, the actuarial approach relies almost exclusively on historical and demographic variables that are amenable to change. There's no known approach to altering one's gender or age or criminal history. These are pretty much set in stone.

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Dr. Seagrave has performed risk assessment with mentally ill adult and adolescent offenders and has served as the director of the only adult forensic hospital in New Mexico. His research interests include the application of psychopathy to juvenile offenders and the assessment of attention deficit/hyperactivity disorder (ADHD).

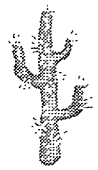
Criticisms of this actuarial approach led to a new model of evaluating violence risk, and this is the structured or guided clinical assessment approach. With this approach, clinicians assess for the presence of factors that have an empirical relationship to violence. The guided clinical approach focuses clinicians on the relevant data to collect in the course of an assessment. Data collection methods include a clinical interview with the child, record review, interviewing family and other collaterals, and sometimes psychological testing. The approach hopes that a final opinion on violence is substantiated by the best available research, even though data haven't been plugged into a statistical formula. Recent studies of this approach have demonstrated that it's as good as actuarial predictors and sometimes even better.

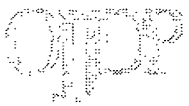
The major trends in clinical risk assessment have been mirrored by similar movements in the juvenile justice system, as seen in the movement moved away from violence prediction to a process of risk-based classification for violent juvenile offenders. As the number of delinquent juveniles increased immensely over the 80s and 90s, with more and more violent behaviors, a need also grew for standardizing effective screening tools for classification purposes. As you all know, classification decisions are made at multiple points in your system, whether it be for intake, detention, probation, or classification. They also assess different kinds of risk, whether it be for suicide or general recidivism versus violent recidivism. Today I'm going to focus on risk screening and assessment for the purposes of classification to secured care.

Juvenile offenders who are facing secure placement are noteworthy because they are the most likely group of young people to be violent and they pose very great challenges to juvenile justice officials. These children pose the greatest risk of harm to the public as well as to other youth in juvenile facilities. They exact great costs from program staff, whether through assaultiveness or staff stress or burnout. These young people also exact great financial costs from the juvenile justice system. They increase the need for staff overtime. They expose the system to great civil liability and public scrutiny in cases that are fairly high profile. They're downright expensive to maintain in secure care with the cost of an average secure bed running from $35,000 to $65,000 per year. In some cases, costs for other offenders are probably even more, especially sex offenders.

In response to these issues, juvenile justice agencies have developed risk screening instruments with the hope of better decision making. [See the reference list on page 55.] The juvenile justice system has developed some risk screening instruments to meet certain system or administrative goals: reducing program placements, decreasing institutional

Violence Prediction	Violence Risk Assessment
• Dichotomous • Dispositional • Static	• Contextual • Interactive between individual and setting • Dynamic





Actuarial Prediction

- Statistically-derived formula that calculates a percentage likelihood of future violent behavior

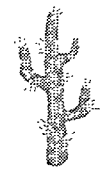
Structured Clinical Assessment

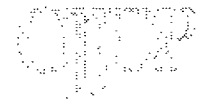
- Evaluate for the presence of factors that have an empirically demonstrated relationship to future violent behavior

overcrowding, and enhancing cost efficiency. We all hear about risk screening really getting kind of the short end of the stick in terms of services and resources. Risk screening also helps to insure equitable and consistent punishment. This is certainly not my area, but it is something that needs to be considered in performing evaluations. Essentially, you want a risk instrument that allows you to concentrate resources on those young people who are at the highest risk, while reducing efforts for those at lowest risk. Determination of who is high risk must include the situational factors and a risk screening tool can provide some benefit in this regard by relaying primarily the historical and offense severity characteristics. The tool must address such things as public safety considerations, the level of control necessary to manage a youth's violence risk, and the juvenile justice philosophy of least restrictive setting. Here are a couple of different risk screening instruments that have been used for classifications in secured care. As you see, they weigh the severity of the current offense most heavily. Also included are number and the history of prior incidents, the number and the severity of those, and the age at which the first offense occurred and then histories of prior supervision, mental health treatment and other placements. Tally up these items and use this score to make your assessment. Research suggests that these tools can serve a positive role in achieving certain administrative and system goals. A study by Chrisberg and Collins published in 1993 examined the effects of risk screening the secured care populations of 14 different states. The study showed that roughly one third of youth in secured settings such as institutional care and training schools were classified as low or moderate risk, suggesting they did not require the security of an institutional setting. These researchers also calculated the needed bed space as a result of this. Across the 14 states, they recorded an average reduction in needed bed space of 31%. With costs of secure beds running

Benefits of Violence Risk Screening

- Reduce inappropriate placements
- Impact institutional overcrowding
- Enhance cost efficiency
- Contribute to consistent and equitable classification decisions





Typical Risk Screening Items

- Severity of current offense
- Number and severity of prior offenses
- Age of first offense
- History of probation/parole supervision
- History of out-of-home placements
- History of mental health treatment

from $35,000 to $65,000 a year, that's no small finding. I'm sure it's of much interest to administrators and decisionmakers.

Although risk instruments have demonstrated some benefit for the juvenile justice system, they are not a panacea for the complicated issues encountered in placing high risk youth. These instruments have several limitations that need to be taken into account and which may obscure the accurate identification of dangerous youth who are suited for secure care.

The first limitation is that risk tools typically don't measure the potential for violent behavior. In their development and research, the most frequently used outcome measure with these instruments is any kind of recidivism. As such, they are more measures of general recidivism than they are of violent recidivism. Secondly, the screening tools focus on static or historic variables that are unchangeable: the age of onset and history of delinquent offenses are static historical variables that will always be there. You can actually use someone's history. Third, the severity of offenses is often not a good predictor of future violence, and yet it is usually the most heavily weighted item in a risk assessment instrument. For example, there are very dangerous juveniles with long histories of serious offenses who have escaped official detection, and then they enter the system on a very minor charge. On the flip side, there are homicide perpetrators who pose little risk to others, other than their victim. That's where proportionality comes into it. Finally, while this tool can identify some high risk youth, they miss others who are high risk for reasons other than their delinquent background. Some examples are active mental disorders and serious family problems.

I'd like to present a forensic model for violence risk assessment that can provide valuable assistance to classification panels. This model mitigates the pitfalls of the pre-screening instruments. The forensic model incorporates the solid predictive power of histori-

Limitations of Risk Screening Tools

- Developed for general recidivism
- Emphasis on static risk factors
- Index offense is NOT a good predictor of future violence
- Minimal to no mental health issues

Forensic Model of Risk Assessment

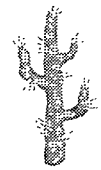
- Examine an array of violence risk factors and rehabilitation needs
- Public safety vs. offender needs
- Assist classification and dispositional decision making
- Provide a "blue print" for rehabilitation

cal variables with the dynamic risk factors that have an empirically proven relationship to violence and are amenable to rehabilitation or change. In providing technical support to classification panels, forensic psychologists assist placement decisionmaking by determining whether a juvenile needs to be placed in secured care. Once a juvenile has been determined to require secured care, the assessment then turns to a final delineation of the dimensions of a program that will need to be there in order to insure public safety and to meet the offender's rehabilitation needs—a blueprint for treatment. Do they need to be locked up? And, if so, what needs to change when they are locked up? From this perspective, the violence risk and dispositional assessments work hand in hand in the classification process. The first one identifies the risks and the second one provides recommendations on how to change that. The forensic assessment provides intervention strategies to reduce or manage the youth's violence risk by translating specific risk factors into rehabilitation goals. The classification panel can then assess change that is relevant to future decisionmaking, such as lesser levels of security and release into the community. It is for these reasons that it is vital that these risk assessments include dynamic, changeable variables and not just static, historical ones. If you base your decisions on static, historical variables, nobody would ever notice change. Their violence risk would always be the same. How do you know when it's the right time to transition a juvenile from a secured facility to a less restricted one?

I'd like to provide you with a brief overview of the research literature on violence risk in adolescents. This is an integration of work by sociologists, criminologists and psychologists. Some research has been supported by OJJDP funding. I'd also like to recognize Tom Grisso, who is a forensic psychologist and researcher in the area of violence risk. He allowed me to use his framework for assessing violence risk in youth. There's a reference for an instrument that he and some other folks are developing right now that's gone through some initial standardization and research. It may be available in the near future. I'd also like

Factors Associated with Juvenile Violence

- Historical
- Clinical/individual
- Contextual
- Protective



to recognize a couple of my supervisor/mentors: Tom Grisso and Frank DiCataldo really provided a lot of support.

I've organized a long list of violence risk factors according to historical variables, clinical or individual variables, and contextual variables that have a demonstrated relationship to violent offending in young people. I also will discuss the protective or resiliency factors that may mitigate violence risk in juveniles. There are several different ways to organize these factors. They really hit you with a mass of different information. I'm trying to use a framework here that's consistent with the forensic model for coherency. You can organize these factors in different ways. Basically, they have five major domains: the youth themselves, the peer group, home, family, and school and community.

I began with the historical factors. Again, this is specifically a compilation of all the best research on violence and violent recidivism with adolescents. The research from 1998 is probably the best resource in terms of violence risk factors as well as interventions that work. The historical factors refer to those events in the past that may have predisposed the youth to act violently. With respect to a child's history and age of onset of violence or delinquency, the risk for future violence generally increases incrementally according to the number of prior violent episodes. It also increases incrementally with the number of prior non-violent delinquent acts and with the age of onset of the behaviors. Behaviors that are early markers for trouble later on can include aggressiveness, oppositionality, and defiance. The most striking non-violent delinquent behavior that includes a violence risk is drug dealing. Drug dealing in adolescence quadruples the risk or probability of violent behavior.

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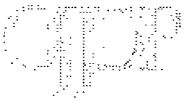
It is important to note, however, that violence risk with juveniles is difficult to base on criminal acts, because illegal behaviors are so common in adolescence. In some communities almost two thirds of the males will have a juvenile record by the time they reach late adolescence. Serious violent acts are also committed by a wide variety of youth with different backgrounds and personalities. The majority of these juveniles discontinue their delinquent behavior as they approach adulthood. This is the desistance phenomenon of juvenile delinquency.

Another study examines age specific rates. There very low rates at ages 12 and 13, peaks or spikes at age 17, and then a gradual decrease, rather quickly, to pre-adolescent rates in early adulthood. Researchers have made attempts to identify which young people desist—the majority of them, as well as identifying the minority of kids who are the persisters, or the ones that go on adult violent behavior. Research suggests there's a greater risk of harmful aggression in adolescence and later on into adulthood when the youth's aggressive behavior pre-dates the adolescent years. Del Elliott in his 1994 paper, reported that about 50% of youths continued their violent behavior into adulthood if their first violent act occurred before age 11. This is contrasted by the 30% or so who continued if their first violent behavior occurred in the pre-adolescent years, between 11 and 13. For children whose violent behaviors began in the adolescent years, only 10% of them persisted into adulthood. It's not a perfect model, but it's pretty strong. The earlier the age of onset, the greater the likelihood that the violent behavior will persist.

Similarly, Terry Moffat described two developmental trajectories for delinquent and violent offending that are pegged at the age of onset of these behaviors. For people exhibiting "life course persistent belligerence," early aggressive acts were typically seen prior to age 12 and antisocial and violent conduct were more likely in adulthood. Her study group of adolescence-limited delinquent youth began their violent behavior during the adolescent years, after age 13 or so, and stopped or desisted as adulthood was reached. The later it starts, the quicker it stops is what we see here. It's not a perfect model, but it's a strong model. A particularly difficult thing about the recidivism seen in this study, however, is that the nature of their aggressive acts can be quite similar if you just see it on the inner cross section. If you look at them on one day, for one incident, they can look very much the same. If a youth is currently engaging in violent behavior, the likelihood they continue in adolescence and persist on into adulthood is much greater if the earliest aggressive acts occurred before age 12 or 13.

Historical Factors

- History of violence and delinquency
- Age of onset of violence and delinquency
- School problems
- Victim of maltreatment/abuse
- Prenatal trauma and pregnancy complications



The majority of delinquency research is on boys. This model, likely, will not work for girls. The little research out there is suggesting that girls who have an adolescent onset of violent behavior have just as bad or worse outcomes than the boys that have early onset. So even though a girl's violent behavior may start at age 13, 14, or 15, these girls are showing very negative outcomes. There are high rates of teen pregnancy, dropping out of school, psychiatric illness, suicide attempts, and later criminal behaviors.

Another historical risk factor is school problems: educational achievement, low interest, truancy, and drop out. Each factor alone roughly doubles the risk of violence at ages 14 to 16. A history of victimization by abuse is also associated with a higher risk of violence. Physical abuse appears to double the risk of violent offending. Neglect seems to be the worst, nearly tripling the violence risk of a juvenile. Sexual abuse is a more tricky issue. With boys, there's some suggestion that sexual abuse may actually decrease their risk slightly. Sexual abuse as a risk factor for girls needs to be clarified by the research. It may be more of a risk factor for girls than for boys. Pre-natal trauma and pregnancy complications are an historical factor. These are most significant for children raised in really bad families. But with good family support, good parenting, it doesn't necessarily have to be a risk factor for violence later on.

Clinical risk factors for violence reflect the various clinical symptoms of mental disorders and substance abuse. The symptoms occur in 50% of the detention population, and are probably even greater in the secured placement population. In the adult violence risk literature, the co-existence disorder and substance abuse creates a synergistic effect for violence. The rate or probability of violence with both a mental disorder and substance abuse is much higher than with either one alone. If you've got both going on, you've got some real problems. Individual risk factors have more to do with a youth's predispositions, traits, tendencies, and common personality characteristics that may be emerging at that age. Substance abuse is a tricky one. In general it raises the risk of violence, but for some children it may actually mitigate risk.

Behavioral disorders have been shown to indicate violence risk. We don't know whether young people with mental disorders are more likely to engage in violent behavior than other youths. What we do know, though, is past histories of aggressiveness and the presence of some mental disorders indicate a risk for future aggression. About 50% of aggressive youth suffer from depression. This is not true for adults, according to the literature. Juveniles with depression often display anger, irritability, and demandingness, so

Clinical/Individual Factors

- Substance abuse
- Mental/behavioral disorders
- Personality traits
- Negative attitudes/cognitions
- Psychopathy

Mental/Behavioral Disorders

- Depression
- Attention/hyperactivity disorders
- Anxiety/trauma disorders
- Psychotic disorders
- Organic brain syndromes

depression is often not identified as such. Adolescents who present with those kinds of characteristics are pegged as difficult and oppositional, not as depressed. There's also a pretty thin connection between violence toward others and violence toward oneself. The depressed child's behavior may be directed toward him or herself as much as it is directed toward others. A good example is that homicide rates increased disproportionately for African American youth in the 1990s, but so did their suicide rates. Be alert for symptoms of depression.

Research suggests that hyperactivity alone doubles the risk of violent behavior around the ages of 14 to 16. Youths who witness or who are victims of traumatic events sometimes experience symptoms that influence violent behavior. A child may have post traumatic stress disorder (PTSD). They experience feelings of dread associated with recurrent recollections of the traumatic event and have dissociative-like symptoms that keep them out of touch with their anger. Adolescents with PTSD may also demonstrate a sense of foreshortened future. These children don't think they're going to live very long. When I worked in a high crime area, I asked the youngsters how long they thought they would live. Not infrequently, they said they were going to live to be 20 or 22. In terms of violence risk, this decreases one's motivation to avoid risks. They put themselves into situations where they might be victims of violence or they might need to act violently.

Psychotic disorders are pretty rare in kids. The rate was about one or two percent. Schizophrenia is a good example of a psychotic disorder that very rarely onsets in childhood, and only occasionally in the adolescent years. When schizophrenia is present, usually it is manifested as hallucinations or delusions with paranoid content as well as thought disorganization. These increase the risk because the juveniles feel threatened so they need to protect themselves. These folks are also very over-stimulated and get agitated easily by lots of noise, activity and unpredictability. Therefore, put them in a detention facility where there is a lot of clanging and yelling and unpredictability about what's going to happen and the violence risk rises. These youth are not be able to screen that information or that stimulus out and then they end up getting agitated. Perhaps they're not identified as being psychotic and are looked on as behavior problems.

Organic brain syndromes may occur in seriously delinquent young people. Head traumas from accidents, fights, child abuse, developmental, genetic abnormalities, nutritional deficiencies, and toxic exposure are the usual causes. I'd also put some learning disabilities into this category.

Juvenile Psychopathy: A Brief Review

The Background on Juvenile Psychopathy

- The genesis of chronic and serious antisocial conduct almost invariably begins in childhood; however, the predictive capacity of childhood antisocial behavior for adult antisocial behavior is less than perfect (i.e., only 25–40% of CD youth go on to become adults with ASPD).
- Researchers are attempting to identify the future serious, violent, and chronic offender by assessing for the presence of psychopathic traits in especially severe subgroups of CD youth.

The Adult Psychopathic Offender

- Two-Factor Model of Psychopathy using the Psychopathy Checklist (PCL, PCL-R)
  Factor 1: Interpersonal and affective traits
  Factor 2: Chronically unstable and antisocial lifestyle
- 90% of adult offenders defined as psychopathic with the PCL meet criteria for ASPD.
- The prevalence of ASPD and psychopathy are represented differentially in adult offender populations (i.e., 50–80% of adult offenders and forensic patients meet criteria for ASPD, whereas only 15–30% of ASPD subjects meet PCL criteria for psychopathy).
- Psychopathic adults tend to be especially serious and persistent offenders (e.g., commit a greater number and variety of criminal offenses, more often aggressive and violent, recidivate quicker for both general and violent offenses).
- Treatment outcome studies with psychopathic adults are limited. While preliminary results provide no conclusive evidence that adult psychopathy is either treatable or untreatable, a few studies are often cited as supporting that psychopathic adults show less benefit (and possibly worsen) from psychotherapeutic interventions relative to non-psychopathic offenders.

Juvenile Psychopathy Instruments

- Modified PCL-R (Forth et al., 1990) or PCL: Youth Version (PCL: YV; Forth et al., 1997)
- Psychopathy Screening Device (PSD; Frick et al., 1994)
- Childhood Psychopathy Scale (CPS; Lynam, 1997)

Critical Conceptual and Methodological Issues in Juvenile Psychopathy

- Developmental status
- Psychiatric comorbidity
- Race-ethnic and gender
- CD subtyping
- Cautions and labeling

Let's look at more of the individual factors. Personality traits, meaning primarily chronic anger and impulsivity. Anger is often an activator of aggression, and impulsivity leads to risk-taking behavior. The research suggests that the risk-taking propensity of children, above and beyond the usual kind of risk taking by an adolescent may triple a child's violence risk, a pretty strong predictor on that.

Negative attitude and cognitions that encourage violent responses include such things as believing that violence is a justifiable response to being disrespected, or that one's social status and self-esteem is boosted by aggression. The deficit for thought processing problems is seen in youth who perceive hostile or aggressive intent in others even when none is intended or they're in a neutral situation. They're adolescents who seem to have a chip on their shoulder; they're almost expecting that things will come out of the woodwork and come at them. They distort what's going on in social interactions. These juveniles are at high risk for violence. Adolescents with cognitive processing problems minimize or rationalize the impact of their violence on others. Some of the research suggests that pro-violence attitudes at age 14 can double the probability of violence later on.

I want to spend a little more time on the assessment of psychopathy in young people. It's a topic that has received increased attention over the last ten years. I am currently writing a paper that reviews all the literature on psychopathy. How prevalent is the discussion of psychopathy among folks like yourselves? How many people have talked about psychopathy specifically in any way? A few? Has anybody tried using instruments for psychopathy? Been using the Herr? This is important to juvenile justice, obviously. I'll go through some things on why it should be obvious, and add some cautions.

Seeds of the adult psychopath are almost always sown in childhood and adolescence. More importantly, psychopathy screening instruments have been developed for juveniles, are being researched, and may soon be marketed to you all as a means of early identification of today's violent juvenile offender who may become tomorrow's chronic violent offender in adulthood. It's going to be coming, soon. They're going to be knocking on your door to use these instruments, and showing you it has some predictability for violence. I'm here to say, "Hold on for a second."

Psychopathy screening is rife with difficulty because of the risks of false positives, of identifying a child as psychopathic when he or she is not. I'm going to review some of the research on adult psychopaths and then what they've been doing in the research with juveniles.

The adult psychopathic defender is not your run-of-the-mill antisocial personality. Psychopathic adults are qualitatively different than other adult criminals. They have distinctive criminal careers. Psychopathic offenders begin their criminal activities at a relatively early age. They continue to engage in these activities throughout much of their life spans and they commit a much higher rate of community and institutional violence than non-psychopathic offenders. Researchers are currently attempting to identify the future adult psychopath by assessing for the presence of these traits in adolescents. Some of the studies are going down to age 8. This is no easy task. Even in childhood, problems are almost always present when we look into the backgrounds of adult offenders. The same does not hold true in the other direction. That is, when we look prospectively from serious conduct problems in children into the future, about one-third of conduct disorder youth become

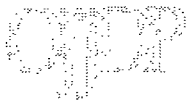
antisocial adults. Again, if you just look at conduct problems in childhood as a perfect predictor of adult recidivism or adult violent behavior, you're going to be wrong two out of three times. The juvenile psychopathy researchers are attempting to fine tune this predictive ability for adult psychopathy and adult violence by extending the psychopathy construct on children. This involves identifying the personality traits and behavioral characteristics that signify the adult psychopath. The most widely used and best validated psychopathy instrument with adults is the Herr Psychopathy Check List (PCL). This instrument has 20 items and is rated by a clinician, usually from a semi-structured interview with the offender and/or from a detailed record review. Research studies with the PCL suggest there are two primary features or factors to the adult psychopath. Factor one has more to do with personality traits of the psychopath. Factor two has more to do with behavioral characteristics, especially antisocial conduct.

Here are examples of the features for factor one, the personality traits. These guys tend to be glib, superficially charming, and insincere. They're described as being too slick and smooth for their own good; they're grandiose; they're cocky; they will use deceit and deception to manipulate others. They have a callous disregard for the rights of other people. They feel very little empathy. They lack remorse or guilt for the maladaptive behaviors, and they fail to accept responsibility, rationalizing and placing blame on others or circumstances for their conduct.

Factor two from the PCL has more to do with the behavioral characteristics of the chronically unstable and describes the antisocial lifestyle of the adult psychopathic offenders. These guys need stimulation. They become bored easily and they need to be where the action is. They also tend to be hot-headed, short tempered, and have poor behavioral controls. They're impulsive. They have charges and convictions for many different types of offenses, and they often live day-to-day, lacking long-term goals. They don't look toward the future nor do they even care about it. They live day-to-day.

Although most psychopaths are diagnosed with antisocial personality disorder, only a minority of those, 15 to 30%, are psychopathic. We're talking about a relatively small subgroup of the adult offender population. Psychopathic adults commit a greater number and variety of criminal offenses. They are typically more aggressive and violent than other offenders. Studies have shown that psychopathic violence tends to be more instrumental, predatory, and remorseless, and is guided by vengeance, greed, and anger. Psychopathic adults have also been shown to recidivate more quickly upon release from prison for both general and violent offenses. A one year follow-up study showed that psychopaths were three times more likely to re-offend in general, and four times more likely to re-offend violently upon release from prison. This is a construct and an instrument that has a lot of power in adult offenders, and in some ways it's used very well. The existence of psychopathy is also a very significant risk factor for sex offenders. If you've got a psychopathic sex offender, you've got really big problems.

Several instruments have been developed to assess these traits in young people. All of them are extensions of the adult PCL. These include the PCL youth version, the Psychopathy Screening Device (PSD), and the Child Psychopathy Scale (CPS). The PSD was developed by Frick and colleagues. It's probably the best screening instrument of the 90s. They have a factor structure, similar to the adult PCL with. They renamed the first factor, person-



ality traits, as callous unemotional features. If you start hearing the term CU traits, that means callous unemotional.

I've reviewed 12 studies. I urge you to use some caution with these constructs. They have some value, but we need to be cautious. My most serious concern in this area has to do with the lack of recognition of the developmental characteristics associated with youth, which may provide alternative explanations for elevated scores on psychopathy instruments derived from adults. Put another way, is it possible for some juveniles in developmental transition to appear psychopathic on an instrument and yet actually be manifesting normal developmental characteristics that any normal adolescent would demonstrate? Adolescents by their very nature tend to be egocentric and they lack the ability to empathize or take the perspective of other people. Thus, many children appear to lack sensitivity to others. They imagine that they are uniquely special and they tend to be pretty damn self-centered. Anybody who has worked with adolescents or raised adolescents struggles with these things, hopefully for just a couple of months, but sometimes for a couple of years. These temporary developmental states such as grandiosity and lack of empathy raise a juvenile's score on a psychopathy scale. They may be false positives, and the assessment assumes a high score represents psychopathy. In other words, you can get spikes, or elevated scores on these instruments, just due to developmental issues that may not be the persistent personality traits that portend the psychopathic adult. Nobody's studied that yet. Tom Grisso and I are really making strong statements about this in future presentations.

I just want to mention two other issues from our review: race and ethnic issues, and the premature labeling of youth. There are multiple studies concerning race and ethnicity (many studies were done when the PCL was developed). One published study with adults examines potential differences between Caucasian and African American offenders with the PCL. This study showed that there is a different factor structure for African American offenders. African American offenders were also more often identified as psychopathic. Why this is so is unclear. It certainly is a red flag for me. When we start transferring adult stuff down to juveniles using something that still isn't settled yet, it's troubling. In the few studies that I did review that had an array of race and ethnic background in their subject pools, there are some concerning numbers that come out of the results. Finally, we need to be careful about how we use the term "psychopathy" with children. It's a highly pejorative label and we run the risk of creating a so-called psychopathic adolescent before we have evidence that one exists. If you call an adult offender a psychopath, you have basically signed a death warrant in terms of services. If we start doing this with children, it's really a concern of mine. We don't know if psychopathy in juveniles is the same as in adults. Some researchers are encouraging the use of these instruments before we have good reliability and validity data. We also need to understand the developmental issues. Although I'm critical of some of the literature in this area, I don't want to throw the baby out with the bath water. I'm not questioning if psychopathy transfers down to juveniles; it likely does in some form or fashion. The question is, how does it transfer? And how do we avoid misidentifying the bulk of adolescent offenders who are not going to become psychopathic? Who are not psychopathic and who are not going to become tomorrow's chronic offenders? That is really the big issue in psychopathy in young people.

Contextual Factors

- Negative peer relationships
- Community crime and violence
- Poor parental/family management
- Stress and loss

Contextual factors include negative peer relationships, affiliating with delinquent peers and siblings, peer rejection, and gang affiliation. Gang affiliation and delinquent peer affiliation, social disorganization, poverty, and high crime in the neighborhood are very significant violence risk factors for juveniles. The availability of drugs and exposure to neighborhood adults who engage in violent and in criminal behavior triples, perhaps quadruples, the risk for violence in youth. Poor parental and family management: family conflicts, domestic violence, inconsistent and severe discipline, poor monitoring and supervision also increases the risk factors for violence. Lack of positive parenting is also a risk factor. They are not out there seeing the child's basketball games, getting involved with school activities, or monitoring the problems at school. There are positive things missing as well. Parental criminality, mental illness, and substance abuse, all contribute to a kid's violence risk. Then stress and loss play a part. Stress is probably most significant for youth who have been victims of violence. Examples are: losing treasured objects, the loss of relationships through separation or death, friends shot and killed on the streets, family members incarcerated, and loss of status from disrespect.

Taken together, there are a lot of risk factors. You can get dizzy when you do this work because there is so much to consider. For these adolescents, the weight of each of these factors will differ. For one child, family disorganization and family conflict may impact him tremendously. For another child it may not be as significant. In general, the more risk factors you have, the higher the risk for violent offending. A study by Carrington uses a vulnerability score as a predictor. Five risk factors, such as low family income, low IQ, and poor parenthood practices are verified. Juveniles who have no risk factors at ages 8 and 10 had a 3% violent conviction in juvenile years and adulthood. Adolescents who have four or five risk factors had a 31% conviction rate for violent offenses. *Conviction*. This is a child who has been identified by the police, adjudicated. Naturally there are juveniles out there who are not convicted. The rate is probably higher.

Poor Parental/Family Management

- Current family conflicts
- Inconsistent and severe discipline
- Poor monitoring and supervision
- Parental criminality

Protective Factors

- Broad social support network
- Attachments to parents and prosocial peers
- Commitment to school
- Intelligence

Another study was done about risk factors across all these kinds of domains at ages 8 to 10, with a look at violent offending at age 18. The risk factors we've discussed today correctly predicted violent offenders with 80% accuracy, or 4 out of 5 were correctly predicted—80% accuracy from age 8–10 to age 18. So these factors have some predictive ability and they warrant attention in terms of prevention.

Protective factors such as a support network and intelligence mitigate the risk factors in other areas. This is a summary of interventions that work to decrease violence risk. They are proven methods. I've organized them by institution and family-based interventions, and in order of effectiveness. The top ones are the best proven programs. The lower ones are moderately effective. These programs use skill building, structured interventions, and behavior modification. In the best programs, there is mentoring and relationship building. The best programs aren't just teaching skills.

For those of you who like and need numbers, these are the best programs. They have demonstrated a 35 to 40% decrease in violent recidivism for high risk juveniles. The median recidivism rate for high risk offenders is 50%. These programs decrease recidivism to 30–35%, about a 40% decrease. That is really substantial. I read somewhere that a 1% change in recidivism isn't a big deal. If you look at the social and financial costs, a 1% increase in recidivism is really a phenomenal number.

Two interesting cases illustrate the forensic model in action. Both cases involve very high risk youth, but different in the sense that they have different risk factors driving them.

The first case was a Massachusetts boy who was committed as a youthful offender for a violent stabbing in the school bathroom. He was one of three juveniles, watching the

Interventions for Juvenile Violence Risk

Institutional

- Interpersonal skills training
- Behavior modification
- Positive teaching relationships
- Cognitive mediation training
- Anger management training
- Individual/group counseling
- Educational/vocational training

Community

- Individual counseling (Cog-Beh)
- Multisystemic therapy
- Interpersonal skills training
- Structured family counseling
- Behavior modification
- Restitution (probation/parole)
- Educational/vocational training

door while two other boys roughed up this one boy and took his gold chain. They all started kicking him and stabbed him multiple times. He was committed until the age of 21. There were a number of very high risk factors in his background. His family environment was chaotic. He had school problems and behavioral problems. One of the strongest elements, and I say this with a great deal of confidence, were signs of emerging psychopathic-like traits. This boy was intimidating. He was on the most secure unit in the state of Massachusetts for youthful offenders. It's a segregated unit in an adult prison. He intimidated other juveniles. He said to a mentally retarded boy on the unit, "You're going to prison and you're going to get raped." He also got into a fight, pounding on a boy who was sitting down while he was standing up. He was being callous in interactions with others, but superficial and charming whenever he wanted something. We would be in the middle of an interview and I'd be asking him a question. He would stand up, walk out of the room without even acknowledging me or asking permission to go to the bathroom. He was trying to control the interview. I looked at all of his risk factors. He was a very high violence risk. He had some predatory characteristics. He had no mental disorder, so I recommended to the classification panel that he be put into secure placement. He is the kind of youth who may become a lifelong criminal. I laid out a treatment plan for him that was very specific. It went from this risk factor to this rehabilitation goal. There was individual counseling in terms of behavioral approaches, accepting responsibility, structured family stuff to help his father be a better parent to him, and reducing the recidivism risk. My goal was to break the offense cycle or high risk situations. If you put him in the community, he would associate with delinquent peers, start drinking, getting high, and start dealing. He would put himself right back into an extremely high risk situation. The transition plan was very specific, moving from a hardware secure program, to residential secured, to residential open door, to the community. Risk was assessed along the way. Electronic monitoring was recommended, and the terms of his conditional liberty and probation were to stay away from high-risk settings in the community. He needed to be in pro-social activities such as community service, going to school, and having a job. He needed to strictly adhere to the terms of his conditional liberty and probation. If he failed at any one point, I strongly recommended that he be yanked back in immediately. This is the kind of juvenile who will push and push and push. If you don't give him clear, immediate consequences for his misbehavior, he'll exploit it and then somebody might get hurt. I encouraged them to keep him on a very short leash.

Conclusions

- Violence risk assessment with juvenile offenders needs to consider static, dynamic, and contextual risk factors
- A forensic model of risk assessment provides meaningful information about risk management and placement decision making
- The application of psychopathy to juvenile offenders holds some promise, but should be regarded with caution at this point

The second case had to do with a 14-year-old girl. This girl had seen an amazing amount of trauma, had PTSD, and was really out of control. She had seen a friend murdered right next to her, with blood and pieces of brain splattered all over her. She had seen somebody killed in front of her house. She had seen two guys shoot at each other at a party. She was stabbed just a year later by her ex-boyfriend. This girl was emotionally out of control and her mental health need had not been identified. That was directly relevant to the violence risk. I strongly recommended to the classification panel that she go into a secure program that was well prepared to deal with mental disorders. I recommended some therapeutic interventions that have been shown to be effective with PTSD, and to have her seen by a psychiatrist for meds. I wanted to help her feel better. This girl was so anxious and so hyper-aroused that shaking her hand was like shaking a wet paper towel. She was in overdrive because she was so anxious. Once this is stabilized and some of the anxiety is under control, she'll be able to benefit more from the psychotherapeutic intervention.

Ultimately, one of the take-home messages is that historical variables and the risk factors are important. These dynamic and contextual variables give you a three-dimensional picture of the violence risk. These are things you can target in treatment and things you can change. I wish you the best of luck. It's a tough population. I look forward to seeing you again soon.

Identifying the Elements of a Comprehensive Correctional Mental Health System

Joel Dvoskin, Ph.D.

Clinical Psychologist, University of Arizona College of Medicine, Tucson, AZ

I first went to New York as the Director of Forensic Services; we did the prison mental health services for the Department of Correctional Services in New York. At one of the first meetings I had, I came armed with some complaints from superintendents. They were unhappy because my unit chiefs, the mental health directors in each of the prisons, were fond of saying, "He's not mentally ill, he's a management problem." That's analogous to saying, "He's not tall, he's a Buddhist." You can be mentally ill *and* a management problem; you can be mentally ill and *not* be a management problem; you can be a management problem and *not* mentally ill. These are separate variables. In prison, many people with mental illness are management problems. It's a ridiculous thing to say to somebody, unless your goal is to disavow responsibility for your job. Then it's a really smart thing to say.

The New York system wasn't the kind I was hoping we would be running. One example given to me was a young man who was smearing and eating feces. A staff member actually said, "Well, he's not mentally ill, he's a management problem." I said, "Well, I believe the second half. If he's not mentally ill, explain to me why you think he's eating ca-ca?" And he said, "Well, he's doing it because he's manipulating." I said, "Oh. Let me ask you a question. Do you like cars?" He said, "I like cars, yeah, I love cars." I said, "You like nice sports cars? You like BMWs?" He said, "Oh, I am particularly fond of BMWs." I said, "Well, I tell you what. You put a turd in your mouth right here in this meeting and I'll give you a BMW." I said it in front of witnesses. He said, "Well, Joel." I said, "Well, manipulate me!"

The ca-ca that was going in that guy's mouth wasn't the only ca-ca in that situation. For my unit chief to say that to a superintendent, who's got the legal responsibility to keep this man safe is astounding. As a good friend of mine once said, "Doc, if putting that in your mouth ain't mental illness, it will do until mental illness comes along." For those of you who have direct supervision over your mental health staff, if you're accepting that response, don't. There's nothing in psychology that says that's normal. None. That's a problem. If that's the best way this human being can figure out to get attention, you better figure for the time being that he's mentally ill and is in desperate need of treatment. There are plenty of ways to

get attention. You could sing and get attention. This is a choice he's making and it's not a healthy one. It's counterproductive. It's probably getting him whooped on a regular basis by somebody. That's not normal. That's not right and it's not good psychology or psychiatry to disavow responsibility for such a person by using some sort of cheap categorization of what is or isn't mental illness.

One of the messages I hope you're getting today is that diagnosis alone isn't that interesting. What's a lot more interesting is to look at the individual human being and to figure out what's wrong and what's right with them, what their needs are, what their strengths are, and design an appropriate response.

Now I'm not going to discuss the legal requirements for doing this unless you specifically ask. You all know that the law requires you to do mental health services at least for children who are identifiably seriously mentally ill. The 30-second version from the courts is, "Yeah, you don't have the Eighth Amendment, but you at least gotta do what you would have to do if you had it." It's the same logic in jail, but now there is a real legal hammer against you. The Americans with Disabilities Act and some other different statutory regulations give juveniles even more rights than the Constitution does. Let's just take it for granted that we must, at the very least, not be deliberately indifferent to the serious medical needs, including psychiatric ones, of youth that are incarcerated.

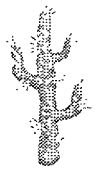
Joel Dvoskin, Ph.D., has been a clinical psychologist for more than 20 years and has worked with and studied some of the most violent individuals in America. He has worked predominantly in maximum security prison and hospital settings, serving violent offenders with serious mental illness. As an administrator for more than a decade, Dr. Dvoskin presided over the nation's largest forensic and correctional mental health system, and served as New York State's Acting Commissioner of Mental Health, running the nation's largest mental health agency, with more than 23,000 employees and an annual operating budget of more than 3 billion dollars.

As a researcher and scholar, Dr. Dvoskin has attained national prominence as an expert in managing the risk of violent behavior, and has written extensively on the provision of mental health services in the justice systems.

Dr. Dvoskin has been a consultant, expert witness, trainer, and public speaker, working with organizations as diverse as the United States Secret Service and the National Basketball Association, in addition to state, local, and provincial governments throughout the United States and Canada. He has consulted with more than 40 states, most often in the provision of mental health services to adult and juvenile justice systems, and as a design consultant in the construction of new secure mental health facilities.

He has lectured on management, domestic violence, mental health law and administration, and prevention of violence in schools and large corporations, among many other topics. Dr. Dvoskin has appeared on national radio and television. His workshops on managing the risk of violence are highly interactive and entertaining, yet they provide a wide variety of practical skills to enhance the safety of anyone who works with people. Dr. Dvoskin studied psychology and law at the University of Arizona, where he received his Ph.D. in clinical psychology in 1981.

He completed a fellowship in forensic psychology at the Harvard Medical School, and currently teaches courses at the University of Arizona College of Law and the Department of Psychiatry at the University of Arizona College of Medicine. He is a fellow of the American Psychological Association and the American Psychology-Law Society, and is a Diplomate in Forensic Psychology by the American Board of Professional Psychology.



I do a lot of consulting around the country on this issue. The most common questions are of almost no interest to me. "Who should run mental health services, the mental health department or the corrections or juvenile justice department?" The answer is, "It doesn't matter." What you need to competently provide mental health services are resources and leadership. If you have the resources and you have the leadership, then you should do it. If you don't have resources and leadership and the mental health system does, you should ask them to do it, and not waste a lot of time. The dangers of each model are equal. The mental health system may not give a high enough priority to the delinquency issues. If it's within the juvenile justice system, certain leaders may not place a high priority on mental illness. That's why you need leadership and I don't care which agency provides it. The best systems are equally likely to be run by the justice agency or the mental health agency. Whoever runs it, as with all things you do, the rules of engagement should be clear. This is very different from my experience growing up in the Arizona prison system. We didn't want anything clear because then we couldn't trade. You know we were always horse trading everything. The more clarity the poorer the deal you could cut. Those days are gone. Sadly for me, because I was pretty good at dealing. Nowadays the rules of engagement between agencies have to be clear. You know exactly what you have a right to expect and demand from the other agencies.

Why have all the speakers today talked so much about multiple agency involvement? Here is a quick tour of multi-agency treatment. Remember your first drivers license? You went down to Motor Vehicles, walked up to a desk and there was a big sign that said, "Information." Unbeknownst to you, the first three letters of the sign had been taken down: M-I-S, misinformation desk. There is an evil genius who can take one look at you and know exactly what line you're supposed to be in. Otherwise they couldn't possibly always tell you the wrong one. They send you to the wrong line. You pick up another line. Four hours later, you get in a third line. If you haven't killed anybody, they give you a drivers license. It's a test of your impulses. They actually do a better job now. The point is, imagine doing that while you're hearing voices that scare you. Imagine doing that five times a week: once to get your food stamps, once to see your probation officer, once to find if you'll be living with your mother or not. From this we get a sense of how difficult and confusing it is for families to manage various systems. Before we start feeling too superior, how many of you know what rights you signed away when you signed your cable TV contract? That's an easy one, as we're a sophisticated group of people. People who have to deal with the health system—which isn't simple, is frightening, and has high consequences—don't do a very good job of managing the system. Part of what we systematically have to do is to figure out a way to help families manage systems—systems that are allegedly designed to help but are very difficult to manage, to work with. Every system that's figured out a way to do this always comes down to the same thing: low caseload. I don't care what name you give it. Scott Engler's a genius for thinking up multi-systemic therapy and his staff deserve a lot of credit. It's a great thing. It really does work and the data's strong.

I want to switch gears and talk about what to do if you're assessed by an expert witness in a lawsuit about the quality of mental health service. In an institution, what things have to be available? We just re-did guidelines for mental health services in jails and prisons, which are not directly aimed at youth facilities, but they're relatively instructive. The theme

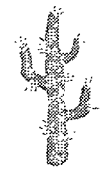
is the word "access." It's clear that you don't have to provide every service to every juvenile or even in every facility, but every child who has a need must have access to services reasonably meeting that need. What are those needs? The first one is some type of screening. Frankly, in the absence of services, screening is a relatively hollow service, unless you're an administrator who needs to go to the legislature for money. The best advantage of screening is that it gives you a way to identify how much mental health care is being given by your staff. It's a great bargaining chip to use when you go to the legislature for money. The law clearly requires some basic way to identify any child who is likely to need services during his tenure.

The second is some type of assessment. Screening, in most jurisdictions, doesn't have to be done by a mental health professional. If you're going to have someone do it who is not a mental health professional, it has to be a person who's trained. It has to be systematically documented, and, most importantly, the thresholds for referral have to be low. In other words, if somebody who is not a mental health professional is making the decision about somebody going to the next step, the tie has to go to the runner. If you have a mental health history, if you look funny, act funny, talk funny or think you're funny, we're going to move you on to the next level of care. Tie goes to the runner. That next step, of course, is assessment by a mental health professional. It's cost effective to have the second step be not what Lisa called a "big casino," or a full mental health evaluation, but rather a 30- to 45-minute assessment by a mental health professional. Because many of those adolescents won't need or will competently refuse care, you may have to do a full scale treatment plan for them at that time. This decision has to be made by a mental health professional.

The third step, if you decide to have three, is a comprehensive psychological/psychiatric evaluation. This is a professional judgment about the level of need this individual has and what the reasonable response to that need will be. If you have a competent licensed professional making that judgment, the courts will presume that it's a good judgment. If you do what that judgment says, you're going to be free from any prosecution. Are there any attorneys here? If anybody disagrees with any of this, feel free to speak up.

The next required step is suicide prevention. I'm not going to talk about this at all because the world's leading expert on the topic, Lindsay Hayes, is here to address you. You must have some type of assessment to identify youth who are at acute or chronic severe risk of suicide, so that they can get appropriate services. That can be part of the mental health assessment or separate. Without stealing Lindsay's thunder, let me tell you that the data show that suicide screening and intervention procedures lower the risk of suicide tremendously. In the New York jails, suicides dropped from 30 a year to less than ten a year by implementing screening and some basic things Lindsay will discuss.

The next thing you must have is a housing option for young people who are made "crazy" by the meat grinder of the general population. Some juveniles are so psychologically fragile they can't function in the general population, either right this minute or, in some cases, ever. There has to be a way to remove a child from the meat grinder and put him in a place that's psychologically safer and more appropriate. There are two types of these. One is crisis beds—the child is moved to a place where he can be watched closely. This is usually for a brief period of time. Most facilities use infirmary beds for that purpose, and that's fine.



You have to have some place where a youngster can be watched by a nurse, if that's necessary. If they're being put on medication for the first time, somebody must check for side effects, unknown allergies, etc. The other type of housing that's necessary is the equivalent of psychological protective custody. This is a lighter-weight housing area or at least one that's more closely observed by staff. In a very small place, a very clever staff will make sure one cell is reserved that is in direct view of the officer on that tier. This is an example of a reasonable accommodation. In a very small place, you can't afford to have a separately staffed unit, but you have to do something. Generally, the courts are very good if you meet the reasonable test.

The next thing is medication. I want to follow up on what was said earlier. Your psychiatrist's job is not to medicate people. The psychiatrist's job is to *assess* whether or not people should be medicated. If everybody that the shrink sees is being medicated, you have one of two very serious problems. Either your shrink thinks he's a Pez dispenser for medication, or not enough people are being assessed. There ought to be more people sent to the psychiatrist than actually need medication. Otherwise, somebody besides the psychiatrist is making the medication decision. Build that into your staffing. In adult jails, we use a caseload of 75 people on medication per psychiatrist. In the juvenile facility you can do more. It's safe to assume that you need at least that much psychiatric time.

The juvenile system is in flux. The psychiatric theories about how often, and under what circumstances young people should be medicated are in flux, also. Some psychiatrists think if you've got air coming out of you when you breathe, you need to be on some type of medication. Other psychiatrists are loathe to medicate children. They will try 50 things before medication. I lean a little more toward the second group. What you want is somebody who's using reasonable judgment and can defend why they do what they do in court.

The next thing is some type of outpatient psychotherapy. The number one therapy is Cog-Beh, which means cognitive behavioral therapy. The data is overwhelming that this is the treatment of choice, other than medication, for depression and anxiety disorders. If your staff, your mental health staff, don't know what that means, you're in deep trouble. If they know what it means but they don't know how to do it, send them out for training, or bring people in to do training. And I'm going to tell you in a few minutes what I think that the treatment ought to be about and ought to include.

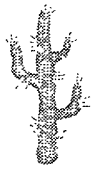
The other point about all of the levels of therapy that you have is that they need to be aimed at skill acquisition. You know, we make this business so much more complicated than it needs to be. If you look at Del Elliott's work, which I think most of you are familiar with, Del Elliott says that basically youth across all races have first offenses at about the same rate. The racial differences come into play at age 18 when the majority of white juveniles go into adult roles, college and work, and the juveniles of color tend not to. This is an oversimplification, but it seems to make the biggest difference. The youth who go into our systems at age 12, 13, or 14, in addition to all the other upsets in their lives, lose the opportunity for normal developmental staging. I mean no offense to anybody, but in a very real sense we leave them worse than we found them. It's not on purpose. I understand that if I'm the next door neighbor of a child who's killing cats and threatening other children, I want him out of here. Somehow we've got to figure out a way to leave youth better than we found

them, even if we have to lock them up. I think we now know the way to do that. We've discovered it in psychiatry and in the mental health system. I think we've discovered it in the juvenile justice system. So, our therapy must be about skill acquisition.

When somebody is in front of me with a repetitive history of violence, I'm going to ask them to tell me about all the bad. "List for me the bad things in your life." Violence is never the first thing they list. Usually it will be, "I got locked up," or "they took my children away from me." If you ask a few questions, sooner or later you will get violence on the list, because that's why they got locked up. We then ask them to go back and list all the times in their lives that this event has occurred. We use the paper used in delicatessens because it's an endless length. We leave a lot of room between events because as you talk to them more they may remember more events. You must start at birth. As has been suggested earlier, if you want to understand me as a perpetrator of violence, you must understand me as a victim of violence. You must understand the role that violence plays in my life. If you tell me that somebody raped a 4-year-old child and ask me, as a psychologist, to give you some nonsense about why they did it, I can spin you a theory that'll just sound so smart. If you ask that child why they got raped, they'll tell you the right answer, "Because he could. He was stronger than me." And the message to the 4-year-old child is that you get and you keep in this life what you have the power to get and keep. It's no surprise that such a child, if faced with difficulties later, might choose to use power. It used to be that when Mr. Hormone would come knocking on the door the violence started. Now, you only have to be strong enough to go like this [motion as if pulling a trigger]. We're seeing violence at younger and younger ages because they can, and that's the message that they were given.

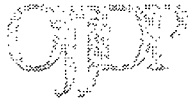
We want to start at birth. Remember, the truth isn't what you're after here. I don't care what really happened. What I care about is what they remember happening, because they are the ones carrying the memory around with them. It's that memory that's shaping the current behavior. We let them tell their story. When this list is up to date and there are 30 or 40 instances of violence, go back and say, "Are there any more?" They may recall 30 more they didn't tell you about the first time. If you take a giant step back and look at that chart, what you will see, jumping off the page at you, is patterns. I've been doing this for 30 years. The only people they ever let me talk to are the most violent individuals, wherever I happen to be working. I have never met anybody who doesn't have a pattern to their violence, not one. Some young people will never get in trouble by themselves, and others will never get in trouble except by themselves. Some juveniles get in trouble when they drink. Some youngsters get in trouble when they're with one group but not with another group, The pattern will jump off the page at you. In order to find that pattern, you have to ask the child about each event. "What was going on in your brain at the time? What were you thinking and feeling? What was going on around you at the time? Where were you living, what time of the year was it? What day of the week, what time of day? Who were you living with, who were your friends?" The first thing you learned in elementary psychology was that behavior is an interaction between a person and a situation. All we're doing is learning about the person at the time and about the situation that he was in.

Once we have that pattern, the next step is to ask the question that we often forget to ask. This is, "What is it about you that makes you vulnerable to these risk-laden situations, when other juveniles who can be in the same situations don't respond with violence?"



The answer to that question will tell you about skill deficits. There are four skill sets of special interest. One of them is: Can they see the risk-laden situation coming before they're in it? The answer, frequently, is no. If you don't stop when you reach a stop sign, you'll die in about an hour. You'll get hit by a car. You can't stop at a stop sign unless you see it in advance and start to apply the brakes before you've reached it. If you don't see the risk-laden situation coming ahead of time, you can't stop. In my consulting business, we do violence prevention work for corporations. Let me just do a little quiz here. Anybody know the most dangerous place in America, according to *USA Today*? Home is actually the right answer, but not according to *USA Today*. Their answer is "the blue." You know, out of the blue. If I ever wake up and find myself in the blue I'm going to run, because that's where all the bad guys live. Every once in a while, one of them comes out of the blue to shoot me. The whole purpose of this is, there ain't no blue! It doesn't exist. Nobody ever just goes off. The closest thing to it is illegal drugs, and nobody ever just takes them. The only exception would be if somebody was stupid enough to smoke dope from an unknown source, and if somebody snuck some PCP in it, then somebody might just go off. Even here you have the forewarning of somebody who's taking dope from people they don't know, which is a risky situation. We have to assess whether or not youth can see trouble coming.

The next skill is, can they avoid trouble, avoid these risk-laden situations? The third skill set is, if you fail to identify or avoid a risky situation, do you know how to escape? Anytime you do a behavioral program you have to build in provisions for failure. As with substance abuse, relapse is a part of recovery. If you can't escape from the situation, can you lower the cost of failure? Let me give you an example of the last one from a real case. A child was raised by an extraordinarily physically abusive father who was the chief of police of a small town. As you might guess, this boy grew up with a distaste for uniforms. He felt compelled whenever he was within the proximity of police to physically assault them. They thought there was something wrong with the guy, but since his father was the chief of police they cut him some slack a few times. As you might guess, the police got tired of being assaulted rather quickly. In addition to thumping him, what they said was that the next time he did this, they were going to charge him with a felony, as he's an adult. We had him in group and I said, "Your problem is when you're around police, that's your risky situation." If you're mentally ill and an American, you can't avoid the police. You're going to have some interaction with them. In group, we taught him to curse at the police. Now you might think the police don't like being cursed, but they much prefer it to being assaulted. We also called the police department and told them what we were doing. The guy began to enjoy this. He would role play cursing at the police instead of physically assaulting them. After discharge, he came back for a scheduled appointment grinning. He goes, "Guess what! I've got a new thing." I said, "What is it?" He says, "Now I just think it!" Like you! He's normal now. When you hear a siren, you don't think, "Oh, thank you for saving me from danger, officer." You're thinking nasty things and you don't share it with them. That's what he did. Even when he was cornered and unable to escape from his risky situation, he had learned how to reduce the cost. That's the idea of this skill set. I'm recommending it, but not as a constitutional requirement. If you want the mental health services to dovetail with what you're trying to do with youth, this is a model that stands up to the scrutiny of research. Research says that skill acquisition is the only way we know to reduce recidivism. It's very clear that



cognitive behavioral treatment, which is nothing more than the teaching of behavioral, cognitive, and emotional skills, is just educational skill building. We've always known that the juveniles who learned to read in the joint had a lower recidivism rate. I knew that 30 years ago. We just haven't generalized it to other skills that you need to live a crime-free life.

What I just described to you was stolen hook, line, and sinker from the substance abuse prevention model. The beauty of this is that it's also the best treatment for substance abuse, it's the best treatment for mental illness, and it's also the best treatment for delinquency. You don't have to have three separate sets of treatment. It's actually cheaper to do integrated treatment. The data show, as Collie said earlier, it's the only treatment that works for co-occurring disorders. This model makes a good deal of sense. It is resource smart in that it allows you to get the most treatment for the least expenditure.

Multi-systemic therapy is exactly like this model except it goes into the child's home after he leaves and travels with him across time. One of the reasons institutional-based treatment doesn't work very well is that it's cross-sectional and doesn't tend to generalize to other settings. The more often that you can have treatment that starts before incarceration and continues after, the better the chance of getting good results.

Juvenile Suicide and the Components of a Comprehensive Prevention Program

Lindsay Hayes

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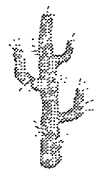
When I first started doing suicide prevention training about 20 years ago, I made the mistake of dealing with the most controversial topic, or the topic that most people wanted talked about first, and that was liability for jail and juvenile suicides. Now, I put the liability issues at the end of the day.

I would like to talk about several interrelated topics in the area of suicide prevention. Suicidal juveniles and mental illness are very interrelated.

I've done training and consulting work in juvenile and adult corrections systems around the country. I plan to talk briefly about research, and the critical components of an agency suicide prevention policy. The amount of money and the level of budget and staffing will obviously vary, whether you're a California Youth Authority facility or a rural juvenile detention facility, but the core components of the suicide prevention program should remain the same. I'll also speak about expert witness work as it impacts the components of a suicide prevention program. When plaintiff attorneys sue a jurisdiction in the event of a juvenile suicide they want to look at personnel files, training records, the track record of your agency in preventing suicides, written policies, and procedures.

I also have biases. I believe you need to have a sound policy at your facilities. If you have any other attitude, you're going to have a number of suicides within your correctional facility. When, after the suicide, you sit down with your medical, mental health, and security staff to dissect the event, you might come to the conclusion that it could not have been prevented. Staff followed the policy; they were trained; you did communicate among yourselves; you did initiate CPR and first aid, you did call the medical staff. It could not have been prevented. This is neither a routine conclusion nor a rare one. The response I've seen all too often, is, "we follow our policy and the youth committed suicide." My first question is, "Let's talk about policy. What kind of policies do you have?" Do you have a two-page outline of what you refer to as your "Suicide Prevention Policy," or do you have a



comprehensive policy that details all the components of a sound policy. You might have followed a policy but the question is, "Is it a good policy?" It might pass ACA standards or the National Commission on Federal Healthcare standards, but is it what we needed it to be? Is there more that the policy should've had in it?

My second bias is that many suicides can be prevented. All too often we ignore suicidal behavior in both juveniles and adults simply because they deny they're suicidal. During the screening process a child might say, "No, I'm not suicidal." Too often staff take the word of the youngster, or the adult offender. "No, I'm not suicidal right now." Then a bad visit from a family member, a bad phone call, or an unsatisfactory court hearing changes the circumstances. A youth says, "I had some idea a couple of weeks ago, but I'm fine now." The behavior is dismissed; the youth is placed in a treatment program and forgotten. Suicide prevention does not begin and end at the basic intake health screening that goes on as soon as the youth comes into the facility. If their behavior and background suggests otherwise, then these juveniles need to be watched very, very carefully. Joel's story about someone who was eating his feces just to be manipulative and is not mentally ill also applies to suicide.

The third bias I have is that too often after a suicide there is no proper investigation or critical review of the incident. Instead we come out with statements, "The suicide could

Lindsay Hayes is the Assistant Director of the National Center on Institutions and Alternatives, with an office in Mansfield, MA. Mr. Hayes is nationally recognized as an expert in the field of suicides within jails, prisons, and juvenile facilities. He has conducted the only three national studies of jail and prison suicide (*And Darkness Closes In . . . National Study of Jail Suicides* in 1981, *National Study of Jail Suicides: Seven Years Later* in 1988, and *Prison Suicide: An Overview and Guide to Prevention* in 1995), as well as co-authored a model training curriculum on jail suicide prevention (*Training Curriculum on Suicide Detention and Prevention in Jails and Lockups* in 1988 and 1995). All three national studies were conducted through grants from the National Institute of Corrections (NIC), U.S. Justice Department. In August 1999, Mr. Hayes was named director of an OJJDP (Office of Juvenile and Delinquency Prevention) project to conduct the first national study of juvenile suicide in confinement.

In addition, Mr. Hayes serves as a technical assistance consultant in suicide prevention in custodial facilities, conducting training seminars and assessing jail suicide prevention practices in various state and local jurisdictions throughout the country. Mr. Hayes also has widespread experience as an expert witness/consultant in custodial suicide litigation, has assisted the Special Litigation Section of the Justice Department's Civil Rights Division, and has previously been appointed to assist special masters in the development and implementation of suicide prevention policies in several adult and juvenile correctional systems under court jurisdiction.

As a result of research, technical assistance, and consultant work in the area of suicide prevention in correctional facilities, Mr. Hayes has reviewed and/or examined over 1,500 cases of suicide in jail, prison, and juvenile facilities throughout the country during the past 20 years.

Finally, Mr. Hayes serves as editor of the *Jail Suicide/Mental Health Update*, a quarterly newsletter devoted to research, training, prevention, and litigation that is funded by NIC; and is a regular columnist for *Crisis: The Journal of Crisis Intervention and Suicide Prevention*. He also authored over 50 publications in the area of suicide prevention with jail, prison, and juvenile facilities.

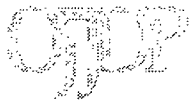
not have been prevented. If a juvenile is really intent on hurting himself, he'll find a way to do it by using broken glass or nails or medication"; "These things happen, it's hard to explain"; "We checked everything"; "I feel very sad the young man did commit suicide"; "The bottom line is we followed procedures."

"We didn't consider him to be suicidal, he was simply being manipulative. I guess it just went too far." The boy who is cutting himself or has a sheet around his neck, saying, "If you don't give me my phone call, I'm going to kill myself," can't be dismissed as being manipulative. The behavior of a lot of our population might appear to be attention-seeking, but either deliberately, or by accident, they end up killing themselves. "We were aware that both his brothers had committed suicide in the past few years, but there was no indication that he needed to be on suicide watch or observation." "I know he threatened to hurt himself prior to the suicide. Do you know how many suicide threats we get up here? Adolescents do it all the time. There's no indication that the threat was a big deal. If this boy had had parents when he was arrested, he wouldn't be here." This is my favorite from the adult system. "Suicide prevention is a medical problem. No, it's a mental health problem. It's not our problem." "It's not our problem, it's the other guy's problem."

The attitude of the academic community has affected suicide prevention. "Statistically speaking, suicide in custody is a rare phenomenon and rare phenomena are notoriously difficult to forecast due to their low base rates. We cannot predict suicide because social scientists are not fully aware of the causal variables involved in suicide." I have been trying to find funding for several years to study juvenile suicide in confinement. Last August OJJDP was gracious enough to do this. One of the reasons a reviewer gave for rejecting my proposal is, "Although juvenile suicide is a topic about which the general public should be curious, it is really nothing more than a minute problem." That was one reason why. Another was "Mental health professionals who have the time for extensive personal interactions with troubled individuals either cannot forecast suicide or are unable to prevent suicide, even if it had been somewhat anticipated. Juvenile suicides are extremely difficult to predict due to their spontaneous nature. To speak bluntly, custodial suicides may constitute less of a readily solvable problem than other situations, and, in view of our present knowledge and our financial limitations, may be expected to continue." These are actual quotes from the academic communities, and from correctional administrators following a suicide. I'm not saying that any of these are wrong or are incorrect. I am saying we often have knee-jerk reactions to cover ourselves. I challenge each one of these folks who made these comments to make those same comments after sitting down and carefully analyzing the suicide. If, at the end of that analysis, they still have the same feelings, that's fine. They carefully looked at the situation, they analyzed the variables and came to the same conclusion. That's fine. Too often we dismiss the youth's non-verbal suicidal behavior, and other types of information that could have been very helpful.

Suicide prevention really just comes down to attitude. This is a quote from a man who worked for the juvenile justice commission in New Jersey. He was a big advocate of suicide prevention in juvenile facilities. He said simply, "Suicide prevention is an attitude as much as it is good policies or procedures. Juvenile facility administrators who believe that most facility suicides can be averted will implement programs that do." Pretty simple stuff.

I'm sure you all remember the conditions of confinement study that was funded



several years ago. It produced good data. One of their missions was to look at suicidal behavior with an emphasis on suicide prevention policies. They identified four components of suicide prevention. A written suicide prevention plan for those at risk was present in 89% of the facilities; screening for suicide risk at admission, 72%; staff were trained in suicide prevention, 75%; at-risk youths observed at least four times an hour, 50%. Only 25% of confined juveniles were in facilities that performed all four of these suicide prevention criteria. The comprehensiveness of each of these four components was not examined. What kind of screening was done? What kind and how long was the training? What were the monitoring procedures? Fifteen minutes can be a very long time between room checks. Are there other levels of observation that were available in this facility? This is the reason why I want to study the comprehensiveness of suicide prevention policies.

I'm going to discuss the main components of a suicide prevention program. They are probably familiar to you. They are consistent with ACA standards, National Commission on Federal Healthcare standards, and performance based standards. My discussion is based on my experience over the last 15 or 20 years examining programs in rural juvenile detention centers and those like the California Youth Authority facility. The first two items, training and screening, have been covered by our previous speakers. Suicide prevention is not a correctional problem—it's everyone's problem. Everyone should be trained. In many facilities all security, staff receive suicide prevention training, but medical and/or mental health staff feel that they are above it. They received the academic training and don't need to sit down for eight hours for suicide prevention. That's absolutely nonsense. A suicide prevention training curriculum should have information that is facility-specific. Ideally, you should have someone in your facility on a full-time basis to become completely familiar with your unique circumstances. A visit once or twice a week is not enough to learn about your facility and your suicide prevention programs. They may know about suicide prevention in the community or the diagnoses and the psychotropic meds, but do they really know what kind of screening you use and how you monitor children in your facility? The bottom line is that everyone—medical, mental health and your security staff—should be trained in the area of suicide prevention. I recommend an eight-hour training course to go through all of the nuts and bolts. More important is the follow-up training. You should have annual training sessions of one to two hours in length. If you do nothing else, have a two-hour annual training. Fortunately, active suicides are relatively infrequent within our facilities. We need the constant reminder that the potential is always there. To do this, offer and even require suicide prevention training on an annual basis, to basically refresh what is taught in previous years, to go over changes in policy or procedures, and to review any incidents in the previous year. It's very important that your training be geared to the academic level and offered on an annual basis.

Your screening at intake should be thorough. It should be multi-faceted, examining medical issues, mental health problems, and suicide risk. It's not enough to have only one question on suicide. The old American Medical Association form that unfortunately is still being used in some jails had only one question on suicide. It was basically, "Does the offender appear to be suicidal or at risk of violence?" That's a nonsense question that isn't really helpful. Now we use direct questions and observations. We look at the current ideation or threat, and prior history. Prior history in your facility is important because of the

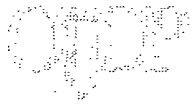
issue of liability. It's unusual for a 14- or 15-year-old child to have a record of being in facilities, unless he's a continually chronic offender. If that youth was in your facility six months ago and was on a suicide watch, whoever is doing the intake should know that. If your files indicate that he was on a suicide watch six months ago in the same facility and he does commit suicide, your level of liability increases dramatically because your agency or facility had information about prior risk. It's difficult to access prior data. It's in a basement or you're not computerized. All mental health clinicians and experts will tell you prior risk is directly related to current risk. If you have that type of information, you have to access it or allow your staff to. As an intake counselor, you need to ask the youth, "Do you have any prior history of suicidal behavior?" If he's been here before you must check the files.

The observations of an arresting or transporting officer are valuable. There should be a mechanism by which your intake staff can directly ask the transporter, "Is there anything that I need to worry about from a medical, mental health, or suicide risk standpoint?" Do not presume that if there's a problem they will tell you about it. You have the responsibility of soliciting that information. Attach it to the screening form as one of first questions asked. You need to know his state of potential suicide risk. It's very important.

The third area, communication, is difficult in terms of establishing a policy. All people involved, including the youth, must communicate. Common sense would say to meet on a regular basis with medical and mental health staff, review referrals, and follow up to make sure the youth was seen. It's all common sense. Invariably, when I read case files of youngsters who have killed themselves, the issue of communication is there. He threatened suicide, was referred to mental health, but for some reason the referral got lost. Medical may say, "No, I definitely remember screening him. The copies of the screening report were sent to the administrator and mental health. Mental health is saying they never got one." Miscommunication is frustrating but it is preventable. A suicidal youth must be tracked. You can't keep a child on suicide watch for an indefinite period of time. Eventually you will have to discharge them. The issue becomes, how are you going to follow them up? Will medical and mental health staff see that child for checkups? Will you wait until he acts up again and does commit suicide? As a previous speaker said, there must be a continuum of services for juveniles who are mentally ill. The same continuum is needed for suicide prevention. Suicidal behavior is not like a faucet you turn on and off. Suicide can happen at any time and can be triggered by a number of external or internal events. You have to keep an eye on these adolescents.

The issue that demands financial commitment is making sure you have a safe housing environment for potentially suicidal youth. It could be one room, or several rooms. You need to have an area in close proximity to your staff. Research shows that many suicides occur in isolation. The single cell housing tends to be far away from staff. They're in the bowels of the facility and are separated from other housing units. This separation gives more opportunity to adult jail inmates to commit suicide. We don't know if this is true in juvenile suicide cases, but preliminary research indicates that it is important that these youth are in close proximity to staff. Having a medical infirmary or mental health unit depends on facility size, but what is important is that they are physically close to your staff.

Clothing is another issue. Do you remove their clothing and use a suicide garment or safety smock? Your protocol should match the behavior. You should have a flexible policy



that allows your mental health staff to adapt the precautions to the behavior. Just because a youth has threatened suicide doesn't mean they should be stripped naked. A juvenile who is assigned a one-on-one shouldn't be stripped naked and in a smock. There does come a point when you must put some youth in special clothing. The protocol should match the behavior. It should never be associated with any kind of punishment.

Probably the most important consideration is how frequently you observe these youths. One confinement study said that many facilities schedule observations at 15-minute intervals. That may often be enough for low level suicidal behavior, or for youth coming down from a more frequent level of observation. There should be at least two levels of observation for youth. One is one-on-one or constant watch. Do not confuse this with TV camera surveillance, or using one inmate observation aides where you have one inmate watching another, as is done in adult facilities. The latter is very dangerous from a reliability and a liability standpoint. I haven't seen it in juvenile facilities, but I wouldn't be surprised if it is being tried, because it's cost-effective. One-on-one or constant observation is exactly that: one employee per suicidal child. That should be your highest level of observation. Some facilities schedule observations at five minute intervals, which is very labor intensive. They feel that there's a large window of opportunity in a 15-minute check. A five-minute check is something that might be useful. Nothing greater than 15-minutes is acceptable. I have seen 30-minute intervals used as a level of observation. The intent was good. "He was on a 15 minute check. We think he's OK, so we'll keep him on a 30 minute check for a day or so." If that's the case, I wouldn't call it a suicide watch. I'd probably call it a mental health observation or something labeled non-suicidal. From a liability standpoint, you would be much better off keeping them on the 15-minute suicide watch if you want to observe them more carefully, or putting them on a level of observation called a mental health observation. The appendices to the NCCAC standards gives four levels of observation: constant, every 10 minutes, every 15 minutes, and every 30 minutes. I've been telling them for years that's very dangerous from a liability standpoint. You shouldn't be advocating putting someone on a 30-minute watch, even if it's a low-level case. If you are downgrading and transitioning that youth back into the housing unit, a 30 minute observation is OK. Don't call it one of your levels of suicide observation.

Your staff needs to be prepared for physical intervention in the event of a suicide attempt. Many suicides are by hanging. All staff who have contact with youths should be trained in first aid and CPR. The ACA standards say, I believe, that at least one staff member per housing unit per shift should be trained. That's a minimum requirement. But you don't want to get into a situation where the one person who is trained on the shift is somewhere else during the emergency. Ideally and hopefully, you will require that all staff be trained in CPR and first aid. Correctional staff should not have the attitude that CPR is a medical responsibility. It's anyone's responsibility. In too many cases, correctional staff wait until medical staff arrive before initiating CPR and first aid. They may be untrained. They may be uncomfortable. They may be in a state of shock. They may not want to risk infection. In a hanging attempt, you have between two and five minutes to successfully resuscitate someone. If you wait five and ten minutes for medical staff to arrive, you will probably lose that youth. It's extremely important to have your staff trained and instructed not to wait for

medical staff to arrive. Your housing unit should be equipped with microshields and a rescue tool. The tool is a hook shaped device that can cut through most material such as a mattress pad, a sheet, or clothing. They are very, very handy. Many suicides can be prevented by staff who physically intervene and provide medical treatment.

The last two items are basically paperwork exercises. Reporting is self-explanatory. All people involved in the incident must report their personal knowledge of the incident. Don't embellish, don't exaggerate, and don't falsify when reporting. These things unfortunately happen in an attempt to make a bad situation better. A poor report will come back and bite them when a lawsuit is filed. Do not report on observations or responsibilities that someone else had. The report should be based on what each person saw and did themselves.

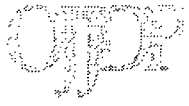
A very important piece for future suicide prevention is the follow-up and mortality review process. In addition to a formal investigation, every suicide incident must be reviewed in a non-pejorative, problem-solving atmosphere. Staff must meet, not to point a finger at anyone, but to analyze the circumstances of the event. Ask, "What can be learned from this event to hopefully prevent future incidents from occurring?" Program modifications will probably be generated by this type of meeting. This is great from a prevention and a liability standpoint. Should you, tragically, have a series of suicides over several years, you can show that you made changes to the system after each occurrence. This will go a long way to show a court of law that you fulfilled your responsibilities.

That is a quick synopsis of some of the critical components of a suicide prevention program. Our agency received a grant from OJJDP last August to do the first national study of juvenile suicide. We want to uncover the who, what, and when for suicide in our juvenile facilities. We should have data in the next couple of months. We're in the first phase of a three-phase program. We are being assisted by the National Juvenile Detention Association and the Council of Juvenile Correctional Administrators, as well as several consultants. The key to the success of this research project is your support in helping us identify suicides occurring within juvenile facilities around the country.

The first phase was a one-page survey sent out to 3800 juvenile facilities around the country. All of your facilities should have gotten those surveys. We asked simply, "Did you have a suicide or a critical suicide attempt within the past five years, from '95 through '99? If so, please, please return our survey." Next, state correctional administrators were surveyed about juvenile suicides that occurred in any juvenile facility during that five-year period. We still need to hear from about 20 states. You know who you are. Please respond within the next couple of days, so we can move on to phase two. I don't want to get in trouble with OJJDP.

The second phase is to ask more specific questions of the facilities where those suicides occurred. We need to know the suicide, the characteristics of the victim, and the facility.

The third phase of the study is data analysis to produce recommendations, if any, for suicide prevention within each facility. One of the key problems we're having is that you might not have jurisdiction over all the juvenile facilities in your state. You might not know what goes on in the county juvenile detention facilities. You might not know what goes on in private juvenile facilities. We need to know, if you don't have that responsibility, who in



your state does? The preliminary data has identified about 85 to 100 suicides that have occurred within that five year period of time. My gut tells me that there are a lot more out there.

I have collected data on about ten juvenile suicide cases during the past few years. With these ten cases, you can't come to any definitive conclusions that are helpful for policy recommendations. What is significant is that I found that most of the information on juvenile suicides is borrowed from the adult field. When you train your staff in suicide prevention, you're using an ACA training manual on adult suicide prevention. Circumstances around children committing suicide in juvenile facilities could be very different than in the adult jail system. The average length of stay prior to the suicide was $7\frac{1}{2}$ months. I know from my own research in the adult field that 50% of suicides occur within the first 24 to 48 hours. Right off the bat, the timing of a juvenile suicide is very different. Something else that's of significance is eight out of the ten victims were in room confinement, time out, or other restrictions in their programming immediately prior to their suicide. In the adult jail we know there is a higher risk of suicide for those in administrative and disciplinary confinement. I wouldn't recommend that you use these ten cases to write a policy. Room confinement was directly related to eight suicides. There might have been an impulsive reaction in frustration to being in that confinement. It might have been the opportunity that room confinement provided and lack of observation. We don't know yet. Eight of the victims had a history of program restrictions. Nine victims had a history of mental illness. All ten victims had a history of suicidal behavior, with five showing suicidal ideation within two weeks of suicide. None of the victims were on suicide precautions at the time of suicide. Finally, a possible precipitating factor identified by the fact finders following the suicide was the death of a family member or friend in five of the ten cases. A cancelled family visit or separation from the family was found in four cases. Impending transfer to a higher level secured facility was found in two of the ten cases. We look forward to releasing the full report on our study.

Panel Presentation

What are the major obstacles your state is facing in providing mental health services to juvenile offenders?

Ralph Kelly, Ed.D.

Commissioner, Department of Juvenile Justice, Frankfort, KY

Good morning. The only obstacle in the topic of mental health services is the almighty dollar—funding. You could do almost anything with your juveniles if you had the appropriate funding. We in Kentucky try to provide comprehensive mental health programming at each of our facilities. Unfortunately, our facilities are small. For every facility we have a full-time licensed clinical psychologist, a child psychiatrist, and professional counselors. We spend a lot of money training our direct care staff, who are called youth workers, because they are the foundation of any residential program. We get no support from the feds in terms of Medicaid for youth in our state-operated facilities. We can transfer the youngster to a private child care agency to generate Medicaid money. If we put him in a group home that we operate, that also generates Medicaid money.

Detention is even more costly to operate. When we get youngsters in detention, they often have no background and no history. When people in detention begin to exhibit problems, we should have a mental health staff to address their needs or at least identify their needs. In our detention facilities, we have correctional counselors who work with youth. When we contract for mental health services with the local community provider, that gets very costly. We have to provide that service because many of these young people come in with a host of problems. Data presented yesterday showed juveniles coming in with many disorders, perhaps compounded by substance abuse.

A continuous problem in Kentucky is that most facilities don't have any mental health services or even the ability to identify children who have mental health needs. Consequently, we end up with a number of young people in detention who should not be there. Right after the series of school shootings, particularly the one that took place in Kentucky, we began to get young people charged with terroristic threatening, which is now one of the statutes in Kentucky. You'll say, "Gee, for terroristic threatening he must have pulled a gun and threatened a whole group of folks." What we got was a couple of kids who threatened their community social worker. We've got a ten-year-old who was arrested for threatening

his teacher. He came into detention. A judge remanded a five-year-old to detention in a county-operated facility a few weeks ago. Wisely, they did not take him. We would not take him in the state-operated detention facilities. These are the kinds of things that happen when you don't have sufficient mental health services in the community. The courts don't have knowledge of the needs of our young people in terms of substance abuse counseling,

Ralph Kelly, Ed.D., has an extensive background in child welfare and juvenile justice services, having worked in a variety of capacities with at-risk children, youth, and families for the past 30 years. Dr. Kelly has held a number of posts in residential and community-based settings, after beginning his career as a youth worker in a residential treatment center. He rose to the position of Executive Director of a multi-functional child welfare and family services organization.

During the early 80s, he served as Executive Deputy Commissioner of the New York City Department of Juvenile Justice. He joined the New York State Division of Parole in 1985 where he held a number of supervisory and administrative positions, including Directorship of an aftercare program for boot camp graduates, the largest and most extensive such program in the nation.

In September 1994, he became director of the New Jersey Division of Juvenile Services, a program serving more than 750 delinquent youngsters in 40 residential and day treatment programs.

In September 1996, Dr. Kelly became the first Commissioner of the Kentucky Department of Juvenile Justice. Since that time, he has overseen the transfer of residential, group home, day treatment, and juvenile probation programs; implemented a strategy for compliance with the U.S. Consent Decree; developed and implemented a 320-hour pre-service training program for youth workers; enhanced the staffing, mental health services, and quality of care in all programs; developed a statewide plan for state operated detention programs; implemented community prevention councils with state funding; developed the Juvenile Intensive Supervision Teams (JIST) program; and implemented intensive in-home supervision in Jefferson and Fayette Counties.

Dr. Kelly has been very instrumental in the movement to professionalize the role of the child and youth care worker. He was the first President of the New York State Association of Child and Youth Care Workers and led that organization to develop the first statewide certification program for child and youth care professionals. In the early 80's, he was the founding President of the National Organization of Child Care Workers Association (NOCCWA) (now the Association of Child and Youth Care Practitioners), further helping to identify the need for the professionalization of child and youth care workers. He currently serves on several boards, including the Inter-Association Child Care Conference, Inc. (IACCC), a regional training organization, and as Regional Representative and Board Member of the Council of Juvenile Correctional Administrators (CJCA).

Dr. Kelly is the recipient of numerous honors for his work, including the Albert E. Treischman Award for outstanding leadership in child and youth care; Outstanding Alumni from the University of Pittsburgh, School of Social Work; and the Life-Time Achievement Award for Services to America's Youth from the Ohio Association of Child and Youth Care Professionals. Dr. Kelly has spoken at a number of conferences and seminars in North America and has achieved an international reputation in the field of child and youth care work.

Dr. Kelly received his Bachelor's Degree in Sociology and Master's Degree in Child Care and Child Development from the University of Pittsburgh. He received his Doctorate Degree in Education from Nova Southeastern University in Florida. Dr. Kelly is married to Sandra E. Kelly, a nurse consultant, and they have one son.

sex offender counseling, etc. These services are not readily available in the community. Kentucky has a particularly significant problem because it's 85% rural. Our largest urban areas, Louisville and Lexington, have a number of resources. In the eastern or western areas these services are not readily available. This makes it very, very difficult.

Even when community providers are available, we find many of them don't want to work with delinquent youth. There is something about being a delinquent juvenile that apparently turns many therapists off. They do not have the expertise to deal with delinquent behavior compounded by mental health disorders. They also lack the interest. They're not interested in working with difficult, delinquent youngsters because, as one therapist told my staff, they curse too much. That's not news to anybody in this room, obviously.

These are the kinds of difficulties we sometimes face. It's also difficult when you have community providers who are not ready to really try to give integrated, coordinated services. My field staff, whenever they do find providers, have difficulty trying to get them to understand and accept the needs of our youngsters. My staff does inform them of what's going on with the youngster; how well they're doing or how well they're not doing, whether they're keeping their appointments or not, and all those kinds of things that we understand are important to providing community supervision to our youngsters, but the community providers don't necessarily understand or accept.

Another big gap in Kentucky is service for very disturbed youngsters. We have a very good mental health staff in every one of our facilities. They get good oversight at all levels. But there are some young people who are very psychotic and need to be placed in a psychiatric-oriented program. Very often they end up in a hospital. When we send a child to the hospital, he stays 30 days. Suddenly the managed care system says, "Well, he's ready to go back." We all know he's not ready to go back. We could keep him there if we wanted to pay the $700 or $800 a day. When he's in the hospital it's a Medicaid-reimbursed situation. But after 30 days, he has to go back. We further find that many of our young people look at hospitalization as detention. The youngsters believe that when they go into the hospital they won't have many demands made on them. They don't have to get up in the morning, go to school, make their beds, or keep the room clean. My staff firmly believe that some children hear about life in the hospital and really act out to go there and get away from the routine of our program's services.

In order to address the needs of our young people we've got to develop our own unit. That's going to be very expensive. I've got to go to the governor and the legislature and lay it out. We really have to have those services. Our own mental health system doesn't have the resources. Our Medicaid system doesn't have the resources. It's really up to the state to come up with the funds for us to develop our program.

Primarily, funding is a very serious issue. I always dwell on the Medicaid piece because today Johnny is in placement in the child welfare system and the feds pump money, Medicaid money, into that system to support the mental health needs of Johnny. But tonight, Johnny goes out and breaks into a car, and tomorrow he's in the juvenile justice system. Suddenly Medicaid funding for Johnny is not available, even though the act he committed that got him into the juvenile justice system suggests that he is in need of significant mental health services. It's a dilemma we need to address. It's patently unfair for that to happen, but that is the way the system works.

How are you currently managing the mental health needs of juvenile offenders?

Tim Walsh, M.A., L.P.

Director, Department of Corrections, St. Paul, MN

In preparation for my presentation this morning on the administration of mental health services, we did a 50 state survey of how mental health services are administered for the narrow population we see in corrections. The survey reflects many of the beliefs that we've been talking about because, frankly, they are your beliefs. We surveyed corrections administrators and directors. The questions we asked are as follows: How is treatment provided? How is it operated? How is it funded? Who provides oversight? What is the trend in your state regarding who has designated responsibility? What kinds of programs do you believe are essential for this population?

The profile we zeroed in on was this one, because we were preparing for a presentation to the legislature. This is the profile we've seen in our state system. We are the back end. We're the backstop to our system. We have a blended system of county and state operated facilities. Most facilities in the state of Minnesota are operated by the counties. We have young people who are serious and chronic offenders. They have severe and consistent mental health issues. We, of course, have the same profile you get in your facilities. They have a dual diagnosis, co-occurring disorders, and so on. When they are in a mental health placement, they look very delinquent. When they are in our corrections placement, they have florid mental health symptoms. They're very aggressive, they're violent, and they present with very bizarre symptoms. They're in need of secure placement because they're at risk for escape or flight. They present a problem for any system they're in. We have one youth in particular for whom the psychiatrist suggested a 15 to 30 year treatment plan in order to see any measurable results. I thought that was a pretty safe range, "Yeah, it's going to be 15 to 30 years." He must have been a psychoanalyst.

We also found that most states operate their own facility for this profile population. Seven states have private operations and twelve have a combination of state, private, or other. I imagine those others are county.

The facilities that house and treat these youth are state funded. We have nine states that have a combination of state and county funds. There's a wide range of per diems. The lowest per diem was $100 per day in North Dakota. Then it goes all the way up to $800 a day. Most places fell within the $200 to $400 range for per diems.

Tim Walsh, M.A., L.P., has over 15 years experience as a therapist, professor, clinical supervisor and corrections administrator. He is currently the Director of the Juvenile Services Division for the Minnesota Department of Corrections. He received his Bachelor's degree in Psychology from Northwestern College and his Master's degree in Counseling Psychology from the University of St. Thomas in St. Paul, MN.

Dr. Walsh is also a licensed psychologist. He has lectured and presented at numerous forums in Minnesota and other states. He is the author of *Go With the Mo: Motivational Primer, The Restoration Handbook,* and *Constructive Cognitive Change Curriculum.*

Facility types are split pretty much right down the middle. Half of the facilities are operated by departments of human services, and health or mental health. The department of youth services or corrections and mental health divisions of corrections operate the other half. Based upon our survey, the trend is toward housing and treating these youngsters within the correctional system.

I want to cover briefly some of your responses about why corrections is taking more and more responsibility for the severe mental health youth who are serious, chronic, aggressive, and violent. The most common response was that there are limited public mental health resources. It is a funding issue. Eighteen of the 42 respondents said the cause is HMO pressures; again we have the "mangled care" idea. Limited federal and state dollars for mental health programs force juveniles from the mental health and human services system into the correction system. Another common reason given was the get tougher policies and a lower tolerance for any deviance or criminality. I suppose the lack of early intervention and prevention resulted in moving those young people into the juvenile justice system. There is a host of other reasons you will find in the results of the survey. There was overwhelming agreement that these are the types of services essential to effective mental health programming in corrections: psychiatric and psychological services, mental health services, behavior management, portability, medication management, independent living skills, and vocational training. The multi-focus that you're seeing in most of the research on what is effective puts these services into an integrated and comprehensive model. We're suggesting that this model will also work with juveniles with serious mental health issues. Other suggestions are strength-based approaches, multi-agency collaboration, individualized treatment plans, and family and significant other involvement. This is a good laundry list of what we might include in a model mental health program for these young people.

I found the survey interesting. It reflects some of the things from the research on youth with severe mental health issues, who are also serious and chronic delinquents. We are seeing movement toward integrated programs within the mental health system. We were able to bring this information to our legislators and say, "This is a critical need; we're hearing this from all over the United States. This is not just a Minnesota problem. It's a problem throughout the United States." We had 100% success at the legislature this year. At the start of our legislative session, they were talking about privatizing the whole system. They also were talking about turning the whole system over to the counties. We really turned the corner in Minnesota. There is a role for state corrections; there is a role for an oversight policy. We can train and set up the best practices and most effective services. We modeled the most effective services throughout the state. I appreciate your responses to our survey.

Results of a Survey of the States Regarding Mental Health Services

Of the 50 states that were sent a survey, 42 responded to the seven questions and areas of interest. A brief summary of the survey results appears in this and subsequent sidebars.

- Twenty-three of the 42 (52%) respondents indicated that their state primarily operated the facilities providing treatment services to juveniles having the profile outlined in the survey. No state indicated that the county or local jurisdictions solely operated such facilities. Seven states (17%) indicated private organizations were operating such facilities and 12 states (29%) had a combination of jurisdictions operating such facilities. Below is a breakdown by state of each noted category.

State Operated (23)	*County/Locally Operated (0)*	*Privately Operated (7)*	*Combination of State/Private/Other (12)*
Alaska	None	Alabama	California
Arkansas		Florida	Massachusetts
Colorado		Idaho	Michigan
Connecticut		Maryland	Minnesota
Delaware		North Dakota	Montana*
Hawaii		Ohio	Nebraska
Illinois		Rhode Island	Nevada
Iowa			New York
Kansas			Pennsylvania*
Kentucky			South Carolina
Maine			Tennessee
New Hampshire			West Virginia
New Mexico			
North Carolina			
Oklahoma			
Oregon			
Texas			
Utah			
Vermont			
Virginia			
Washington			
Wisconsin			
Wyoming			

*Purchased services from other states

Results of a Survey of the States Regarding Mental Health Services (continued)

- Thirty-three of the 42 (79%) respondents indicated that the state (with perhaps some federal subsidies and insurance reimbursement) was the primary source of funding for facilities serving the noted juvenile population of the survey. Eight states (19%) indicated a combination of county and state funding of such services. Below is a breakdown by state of each noted category.

State Funds (33)	*County/Locally Funded*	*Combination of State/County Funded (9)*
Alabama	None	California
Alaska		Michigan
Arkansas		Minnesota
Colorado		Montana
Connecticut		New York
Delaware		Ohio
Florida		Pennsylvania
Hawaii		Tennessee
Idaho		Wisconsin
Illinois		
Iowa		
Kansas		
Kentucky		
Maine		
Maryland		
Massachusetts		
Nebraska		
Nevada		
New Hampshire		
New Mexico		
North Carolina		
North Dakota		
Oklahoma		
Oregon		
Rhode Island		
South Carolina		
Texas		
Utah		
Vermont		
Virginia		
Washington		
West Virginia		
Wyoming		

Results of a Survey of the States Regarding Mental Health Services *(continued)*

- The average daily cost or per diem for residential placement for juveniles who match the juvenile profile of this survey was approximately $230.00. The lowest per diem was $100, with the highest being $480. One facility noted a per diem range up to $800. The lower cost figure on the range was used in calculating the average. Thirty-five of the 42 respondents (83%) supplied information on the per diem question. Below is the breakdown of approximate per diem costs for each state.

State	*Per Diem*	*State*	*Per Diem*
Alabama	160	Montana	Unknown
Alaska	255 +	Nebraska	200
Arizona	—	Nevada	275
Arkansas	400	New Hampshire	300
California	165	New Jersey	—
Colorado	300 +	New Mexico	124
Connecticut	250/800	New York	Unknown
Delaware	251	North Carolina	320
Florida	170	North Dakota	180
Georgia	—	Ohio	480
Hawaii	Unknown	Oklahoma	170
Idaho	245	Oregon	138
Illinois	350	Pennsylvania	Unknown
Indiana	—	Rhode Island	275
Iowa	163	South Carolina	300
Kansas	131	South Dakota	—
Kentucky	157	Tennessee	Unknown
Louisiana	—	Texas	160
Maine	160	Utah	255
Maryland	330	Vermont	180
Massachusetts	190	Virginia	150
Michigan	240	Washington	152
Minnesota	400	West Virginia	260
Mississippi	—	Wisconsin	350
Missouri	—	Wyoming	100

Results of a Survey of the States Regarding Mental Health Services *(continued)*

- Oversight and licensing of the residential treatment facilities for juveniles who match the survey's noted profile varied among all 42 respondents. Twenty-one of the 42 respondents (50%) indicated that their respective departments of human services or their departments of health and/or mental health divisions provided such oversight and had licensing authority over such facilities. In addition, 20 respondents (48%) noted that their departments of youth services and/or their respective mental health agencies had such responsibilities. Below is a breakdown by state reflecting such varied responses.

Departments of Human Services/ Health/Mental Health		*Departments of Youth Services and/or MH Divisions*	
Alaska	HSS/FYS	Alabama	DYS/MH
California	DOH	Arkansas	DYS
Colorado	MH/HOSP/CORR	Delaware	CMH
Connecticut	DOH/DCF	Florida	JJ/DCF/HC
Hawaii	DOH	Illinois	DCFS
Idaho	DOH/Welfare/DJC	Kentucky	DJJ
Iowa	DHS	Maine	DJS/DOC
Kansas	JJA/DOH and Envir.	Massachusetts	CCS
Maryland	DOH/MH	Michigan	CW Lic. Auth
Minnesota	DHS	Nevada	CFS
Nebraska	HHS	New Mexico	CYFD
New Hampshire	DOH/HS	New York	CFS/MH
North Carolina	DHHS	Ohio	DYS/DMH
North Dakota	DHS/MH	Oklahoma	Office of Juv. Affairs
Pennsylvania	DOH/HS		
Tennessee	MH/CS	Oregon	Office of Youth Authority/Corr
Utah	DOH/DHS		
Vermont	SRS-Social Rehab. Services	Rhode Island	DCY/Family
		South Carolina	JJ/DMH
Virginia	MH/ED/SS/JJ	Texas	TYC
West Virginia	DOH/HS	Washington	JRA
Wisconsin	DOH/HS	Wyoming	FS/JS

Montana—unknown

Results of a Survey of the States Regarding Mental Health Services *(continued)*

- Relative to what was the current trend in each state regarding who was designated and given the responsibility to provide residential treatment services for the target population of the survey, 30 of the 42 respondents (71%) indicated that juvenile corrections/juvenile justice has increasingly assumed or had been given that responsibility. Twelve states (29%) looked to health and/or human service/mental health agencies for such services or utilize a combination of agencies (corrections and human services) to provide such services. A breakdown by state for each noted category is as follows.

Juvenile Corrections Responsibility	*Human Services Responsibility*	*Combination (HS/Health/Corr) Responsibility*
Alabama	Delaware	California
Alaska	Iowa	Maryland
Arkansas	Minnesota	Nebraska
Colorado	North Dakota	New York
Connecticut	Vermont	Pennsylvania
Florida	West Virginia	Rhode Island
Hawaii		
Idaho		
Illinois		
Kansas		
Kentucky		
Maine		
Massachusetts		
Michigan		
Montana		
Nevada		
New Hampshire		
New Mexico		
North Carolina		
Oklahoma		
Ohio		
Oregon		
South Carolina		
Tennessee		
Texas		
Utah		
Virginia		
Washington		
Wisconsin		
Wyoming		

Results of a Survey of the States Regarding Mental Health Services *(continued)*

- The stated rationale behind the trend as to why juvenile corrections/juvenile justice agencies were being given the primary responsibility to deliver juvenile mental health services in their respective states was as follows.
  - — Limited public mental health resources available, and responsibility defaulted to juvenile corrections (19 of the 42 states [45%] indicated that as rationale).
  - — Eighteen of the 42 respondents indicated that HMO pressures and limited federal and state dollars appropriate for juvenile mental health programs (lack of resources) forced juveniles to be referred to juvenile corrections since they legally could not refuse taking them.
  - — Seventeen of the respondents (41%) indicated that local "get tougher" attitudes and the need for increased public safety surrounding this type of juvenile offender resulted in juvenile corrections receiving the responsibility to provide secure mental health services to this target population.
  - — Other noted rationale involved: other human services disciplines/agencies just said "no" to providing such services; juvenile corrections was the only discipline providing such services in their state; juvenile corrections "can do a better job" with these clients; federal consent decree directed juvenile corrections to provide such services; reorganization of state youth were given juvenile mental health services responsibility; and traditional mental health services have normally had a narrow approach to providing mental health intervention and treatment relying largely on psychodynamic approaches and not on cognitive behavioral interventions.
- In response to the question regarding what programs and services should be added to the residential facilities in order to make them more effective at treating this target population, the following was offered.

  There was overwhelming agreement and support for the need of the following services:
  - — Psychiatric services
  - — Mental health services
  - — Psychological services
  - — Behavior management services
  - — Supportive living services
  - — Medication management services
  - — Independent living skills
  - — Vocational training, including career development and job placement services
  - — Individual and group therapy
  - — Transitional and aftercare services, including assistance in developing transitional housing resources

Results of a Survey of the States Regarding Mental Health Services *(continued)*

- In response to the question regarding what programs and services should be added to the residential facilities in order to make them more effective at treating this target population, the following was offered.

  Other programs and services felt to be needed and effective in treating this population were:

  — Developing strength-based approach programs
  — Multi-agency program development and implementation
  — Highly structured individual treatment model
  — Small group and teams-focused service delivery model
  — Cross system training and staff development
  — Family and "significant other" participation services
  — Outcome focused management and program evaluation
  — Comprehensive psychological evaluation and assessment services
  — Cognitive therapies
  — Substance abuse treatment
  — Special education services
  — Better coordination policies related to admissions into mental health resources
  — Increase "contracting" for all types of services
  — Increase efforts to access federal funding steams
  — Increase efforts towards literacy, utilization of expressive arts, and developing computation skills
  — Symptom management
  — Specialized treatment for sex offenders
  — Increase social skills training
  — Provide culturally specific activities
  — Increase staff to resident ratios
  — Develop 24-hour intervention therapy services
  — Education of child's parents regarding kids issue

Are there gaps in the current programs or services for the mental health needs of juvenile offenders? If yes, what are the resources or programs needed to meet these gaps?

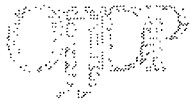
Karen Brazeau

Deputy Director, Oregon Youth Authority, Salem, OR

I would like to talk about the gaps in mental health services. I can tell you a little bit about what we've done in Oregon. We were overwhelmed with youth with emotional problems. Our bed capacity had doubled, but our use of the state hospitals had increased. There was a revolving door system. We would send juveniles who were incredibly in crisis to the hospital and they would be back the next day not changed. This became more of a relief for our staff than treatment for the youngsters. We set out to determine how many youth in our system had very severe chronic mental health needs that would meet the criteria for entrance into another program. A multi-disciplinary team looked at the juveniles and their files. We found about 60 juveniles in our system that met the criteria. Twenty-two percent were females, double the percentage of females in our total population. Surprisingly, Class A misdemeanors made up a significant number of the youth. These children are heavy-duty delinquents. Most of them had had some other kind of mental health placement, many in residential programs. Our staff was primarily concerned about the significant number who had aggressive and family psychological problems. After thoroughly reviewing the 60 cases, we decided 24 of them really needed intensive, long-term services in specially designed settings. I'm not convinced they need state hospital placements, so we will be developing our own facility to serve those children. This will serve only 24 of 3,000 young people in our system. Our staff kept saying, "That's just the tip of the iceberg."

We decided to do an analysis of the gaps in our system. We used a one-page instrument to look at all the youth in our system as of April 1st. We staff was trained in the use of this instrument, and then it was field tested. We'll be happy to share it, If you're interested. We had 2,513 responses. We excluded substance abuse and conduct disorders since almost all of the youth have them. This is the data in terms of the type of psychiatric diagnoses that the young people in our system already have. I looked at the raw numbers and they made me feel like I'm the endangered salmon from Oregon. I feel I'm swimming upstream. When I looked at the survey numbers, I'm convinced that we are providing mental health services to our youth. When individual children were examined, we found most are being assessed and receiving services. I haven't analyzed this for different kinds of disorders. I'm hypothesizing that we do not need more mental health services. We need different kinds of services. The

Karen Brazeau is the Deputy Director for the Oregon Youth Authority. She moved into that position from a career in education where she was the special education director for the state of Oregon. In that role, Karen managed the state's oversight responsibilities to ensure local school districts' compliance with special education requirements and managed special residential schools as well as the educational programs in Oregon's youth correctional facilities. Karen's earlier work was focused on children with severe behavior disorders.



profile of one girl in this group illustrates my thinking. She was with us for four years. She came to us for menacing assault, and harassment, not heavy duty stuff. Her diagnosis was schizoid affective disorder, conduct disorder, and poly-substance abuse disorder, with borderline personality traits. She was placed four times in the Oregon State Hospital, and twice in the psychiatric unit of a private hospital. She had six visits to an emergency room for self-destructive behaviors. She had 564 individual therapy sessions with a trained mental health professional. She had 52 individual sessions with a psychiatrist. She had five consultations with a psychologist. She had 39 individual visits with a physician and 312 documented assessments and interventions with our registered psychiatric nurse. That's a lot of mental health services.

In our state it's not that we necessarily need more but we need different services. As Joel said yesterday, it's futile at this point to talk about who should be delivering them. We have the juveniles. They have been pushed out of every other treatment designed for them including public schools, the mental health system, and the state hospitals. Now they're with us. Collectively we do have a lot of information about what works with young people. If we look at the blueprints or programs and analyze the features of them, we see it's about skill building, stability, relationships, consequences, and spending the amount of time to make a difference in the child's life. I may come back next year and tell you I was totally wrong. In our state we should probably not advocate for more mental health services. Rather we should advocate for more mental health services in the community to keep juveniles out of our programs. We need to rearrange what we're doing to make it more effective.

Do you have legislative funding earmarked for juvenile offenders? If yes, how were you able to get the legislature to do this? If no, are there strategies in place to get funding for these specific needs?

Arthur Murphy

Director, Juvenile Justice Division, Sante Fe, NM

We were asked to talk about potential funding sources to assist in mental health treatment, both within facilities and in terms of preventive care in the communities. Here are some potential sources that we're currently using as well.

We're in the process of learning to accumulate funds to assist us in improving in our mental health treatment. Our conservative estimate of revenue is about $600,000. We are generating funds for identifying foster care placement, and to utilize our juvenile reintegration center. All of that work is done within our juvenile parole and probation offices. It doubles the work that we're currently doing on Targeted Case Management (TCM). Our budget for juvenile justice within the Children, Youth and Families Department is about $50 million. We're utilizing about $4 million for mental health treatment, and most of that is actually full-time employment, salaries, benefits, and some contractual services. It is not a significant amount of money for the kinds of clients our facilities are receiving.

Fifteen day diagnostic services are ordered by the court. We assess and make recommendations to the court for clients that come into our facility for this particular battery of assessments. We hope to get Medicaid reimbursement for this process. We're going through the steps now to become qualified as a center. In less than a year we should begin to receive additional funding. We may be able to apply some of these funds to treatment activities. The estimated revenue is again $345,000. Hopefully, that's conservative.

We're currently working on project case management through our juvenile parole and probation offices. We are being reimbursed for conducting and completing baseline assessments and plans of care. We have contracted with a company called Maximus to assist us in understanding the process, training our Juvenile Corrections Probation Officers, and verifying that the work done meets the federal criteria. We're hoping to be reimbursed from October 1998, and then annually thereafter. Annual revenues estimated again at about $1 million.

Arthur Murphy is a Law Enforcement Specialist, USAF. In 1981 he was a correctional officer for the Penitentiary of New Mexico; 1983, training instructor for the New Mexico Corrections Department Training Academy; promoted to Correctional Officer Basic Training Manager; promoted to Deputy Director for the Training Academy and assigned as Acting Director for the NMDOC Training Academy. In 1990 to 1994 he was a Correctional Training Coordinator for the Oregon Board on Public Safety Standard Training; promoted to Supervisor and Management Training Coordinator; promoted to Assistant Director for Training Operations.

In 1994 to 1999 Mr. Murphy was Personnel Director for the Penitentiary of New Mexico, Santa Fe, NM; 1999 to the present Mr. Murphy is Director for the Juvenile Justice Division, New Mexico Children, Youth and Families Department, overseeing state juvenile facilities and juvenile parole and probation operations.

We're looking at about $2 million in additional monies, which will be very helpful. Some of those monies will go to mental health treatment in the facilities and in the communities.

A comprehensive strategy program has great potential for a positive impact on mental health services. The OJJDP promotes this comprehensive strategy program. Multnomah County, Oregon, calls it the Juvenile Justice Reform Initiative. I was privileged to see it in action. We're utilizing it in Deming. It's community based; All the key players—the judicial system, district attoneys, public defenders, law enforcement, school personnel, JCPOs—come together to staff all the cases within their communities. Our role at the state level will be in terms of supporting this kind of effort by developing preventive care, finding shelter beds, and developing aftercare programs within the communities. The juveniles are going back to their communities. I would prefer to see the tougher clients, the ones we have a lot of concern for in terms of community safety, within our facilities. Most of the clients we have now really don't belong there. We're promoting the comprehensive strategy program here in New Mexico. This will impact the number of clients we get into our state and detention facilities. The more time a client spends in a facility, the more he's going to adapt to that environment, then what are you going to do? It's not a healthy place, no matter what we try to do to reintegrate them. The comprehensive strategy program is going to have its benefits down the road.

Ken Martinez

Deputy Director, Prevention and Intervention Division, NM Children, Youth and Families Department, Sante Fe, NM

What I want to talk about is the impact of Medicaid managed care on juvenile justice and the interface with the judicial system. Many of us have a love-hate relationship with Medicaid. On the one hand, it can provide some very good services through its benefit package; on the other hand, services are very hard to access for a variety of reasons. My experience is in New Mexico but most points can be generalized to other states.

We began statewide Medicaid managed care in July 1997. Over the last three years we've seen a 50% reduction in our residential treatment beds, from 1200 to 600 beds. The length of stays in acute care and residential treatment have been reduced significantly to three days in acute and about 45 to 60 days in residential. There is an absence of specialty services, especially substance abuse services. Most of our juvenile population within institutions and in juvenile probation and parole have substance abuse issues that are usually comorbid with psychiatric components. There's an absence of transitional services. A lot of our youth move from one system to the next system or from one level of care to another level,

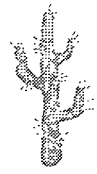
Ken Martinez is a clinical psychologist and a Clinical Assistant Professor of Psychiatry at the University of New Mexico Health Sciences Center. He is also Deputy Director of the Prevention and Intervention Division of the New Mexico Children, Youth and Families Department.

with very little interim care. In our state, there has been a very strong reaction by our juvenile court judges to Medicaid managed care. The reaction has been one of impatience, frustration, and often anger. Before, we had a system that was fairly responsive to the use of residential treatment. Although I'm not a huge proponent of residential treatment for adolescents, this is a viable option for many. We're seeing juvenile court judges being frustrated with the managed care system as a whole, especially the prior approval process and frequent denials of service to the juvenile population. We've increased our juvenile bed capacity about one-third in the last few years. They are at capacity and often over capacity. Judges are using our institutions as places for juveniles to receive treatment, which is not necessarily a bad thing if the facilities are equipped to handle such a severe population. In New Mexico, as Art was saying, a lot of our population in the institutions don't belong there. They belong in intensive treatment on the outside. Lack of services on the outpatient side is a big frustration. The problem with increasing our population in institutions is funding. The cost of residential treatment for juveniles used to be matched by Medicaid. It is still matched by Medicaid in New Mexico at a 74% to 26% rate. This good match is partly because of our high poverty level. A lot of juveniles belong in intensive, group, outpatient therapy. We have a lot of sex offenders. Judges are very reluctant to allow sexual juvenile offenders to roam around on the outside. Many of the sexual offenders are locked up in our institutions to receive care whereas they could be receiving care on the outside.

The Children's Health Insurance Program (CHIP), has helped in the last few years. Each state has a different name for it. We call ours New Mexikids. CHIP has helped the system as a whole. We have been able to bring on presumptive eligibility through Medicaid. Presumptive eligibility allows a certified provider of services to deem a child presumptively eligible for Medicaid while all the paperwork is being processed, a 60-day procedure. From the day the child walks into a provider's office, he is deemed eligible and all charges will be paid by Medicaid, whether he's made eligible or not at the end of the 60 days. That's one benefit of the CHIP program.

The second benefit is 12-month eligibility through Medicaid. Before, a child went off and on Medicaid on a monthly basis depending upon family income. Family income could vary $25 in one month and the child would be dropped off, and then he'd come back on. It was a roller-coaster for everyone involved. Through CHIP, we were able to get 12-month eligibility, which means that even if the family won the lottery the child would still be eligible for Medicaid for 12 full months without falling off. They would re-apply at the end of the 12 months. That's one good thing that's happened recently.

The Human Services Department, the state Medicaid agency, is writing a new Request for Proposal (RFP) for our Medicaid program. The Department of Health , the adult mental health side is also contributing. We're in the third year of a four-year RFP contract cycle. We have learned a lot in the last three years, and we know a lot of things not to do again. We want to change our Medicaid managed care model. We have a very complicated tier administrative system. The hierarchy from top to bottom is the MCO, the behavioral health organization, the provider network, the provider, and then the client. At each level there is an administrative cut of X percent which results in less money for the actual direct service care provider. We want to change that. We're also proposing to change our medical necessity definition. The one thing in our state that has proven to be a barrier to access for



our children, especially juvenile justice children, is the very narrow definition of medical necessity. The youth that are on probation and parole are constantly denied by Medicare using the medical necessity definition. We're very interested in the models in Colorado, Iowa, and Massachusetts, which have more liberal definitions of medical necessity.

As Art said, we're working to get full Medicaid reimbursement for all of the 15-day diagnostic juveniles who come to our institutions for full work-ups. Most of these youngsters are Medicaid eligible. The services provided to them need to be financed through Medicaid. This hasn't happened because they're not considered inmates of the juvenile institution. Until you become an inmate at a juvenile institution, as defined in C.F.R. 22 from the Medicaid bible, you are not eligible for Medicaid services during that time. When a judge asks for a 15-day diagnostic at our institutions, we need to be reimbursed through Medicaid. We also need to establish an adequate provider network in the new RFP. We will propose a full-time liaison between Medicaid managed care and the juvenile courts. Currently there is frustration, anger, and discontent between Medicaid managed care and juvenile courts. Our JCPOs are caught in the middle trying to access services and raising the ire of our juvenile court judges when no secure placement or treatment plan acceptable to the judge can be found. Then the judge commits them to our institutions. Overall we want to focus more on preventive services. While this doesn't help our young people in the institutions, our goal is to prevent a lot of those children from entering the institution by providing the services that are due them by Medicaid prior to being in front of a judge. Judges get upset when services haven't been provided because of denials. We plan to provide a whole gamut of services, especially substance abuse services and those needed by the multi-diagnosed population. Most of our youth not only have a conduct disorder, not only abuse substances, but they also have PTSD, major depression, and a few of the psychotic disorders. These need to be treated outside of the institution. Once the culture of the institution takes a hold of the mentally ill children, they're going to learn that as well.

Luncheon Keynote Address

John Wilson

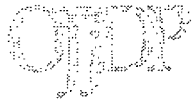
Acting Administrator, Office of Juvenile Justice and Delinquency Prevention, Washington, DC

I applaud our co-sponsoring agency, the American Correctional Association, for the wonderful assistance the provide each year in co-sponsoring these forums that address the pressing and critical issues we face in the juvenile justice system. It is not often that we can get so many state juvenile justice administrators together in one room, along with detention center directors from the states, to investigate and discuss the needs and concerns of the juvenile justice system. This year's forum comes on the heels of the publication of OJJDP's latest edition of *Juvenile Justice*, our quarterly journal that deals with "hot button" juvenile justice issues. The latest edition deals exclusively with the very issue that you've come here to Albuquerque to discuss: the mental health needs of youth in the juvenile justice system. It's encouraging to see the level of national interest in examining ways to work together to improve the delivery of mental health services to this special population.

As I noted in the foreword to my journal, and I'm going to quote myself. As that noted pundit, John Wilson, once said, "If we are to succeed in preventing and reducing juvenile delinquency, we must address not only the offenses that bring juveniles to the attention of and to the juvenile justice system, but also the underlying problems they face, including the mental health problems that affect so many youth in the juvenile justice system." Did everybody write that down?

During the course of this forum, you will be hearing from some of the authors who contributed articles to this journal. They have "real world" experience in overcoming the obstacles of identifying and providing effective treatment to these young people, who suffer from everything from conduct disorders to chronic substance abuse; from post traumatic stress disorders due to physical or sexual abuse to severe depression; from schizophrenia to bipolar disorders.

Although no reliable figures exist at the present time on the numbers of juveniles with mental health needs in the juvenile justice system, it is safe to estimate that at least one out of every five juveniles in the system has a serious mental health problem. In addition, evidence indicates that the level of multiple mental health problems among the juvenile



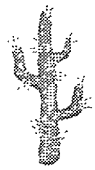
offender population is great, especially among youth whose primary diagnosis is conduct disorder. OJJDP's 1994 Conditions of Confinement Study examined the perception of public and private detention center and training school administrators with regard to the problems faced by youth detained in their facilities. These administrators indicated, in their assessment of the situation, that 75% of the juvenile offenders had significant family problems, 44% exhibited disruptive behavior, 43% demonstrated violence toward others, 52% showed symptoms of depression, and 51% appeared to have been abused by their parents. I know things have changed a lot since then. While this picture is far from complete, these figures indicate that substantial numbers of juvenile offenders have mental health and other treatment needs that the juvenile detention and corrections system must begin to address while those children are in our care. We need more research to gain more definitive answers to such questions as, "Who are these children? How many of them are there? What is the true nature and scope of their problem? How can we best provide needed mental health services?"

I want to talk about some of the challenges we face. One of the biggest challenges the juvenile justice system faces today is the lack of services to meet the needs of youth with mental illness. Even in today's climate of greater system coordination, youth who are determined to be both "mad" and "bad" are inevitably bounced between the mental health, education, child welfare, and juvenile justice systems. The end result is that their needs are not being effectively met by any of these systems, either alone or together, resulting in tremendous costs to society, as well as to the juveniles and to their families. The juvenile justice, system, as has been amply illustrated, has become the default system for provision of mental health services. This is not, however, a challenge that the juvenile justice system can

John Wilson is the Acting Administrator for the Office of Juvenile Justice and Delinquency Prevention within the U.S. Department of Justice, Office of Justice Programs. Mr. Wilson joined the department in 1974 as an attorney advisor in the Office of General Counsel for the Law Enforcement Assistant Administration. He served as Senior Counsel to the Office of Juvenile Justice and Delinquency Prevention from the program's inception in 1974 until 1992, when he joined the Office as its full-time Legal Counsel. He served as Acting Administrator for the Office from January 1993 to October 1994 and was appointed as Deputy Administrator by the Attorney General in December 1994. In February 2000, he was appointed Acting Administrator of OJJDP. He has also served as a member of the U.S. Advisory Board on Child Abuse and Neglect.

Before coming to the Department of Justice, Mr. Wilson was a program administrator and caseworker at the Michigan Department of Social Services. He served as a member of the Montgomery County (MD) Juvenile Court Committee from 1986 to 1992, with the last three years as the Committee's Chair. He has lectured and taught courses in the legal rights of children, juvenile justice, and family law, and has been published in the *Children's Legal Rights Journal,* the *Juvenile and Family Court Journal,* and *Corrections Today.* He also co-authored the office's *Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders* (1993) and is editor of *A Sourcebook: Serious, Violent and Chronic Offenders* (1995).

Mr. Wilson has an A.B. in history-economics from the University of Michigan, Ann Arbor; and M.B.A. in management from Wayne State University, Detroit, MI; and a J.D. (Cum Laude) from the Detroit College of Law, Detroit, MI.

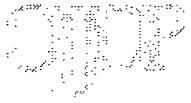


effectively meet alone as some in Congress suggested during last session's reauthorization debate. There was actually a move to take mental health responsibility and just transfer it from the mental health service to the juvenile justice system. The problem is that there was no discussion about taking resources that are in the mental health system and transferring those resources to the juvenile justice system. So we at the Justice Department, commenting on those provisions, injected a note of caution and the reauthorization didn't happen. I don't know how it would have come out if it had. But it's an issue we're probably going to have to face, if not in the remainder of this session of Congress, in the next Congress for sure.

We also face an additional challenge that stems from a change in the philosophical underpinnings of the juvenile justice system: from treatment and the best interests of the child to a focus on punishment and deterrence. Even as juvenile arrests plummet, there's a trend toward greater use of the formal processes of the juvenile court, of punishment and incarceration. The transfer of more juveniles to the criminal justice system continues unabated. Treatment and rehabilitation are too often afterthoughts. This situation creates a formidable challenge to maintain the treatment and skill development approaches which are needed if we are to successfully address the needs of juveniles in the juvenile justice system. We all know that these youths will be returning to our communities, and it's our job to make them better positioned to be law-abiding, productive, and healthy citizens instead of tomorrow's adult criminals.

A third challenge to the rehabilitative philosophy of the juvenile justice system is what I call the mystery of managed care. We've talked about that a lot already. I've learned in one morning a lot more about managed care, some of the issues that surround it, and some of the impact that managed care has had on the juvenile justice system. Suffice it to say that managed care presents some still evolving challenges to the juvenile justice and mental health systems that have yet to be resolved. You're going to play a critical role, and can play a critical role, in helping to resolve those issues. Clearly, managed care has already played a significant role in transferring some juveniles from the mental health system to the juvenile justice system. That's a trend we need to address forthrightly, showing the same kind of vigor in talking with policymakers and legislators that we exhibit in talking among ourselves. By restricting and limiting the availability of mental health services, managed care has caused many young people to be placed inappropriately in juvenile justice facilities, rather than in mental healthcare facilities and programs that could more adequately and much more appropriately address the juvenile's needs. If this situation remains unchecked our juvenile justice system will continue to receive substantially more young people from the courts without the benefit of adequate mental health services. The juvenile justice system, we all know, is simply not equipped to assume this burden.

So what is OJJDP doing to help you face these challenges? We are, I think, leading by example through our research, demonstration, training, and technical assistance programs. Some of you may be familiar with the 1992 monograph entitled, "Responding to the Mental Health Needs of Youth in the Juvenile Justice System," This particular document remains the single most comprehensive source of information on this issue, and this year we are funding a revision and update of that critical publication. I'm happy to report that since 1992 there actually has been a lot of progress made in supporting mental health services for juvenile offenders. In fact, in 1993, we supported training and technical assistance to



teams—called policy academies—of state policymakers charged with developing state plans for improving mental health services in 11 states in cooperation with other federal agencies and the National Coalition for the Mentally Ill.

More recently, OJJDP has developed a comprehensive mental health strategy to address the needs of delinquent and at-risk youth. There are three areas of emphasis within this strategy. The first is research on the incidence and prevalence of mental illness and co-occurring substance abuse problems among juvenile offenders. Second is the identification of appropriate mental health screening and assessment protocols for use in juvenile justice settings. The third is to improve mental health services for these children and their families. Why research? I think we would all agree that the first step is to more precisely identify the nature and scope of the problem. Many have speculated that youth in the juvenile justice system have higher rates of mental disorder than those in the general population and there is clearly some research evidence to support this. However, there are no systematic, national-level data to confirm or deny this hypothesis. Therefore, in collaboration with the National Institute of Mental Health, OJJDP is co-sponsoring a study of alcohol, substance abuse, and mental disorders among juveniles in the Cook County Detention Center, near Chicago. Based on preliminary data from that study, over 85% of the 1,800 juveniles in the study meet DSM criteria for one or more disorders. As you might expect, the greatest proportion meet criteria for substance abuse—48%. Second was disruptive behavior disorders—42%. This is consistent with the information that we have had in the past. In addition, close to 20% displayed clinically significant signs of depression, and a similar percentage suffered from significant anxiety symptoms. The presence of these conditions has important implications for the work of juvenile justice practitioners, further demonstrating a need for behavioral healthcare within the juvenile justice system.

Screening and assessment is the second area of focus. The area of screening and assessment generates the second largest number of inquiries from the field. (I'll tell you which was first shortly.) There is an urgent need for screening and assessment instruments and protocols that are appropriate for juvenile justice populations and juvenile settings. All too often, adult measures and standards are applied to children and adolescents with predictably negative results. Young people have different needs and different abilities and we have to do better in the area of screening and assessment. One specific type of service that merits further consideration is the community assessment center, a concept that OJJDP has supported for five years. We're conducting a national evaluation that's gone on for two and a half years. Community assessment centers provide centralized intake and assessment for youth entering or youth at risk of entering, the juvenile justice system. Juvenile justice practitioners and community-based service providers screen youth and, if necessary, conduct more in-depth assessments of juveniles' mental health needs. Most of community assessment has a mental health component. We believe that obtaining accurate and comprehensive information at the "front end" of the system will greatly enhance referral, treatment, and placement decisions. There's always a note of caution about community assessment centers. You've got to be careful about not using them for net widening the juvenile justice system. We take great pains in our demonstration programs to insure that that doesn't happen.

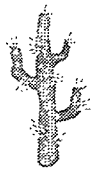
Even the best assessment is meaningless if appropriate follow-up services are not available. Improving services to children and families is the third component of OJJDP's

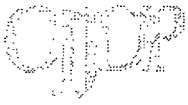
mental health strategy. In looking at the continuum of mental health services offered under current programs, it has become clear that there is not only a lack of programming for juvenile offenders in detention programs and in secure corrections, but also a lack of re-entry or aftercare programming for youth returning to their communities from institutional placements. Instead of addressing these gaps in piecemeal fashion, OJJDP believes that the best strategy is to develop a comprehensive service delivery model that's tailored to each state and local system. We saw this morning how different these systems are. Within each of these systems we need to work to provide a continuum of mental health care. One of our most recent initiatives seeks to do just this. The Mental Health and Juvenile Justice Initiative is a $1 million research and demonstration effort that calls for research activities designed to support the development of a model for providing comprehensive mental health services to youth at every critical point in the juvenile justice system. The model developed under this initiative will subsequently be used in a demonstration and evaluation phase that will lead, hopefully, to replication, further evaluation of the model, and use of this kind of systemic planning process in jurisdictions around the country.

We're also working closely with other federal agencies to increase our joint capacity for meeting the mental health needs of juvenile offenders. The OJJDP has been active in the Federal Partnership for Children's Mental Health Organized by the Center for Mental Health Services. Administration in the Department of Health and Human Services. The goal of this collaboration is to develop comprehensive mental health services for seriously emotionally disturbed juveniles, delinquent and at-risk youth, and their families. And we're putting the money in to make sure that that focus is there.

In addition to developing resources within your own jurisdictions and utilizing appropriate and accurate screening and assessment procedures, you need to remember that your advocacy plays a critical role. There are still too many people, many of them in policy positions, who continue to believe that delinquents are just "bad kids" who "need to be taught a lesson." Personally, I'm not sure what lesson we're teaching when we treat 12-year-olds as adults, when we lock up an adolescent for years while denying him or her access to basic treatment services, including mental health care. Juvenile justice policymakers and practitioners, as well as the public, need to continue to be educated regarding the many factors that underlie delinquent behavior. That's a job for every one of us in this room.

Now that we've spent some time highlighting the challenges that you face, let me focus on several of the unique opportunities available to you in the juvenile justice system. As I mentioned, there are juveniles in detention and secure corrections who desperately need behavioral healthcare services. There are resources available to help these youths. The first is in the area of training and technical assistance. The decisionmaking process, of judges, prosecutors, probation officers, law enforcement and others, is a crucial determinant of whether youth are diverted into the mental health system or into the juvenile justice system. Your expertise can be tremendously valuable in making sure that their decisions are based on accurate and complete information and the best up-to-date information on mental health services. Our technical assistance and training projects can help you identify ways to provide this information, and don't forget that OJJDP's Formula Grant, State Challenge, and Juvenile Accountability Incentive Block Grant funds can be used to support this work at the state and local levels. In fact, both the Formula Grants program and the State Challenge program have





specific provisions that foster the coordinated delivery of health and mental health services between the juvenile justice system and other systems. It's important that you are aware of these resources and take advantage of them.

Second, there is a huge need for community-based diversion and treatment programs for juvenile offenders and at-risk youth. Often, a judge and prosecutor will agree that a delinquent youth would benefit more from, for example, a day treatment than from a 24-hour detention facility. If no such program is available, they're likely to place that youth secure detention because it's the only option available, even if the child could be taken care of in the community, often at less cost. We need to develop that continuum of community-based services. At the other end of the system, there continues to be an appalling lack of aftercare programs for youth coming out of detention and secure confinement. I know we talked about that a bit this morning, but I think it's important for those of us in the detention and corrections field to work hard with parole and other officials to provide quality aftercare programs to reintegrate juveniles into the community. There are a lot of models out there, like our Intensive Aftercare Program model, that you could use to help bring those services to those youth.

A fourth area of opportunity is services for female juvenile offenders. Between 1987 and 1996, the number of female delinquency cases rose 76%, compared with 42% for males. The female offenders have unique needs that challenge the juvenile justice system. It was interesting to hear this morning that in Oregon about twice as many females needed mental health services as males. This may be because a lot of girls in the system have been victims of sexual and physical abuse, entered the system pregnant or as teen mothers with all of the problems that these kinds of situations bring to females in the system. We can't continue to put girls into programs that are designed to meet the needs of boys. We have to work harder.

OJJDP's helping to fund a longitudinal study on the development of conduct disorders in girls under a 1999 interagency agreement with the National Institute of Mental Health. This project will give us a better understanding of the developmental processes in girls and help identify effective means of prevention and treatment programs that effectively respond to their unique needs.

A fifth opportunity lies in the area of juvenile sex offenders. Remember I said that the area that generated the second largest number of inquiries was assessment. Sex offenders is the area that generates the most inquiries. Many of these youth are in the juvenile justice system. They are treatable, but in most cases aren't getting treatment. Even in jurisdictions with specialized sex offender treatment programs in different units, juveniles can remain on waiting lists for months and, in some cases, years. We had a program which congress authorized in 1992, to provide treatment services for juvenile sex offenders. This wasn't for just any sex offender. Congress said, "This is a treatment program for juvenile sex offenders who are victims of child abuse and neglect." These young people were victimized in the first place. Since 1992, Congress has provided not one penny for that program. It's in the statutes, one of the parts of our federal program. We have not even succeeded in getting OMB to request funding because it's not an issue that a lot of people want to spend money on, it's a real challenge to get support and provide those services. This year, we're continuing to fund a project designed to create a juvenile sex offender typology. We hope that this will give corrections officials better tools to make placement and treatment decisions for these youths.

There are a lot of other programs and services that OJJDP supports that will help you do a better job of providing mental health services. Comprehensive Strategy; Performance Based Standards program, addressing disproportionate minority confinement in detention and corrections, can certainly have an impact on delivering appropriate services. Perhaps give some of those services to the front end of the system. Suicide prevention and learning disabilities are two program resources out there. We recently put out a solicitation for programs to provide mental health services for Native American youth as part of a larger service provision. Hopefully, by working together, we can begin to really make a difference in addressing this issue.

As juvenile justice professionals, you have many strengths that allow you to respond successfully to the challenges and opportunities posed by the juvenile justice system. Individuals with co-occurring mental health and substance abuse disorders, for example, make up a large proportion of the detained and incarcerated population. Because these conditions fall under different agencies or programs, the result is often treatment that is both fragmented and ineffective. Yet, many states are moving to develop integrated service delivery systems for mental health and co-occurring substance abuse disorders. We know that it can be done, because it is being done around the country. We can all agree that meeting the treatment needs of juveniles will require further changes in the ways that both mental health and juvenile justice systems operate and the way they work together. We need to combine treatment and sanctions into a seamless system that provides support and accountability for youth in the system. Mental health and juvenile justice practitioners must work harder at understanding each other's viewpoints, goals, and practices, and dedicate themselves to enhancing collaboration between the two systems. We can't forget the mental health system, we have to work with it. This is not easy, but it is essential. The rewards will be worth the effort. Thanks to all of you for taking what you learn at this juvenile justice forum and putting it to work in your jurisdictions in the future. Thank you very much.

The Relationship Between Mental Illness and Juvenile Delinquency

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I want to discuss my time in this profession, and how it relates to this topic. In September of 1972, I helped a gentleman set up a program for juvenile substance abusers, at Hill House in Carbondale, Illinois. A former heroin addict, who has since passed on, and I collaborated on this program in 1972. When we looked at the issues of substance abuse, a severe abuser was someone who would drink a few beers on the weekend, smoke a joint, and swipe diet pills from the medicine cabinet. That was our idea of a serious abuser. How times have changed! We have seen an increase in heroin, an increase in methamphetamine use, and the devastation crack has done to a lot of people. It's important to consider the social context and environment in 1972. There wasn't much violence in comparison to what we have today, although we have had a decrease in the last few years. Teacher/student ratios were much lower than today. Classroom behavior was handled better than it is today. Also, juvenile justice agencies were allowed to diagnose a child as emotionally disabled, which hooked them into the rehab service delivery system. We could give them case management, aftercare, university training, job training, and buy them materials such as toolkits for mechanics. That was the social context when I started. I began the research for my doctoral dissertation in Chicago. I examined impulsive and premeditated violence and compared these two groups to a group of property offenders. Cognitive issues, sensation-seeking, arousal-seeking, and learning disabilities were possible causes of violent behavior. There was very little solid research in the field of violence.

In the early 70s, we also had a model of community mental health service delivery. Research was underway by the government to insure that services were available for our clients in the field. Today we're back to where we were in the late 60s and early 70s, with a need for more community-based services and, once juveniles are in institutions, to provide the best quality care we can. There's a heavy demand and competition for the few dollars we have. I think 14 or 15 states are now spending more on their corrections and law enforcement budgets than they are on their education budgets. Schools and infrastructure items need massive inflows of money. If this is true, we should begin to ask some hard questions.

There is new information from the Surgeon General's office about individual risk factors on child and adolescent mental health. It was published in March 2000. It's a very current document with some year 2000 citations. I also have some newer information on genetics and neurology that tells us about substance abusers and violent youth. In the next few years we will begin to understand the neurology of the human brain, and how it drives behavior. The challenge with so much new information coming out is to stay current and to integrate it into our system. We now have a pretty good idea why there's a link between attention deficit disorder (ADD), alcoholism, and conduct disorder. Some of the newest neurological research using SPEC scans, is showing us some of the dynamics behind violent alcoholics and domestic perpetrators, as well as the mental issues of stalkers. We're starting to see set patterns. Once the patterns are identified, the treatment is a combination of cognitive behavioral therapy and medications. I definitely support utilization of psychiatric meds. But these medications should be a last resort, not the first resort. As part of a whole treatment plan, I support medication.

I began working with juveniles but very quickly moved to adults. I was at a federal penitentiary in Illinois and then went to Santa Fe. When I returned to New Mexico after being at the National Institute of Corrections, I realized I was very tired of working with adults. What could you really do with a 40-year-old heroin addict? Teach him some coping skills and reduce the chance of relapse—That's about it. Now I have a position with the University of New Mexico. Ninety percent of my work is in substance abuse, violence prevention, and early intervention.

Four or five years ago, development psychologists started to say the basic elements of personality form by the age of three. We used to say an age range of seven to ten. If you accept age three, then our whole view of prevention, intervention, and treatment needs to be reordered. Everything after age three or four is early intervention; everything after five or six is treatment. Prevention is prior to birth. The focus has shifted with what we're learning.

Henry Cellini, Ph.D., is a trainer, consultant, author, and educator specializing in management and treatment of violent juvenile offenders, drug abuse prevention and intervention, juvenile street gangs, mental health, and violence prevention issues. He is a part-time instructor for the Substance Abuse Studies Program. This program brings the latest prevention information and research to educators on a variety of issues related to violence prevention and substance abuse issues.

Dr. Cellini has worked with juvenile substance abusers since 1972, when he helped start a therapeutic community program called HillHouse Drug Abuse Therapeutic Community in Carbondale, IL. Over the last 25 years, Dr. Cellini has worked with both juvenile delinquents and adult offenders with a primary focus on substance abuse, violence, and deviant sexual behaviors. His work has included serving on a training faculty for the National Council of Juvenile and Family Court Judges, providing training on what works in treating special populations of high-risk juveniles.

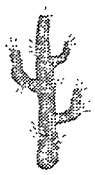
In addition, Dr. Cellini has produced a booklet entitled *Alcohol, Tobacco and Other Drugs*, along with a Drug Use Poster and Eye Exam Chart. Dr. Cellini, along with Dr. Barbara Schwartz, edited the books *The Sex Offender Vols. I and II*; Dr. Cellini's chapter was on assessing juvenile offenders.

The Surgeon General's report indicates that abnormalities in the nervous system influence behavior, thoughts, and emotions. These abnormalities can result from injury, infection, poor nutrition, substance abuse, inhalants, and lead. Infection ties into a current theory regarding the development of schizophrenia. This theory seems to hold water. The hypothesis is that a fever from a virus contracted in the seventh or eighth month of pregnancy could tend to cause lesions, injuring the developing brain. There is high correlation between mothers who report cold and flu in those months and the subsequent development of schizophrenic behavior in the child. We have to look at these as additive factors. Biology makes a difference.

In the last two or three years, neurological and biological research has been telling us that substance abuse craving comes from the part of the brain called the nucleus. The prefrontal cortex is the internal editing component of our brain. It controls consequential thinking or the ability to solve problems. Criminal thinking taps that area. We know from Positron Emission Tomography (PET) scans that the prefrontal cortex area shows decreased activity for three behavior problems: conduct disorder, attention deficit hyperactivity disorder, and problem drinkers. All three groups tend to have under-activity in this area. Why is this so important? The limbic system regulates emotion; understanding this is important in terms of violence and substance abuse. Bruce Perry M.D., neuropsychologist at Baylor University, found that the nucleus area physically stretches if there is a genetic predisposition. This is an organic change in the brain never to be repaired. Dr. Perry also found that children who have been physically and sexually abused show the same pattern. Logically, this makes sense. If a child at three, four, or five is being terrorized by an older child or adult, the body will pump adrenaline. Adrenaline is our body's form of speed. The adrenaline molecule is chemically very close to the amphetamine molecule, with a couple of minor switches at the tail end of the chain. Substance abusers, and children who have been chronically abused, have underlying organic links.

A lot of good information is coming from many fields. Some people believe the psycho-social risk factors are genetic, and some believe they are environmental or sociological. Other people believe poor parents cause these problems through lack of discipline. New research is telling us that discipline is learned by age four or five. Treatment after that age tries to change the behavior—a very different concept. Some psycho-social factors may be hostile families, domestic abuse, or a constantly enraged or alcoholic parent. My parents have passed on. One of the reasons I became an expert on substance abuse and violence is because I grew up in a home with an alcoholic Dad who used to beat my Mom. I grew up going to sleep at night or waking up in the morning not knowing when it was going to occur again. I was in a lose/lose situation. One morning I intervened when he was going to beat her, and he never beat her again. I helped Mom, but sure alienated Dad for a long time thereafter. We tried as a family to find help, but none was available at the time. Now, mandatory arrests and treatment programs exist. A lot of positive changes have occurred in the last 35 years.

I am under contract to the state of Illinois to develop a program for sexually violent predators. When it was initiated two and a half years ago my assignment was to figure out if we could treat psychopaths with the rest of the population. I reviewed 500 clinical articles. The level of psychopathy among parents is a major psycho-social issue. A parent who was



raised by a very aggressive sociopath, or a primary psychopath, i.e., a criminal, is definitely at risk to perpetuate these behaviors. Overcrowding, family size, and lack of bonding to one or both parents are tied to mental health. Economic hardship, or poverty, means a lack of options and early interventions. Child abuse is also a definite risk factor for many disruptive disorders. Research says children witnessing violence as they grow up tend to be twice as likely to grow up to be violent. Gerald Patterson and a colleague researched the impact of family management on the development of mental health and delinquency problems. Their study found that the vast majority of repeat delinquents, three arrests or more, had poor parental supervision. The parents didn't know where the children were and indicated they didn't care. They didn't care about the peer group. They didn't know how to praise or discipline their children. These were families that raised delinquents.

Another intriguing piece is the genetic risk factor. We know that clinical depression in a family is related to the development of mental health problems in children. Treating parents may be out of your purview as juvenile justice administrators, but it's very important to provide or make sure that services are available to the parents if they're not under some form of justice or human services department sanctions.

The interaction between individual differences and developmental changes often determines the ultimate effect on the adolescent. Please read Dr. David Lichen's book called, "The Antisocial Personalities," published in 1995. His issue was criminal justice. He argues that clinicians should go back to using the old terms: sociopath, psychopath, and others. For funding, we use the DSM IV in our reports. I totally agree with his comment because it's much easier to design a treatment plan for a child if we know what's really underlying their thinking. Are they a common psychopath, i.e., a common criminal? Are they character disordered or show character neurosis, low self-esteem, and anxiety disorder? Only one article out of the 500 I reviewed said psychopaths were treatable, and it was shaky at best. And psychopaths toxify the treatment environment. We have to provide some treatment for these young people by court mandate, or to avoid federal court mandate. The main question is, Do we include psychopaths with other kids and toxify the entire treatment system? In my experience one psychopathic child in a treatment program can sabotage every effort you make. I've found almost no evidence of successful treatment for psychopaths. There are special programs for psychopathic juveniles in England, but not one is having any success that I could find. We, as a profession, have to make some very tough choices. What do we do with those children? Luckily, psychopathics are three to five percent of the total population. All it takes is one in a treatment program to ruin everything you're trying to do. Give him individual therapy off to the side. Then children in our groups who are only partially motivated to get better will have a chance.

Seven or eight years ago I put together a two-day course on the effects of divorce on children and their parents. Much of the clinical literature shows that parental death and divorce have major mental health effects on the children. Children from homes with a second factor, such as hostility prior to divorce tend to turn to substance abuse and develop major depression. Parental fighting through the children after the divorce or separation is also a major predictor that these kids will be coming to juvenile detention centers, needing mental health treatment, and exhibiting juvenile substance abuse. A question to ask is, "How

many fights did you witness?" You should see a very strong correlation between the behavior in the home and that of the children.

Two years ago the National Institute of Mental Health (NIMH) published a very powerful study about genetics. It was the findings of a ten-year study looking at the genetic underpinning of major mental disorders. This document is available at the NIMH website. It is a superb piece and well worth looking at. They found there was a likely genetic component to autism, bipolar disorders, attention deficit disorders, and criminal temperament. Dr. Lichen's work, "The Antisocial Personalities," reported 33% of his cases had a genetic underpinning for criminal temperament. The underlying temperament issue was primarily aggression. If a parent is having problems controlling aggression, this behavior will often affect the child who has a genetic predisposition. This is a double whammy, for lack of a better clinical term. A few years ago we didn't have this genetic information.

Over the last ten years I have seen professionals move away from diagnosing learning disabilities to diagnosing attention deficit disorders. Insurance companies started catching on to that, and began denying services. In the last two years, I've seen another bothersome trend. More and more children are being diagnosed with bipolar disorders as a way to access service. This is as close to a crime as we're going to get within the system for this reason: bipolar is a lifetime diagnosis. A bipolar diagnosis will probably move all these young people under the Americans with Disabilities Act. Twenty-five years ago we were taught not to label children. Please think through misusing a diagnosis to access services. I know I'm here with a lot of administrators, you can take that ball and run with it.

The other issue is the child's self-esteem. After a major mental diagnosis, a couple of adolescents have told me, "Oh, the clinician told me he's just doing it so I can get services." What the clinicians didn't tell him was how that diagnosis might affect future employment. We need adequate services. We shouldn't have to manipulate and massage diagnoses to fit current managed care or other Medicaid criteria.

Recently, I walked into a detention center. On any given day about 25 to 28% of their residents have a diagnosis of bipolar disorder. Research data indicates this is a rare disorder for young people, about four to seven percent—the major onset of bipolar is about age 35. The motivation is access to services. The clinicians must consider how this will affect that child at 18, at 25, at 30, etc. It's an issue we need to be aware of.

Traumatic Brain Injury (TBI) is another risk factor. I found a quick screening tool for TBI published by the New York Psychiatric Institute. The five questions take ten minutes to administer and score. A score at a certain point suggests TBI. Children who have head trauma will not benefit from cognitive behavioral therapy, or will not respond as quickly as someone who doesn't have head trauma. Youths with substance abuse will also have TBI-related or TBI-type symptoms. Often these children are treated for depression, impulsivity, or other types of problems. We find also that those who were physically abused develop insecure attachments, psychiatric disorders, post traumatic stress, conduct disorders, and have impaired social functioning.

I've noticed over the years that children who have been physically or sexually abused, or involved in a divorce, will frequently behave "relatively normally" for a year or two. The behavior problems resulting from these environmental stresses tend to hit the child

the third or fourth year. Often in cases of divorce and/or child abuse, the child tries to help out the custodial non-offending parent. The underlying dynamics will ultimately take over. Frequently clinicians miss noting there was a horrible separation and divorce, four years ago. Until we deal with that as a trauma, the child will continue to go back to substance abuse and from there into depression, anxiety, mood problems, and related mental health issues. This link is very important. I understand you don't have a lot of time for full-blown assessment, but look for this link. Juveniles who are depressed act out impulsively rather than dealing with violence, and will self-medicate.

Other research is looking at emotional and physical abuse and the relationships to depression, conduct disorder, and delinquency. Cognitive behavioral therapy and social learning are the two approaches that work the best. There isn't a solid way to assess the effects of emotional abuse. It all depends on the temperament of the child. You can have two children in the same home; the one's whose basic emotional nature is to be shy and more sensitive will be devastated by emotional abuse. The other child, a little more aggressive and assertive, will talk back and not be bothered as much. It's very difficult to prove this because of the temperament issue.

The Surgeon General's report also looked at peer influences. Association with these maladaptive peers can create adverse social outcomes such as delinquency. The interaction of risk factors is the key thing to measure statistically. How do these factors connect with others, ultimately creating the behavior we're seeing? The Center for Disease Control recently suggested a new model program evaluation—the logic model. It insists we try to identify the interaction effects on children and their families.

When we work with someone who has a lot of these factors present, aren't we really within their family, trying to improve the quality of life? How do you measure and evaluate quality of life? It's very difficult. It depends on this interaction effect. About eight to ten years ago the OJJDP started pushing prevention issues. We know our systems can't handle the projected increase in delinquency for the year 2010. (See the OJJDP 1995 report.) They looked with clear focus and said, "We've got to do better prevention." How do we prove that prevention works and enhances quality of life and reduces these risk factors? Suppose a suicide hotline in a rural area gets 100 calls a month. How do we know how many suicides were prevented? We don't. Certain services need to be offered just because they should be. We don't need to evaluate them. Certain programs should be provided just because they should be. Recall the old adage, "If you have to try to explain to someone the nature of God, it's not going to work. You either have faith or you don't." Certain programs need to be there to help improve the social safety net or quality of life, other programs do not. The interaction of the psycho-social risk factors with neurological damage, low birth weight, and others is key.

Stimulus-seeking behavior is a genetic trait and we know its location in the brain. Even in infancy, high-sensation-seekers show low levels of MAO inhibitors. There is an inverse relationship between MAO inhibitors and fearlessness. Programs cannot change biological traits. A high-risk-taker is still going to be a risk-taker. We need to help them direct their energy pro-socially rather than using confrontative forms of treatment such as boot camps. One article I read on anger management suggests a low-fear message approach to dealing with these youth. We don't need to confront them. They know more about their

substance abuse and criminal behavior than we ever will. Psychopaths lack a sensitivity to physical pain—tests have determined they have a low sensitivity to pain. Verbal confrontation does not work with them at all. If that's true, why don't we figure out ways to get to them that are less draining on our staff?

Learning difficulties are tied into interaction. Many of our juveniles have major problems with learning. We put them in a cognitive program, which involves learning, to change their thinking, and then we try to shorten it. In the last 25 years, I've never heard anyone say, "We're taking a training program, and it's so good we're going to add three weeks." Usually I hear, "Well, we don't have the staff to do it the way the research says, so we're going to modify it." I've never seen a program modified to be longer. They're all shortened. So that's a key issue: How long does it take to effectively deliver services to this group?

In 1996, a team of researchers at the University of Texas Medical School at San Antonio found an alcohol-associated gene. The newspapers said, "Alcoholism Gene Found." The researchers said, "Alcoholism-associated gene." The gene is the DRD2A1 allele—allele refers to the gene strand. They found 70% of severe alcoholics tend to have that gene. Severe alcoholics, as defined in their study, were people who had jobs, and relationships but whose health was impacted or their interaction with the criminal justice system was an issue. This study of 29,000 adolescents, looked for a relationship between alcoholism and delinquency. Genetics account for 70% of severe alcohol abusers. It doesn't account for 30%. We need to look at that percentage of alcoholism. That gene also tends to be a determinant of compulsive behavior like gambling, smoking, or drug use. So, it is related to compulsive behavior. A lot of sex offenders have a compulsive disorder. Most people like to use the term "addiction," which I use just for drugs. Underlying this behavior is compulsive disorder.

Because of the human genome project at 12 sites around the world, research is coming out literally hand-over fist. Every month there is new information. This same gene tends to be associated with pleasure-seeking behavior and addiction. A team of people at Harvard Medical School, part of the genome project, said it may also play a role in murder and violence. Subsequent studies have found that it is associated with the most heinous forms of violence. A person in a state of rage might stab someone 20 or 30 times.

Certain people, because of their genetic wiring, coupled with their upbringing, get great pleasure in hurting others, i.e., psychopaths, or sexual sadists. They've merged aggression and pleasure because of the extreme amounts of dopamine released. Our clinical understanding of the most violent and most serious substance abusers is growing. Recent dopamine research says, "If an individual is genetically predisposed for addiction, then in those individuals, marijuana can be addictive." Maybe you have a friend, family member, or client who said they tried marijuana, but they didn't like it. All it did was give them a headache. The answer is that the body is not genetically wired to respond to marijuana with dopamine. On the other hand, haven't you known people who, after one drink of alcohol, had a problem for the rest of their lives? We now know that our brains are wired differently, explaining why certain people like certain drugs.

Marijuana ties into some mental health concerns. One researcher in Utah examined SPEC scans of the brains of chronic pot users. Chronic was defined as a few joints a week, which is low compared to some of our youth. Marijuana is fat-soluble and bonds with the

nerves in the temporal lobe that have to do with short-term temper and irritability. It literally eats holes in the brain, and some people refer to them as "pot holes."

Great strides can be made using this information. Now that the shape of the opiate endorphin and receptor site is known, medical scientists can molecularly design pain medicines that will actually fit into the receptor site but not be addictive. The down side for us is that illegal chemists have the same information and are trying to design drugs that can get us addicted more quickly. How many of you have heard of Nexus, not the hair stuff, but the hallucinogen? It's a designer hallucinogen that allows a person to trip for an hour and a half. If you get home at 3:00 from school and your parents get home at 5:00, just pop a Nexus real quick, have a full blown psychedelic trip, and be relatively normal by the time they show up. A long work lunch break, instead of a martini lunch, can be a Nexus lunch. That's what the designer chemists are doing.

For the first time, a genetic predisposition for violent alcoholism has been found. This predisposition may be a factor of domestic abuse. My Dad was a mellow person when he wasn't drinking and very violent when he was. This pattern is also tied into insulin uptake. My Dad was pre-diabetic. They also found that one out of 30 normal kids have the compulsive gene mutation. The question begging to be answered is, "What is it about the families, other genetic issues, other temperament issues, the neighborhood, the school, and the community that allows these kids to turn out fine behaviorally?" I am definitely looking forward to the answer.

The basic personality structure is locked in by age three, and is modified for the next seven years. The brain continues to grow in most people, increasing roughly 25% from age 10 to age 18. While these youth are in your system, the brain is physically growing in mass and the neurology is changing as they reach maturity. We must try to keep drugs out of their systems and minimize other risk factors. Puberty, when hormones hit, also makes the brain grow its last little piece. I highly recommend a book called, "Change Your Brain." It's written for the lay person. The author is a psychiatrist who works with delinquents and adult offenders. Using a SPEC scan, he was able to include in his book a photograph of the brain of a child on marijuana. I've talked to several groups of young people in the last year and a half, and shown them that photograph, saying, "You're telling me marijuana has no effect. Here's a photograph of a kid's brain on drugs." If nothing else, the jaw drops a little bit, giving you a brief moment to intervene. It catches their attention and that's 90% of the battle when dealing with delinquents. When we get their attention maybe we can do something.

The author recommends psychiatric medication as a first line of defense. I disagree; medication shouldn't be the first line of defense. He also makes nutritional recommendations as a counseling approach. Solid clinical research says there is a major relationship between diet and behavior. The American Psychological Association, has a book called, "Diet Behavior Relationship" that summarizes all of the clinical literature prior to 1999 on how diet affects behavior. The suggestion is that a diet with more protein and less carbohydrates will mean fewer behavior problems. He also says it is possible to use diet alter brain chemistry for the violent person and the substance abuser. His study confirms what five or six other researchers have found—that children who are violent tend to have increased problem-solving ability. One aspect of cognitive therapy is called negative self-talk: "I'm no good, I'm worthless." The client looks for examples in their environment to prove that. Our job as

clinicians is to break that negative self-talk, and intervene with some positive reinforcement. Depressed juveniles or adults both can have this problem. Prozac tends to under-stimulate that part of the brain and correct this problem. Medication in certain situations can make a difference.

There maybe an increase or decrease in activity in the left temporal lobe, the area damaged by marijuana. People who want to dispute the addictiveness of marijuana say, "Marijuana can't be addictive. I've quit several times for a month." Marijuana is fat-soluble; it takes 28 to 35 days to get out of the body. I wonder why they could quit any time they wanted to for four weeks? That's when the final withdrawal symptoms will kick in. Clinical research now supports the fact that they feel awful for five to six weeks. Aggression and irritability increases. You get the opposite effect of being high. They have a short fuse. In forced detox, expect clients to act out in four to six weeks.

The limbic system is the seat of emotion. Our moods and anxieties are housed there. Youth who tend to be violent, have disturbances or increased activity in that area of the brain. During the last five years, we've learned more about the human brain than in the whole course of history. In the next four years, we're probably going to learn much more. The challenge to all of us is to try to stay current. Thank you.

Gender Specific Interventions that Work with Detained Mentally Ill Juveniles

LaWanda Ravoira, DPA

President and CEO, Pace Center for Girls, Inc., Jacksonville, FL

I am the President and CEO of Pace Center for Girls in Florida, a non-residential community-based program. We have 17 programs and currently serve about 3,000 girls a year in a day treatment and in a transitional services program.

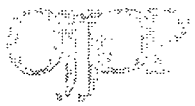
My topic is intervention for girls in a gender competent way. The gender competency strategies that will be discussed here do not cost money to implement and apply to all programs. It's a different way of training and developing staff. When you develop programs or direct dollars to different programs, be sure that they provide gender competent services and use these strategies as part of their programs.

First, we'll take a look at what's happening in this country in girls' programming. Over the last ten years we've seen an 11% increase in young men entering the juvenile justice system, compared to a 23% increase for girls and young women. Now, we know that young men still make up the greater part of the population in numbers. When we look at the dramatic increase in girls entering the system, we must all be alarmed and recognize that we have to do something to stop this trend.

The second trend is the criminalization of girls and young women. What we are seeing behind the offenses that bring girls into the system follows several pathways. The first pathway has to do with assault. As in the past, the majority of assault and battery charges are family-related incidents of assault. A daughter hits a mother or a step-mother or a father or a step-father. Those things used to be handled in family court or as domestic violence issues. Now, they're being handled in criminal court and the girls are ending up in institutions or in the juvenile justice system.

The second pathway for girls into the juvenile justice system is through drugs, often selling drugs. When we look behind these charges, there are two important issues. The gateway is typically involvement with a male partner, often much older, perhaps as old as 45 to 50. The girls become involved in dealing drugs as a way of pleasing the male partner.

These critical issues are based on victimization of girls, and girls' tendency to please the males in their lives.



The third path for girls to enter the system is through offenses. Girls are being charged with far less serious offenses than their male counterparts. We are not comfortable with girls acting that way. We still live in a society that believes girls should act like girls, so we have far less tolerance for girls who are acting out than we would for young men.

We live in a society where girls are caught between a child's world and an adult's world. Too often we see girls as adults and forget that these are girls who have lost their girlhood or they have never experienced the safety of girlhood. Society reacts to these girls by labeling them as bad, mad, or sad. Past presentations mentioned the labels we give to adolescents in the mental health facility. Labeling falls into three areas for girls: they're bad, or they're mad, or they're sad. The girls we work with in the juvenile justice system have multi-layered and cumulative losses over time. Their lives have typically been defined by loss and by giving things up.

They have lost their self-esteem. Until the age of eight, girls have very high self-esteem. They're willing to take risks and they feel good about themselves. When puberty starts, girls' self-esteem plummets. They feel really awful about themselves and they're less willing to take risks.

Girls have lost their educational and vocational opportunities. We live in a world where girls are still not given equal access to math, science, and technology. We know that these are fields where there are long-term self-sufficiency opportunities.

Girls have lost their health, their houses, and control over their bodies. One in four

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Dr. Ravoira is a national and state conference presenter on a wide variety of concerns related to at-risk girls. She also serves as the Board President for the National Girl's Caucus, a national membership organization whose mission is to focus national attention on the unique needs of girls and young women who are at risk or in the justice system in order to create change.

Prior to her tenure at PACE, she was the Director of Program Services for the National Network of Runaway and Youth Services in Washington, D.C. Additionally, she served as an administrator with Covenant House/Florida, Ft. Lauderdale, an international child caring agency that provides residential and non-residential services to homeless and runaway youth. In this position, Dr. Rivoira was responsible for the administration of the residential and non-residential programming for males and females, including the adolescent pregnancy and parenting program. Previous experience includes working as a social worker with inner city youth in New York City with Catholic Guardian Society. Dr. Ravoira authored *Social Bonds and Teen Pregnancy* (Greenwood Publishing, 1992); *National Girls Caucus* (Journal of the Office of JJDP, VI, #1, 1999) among other publications and has extensive teaching and research experience. She holds a Doctorate in Public Administration, Master's in Allied Health, and Bachelor's in Sociology.

girls grows up in this country being sexually abused before they've reached their 18th birthday. Studies show that anywhere from 50 to 90% of the girls that we see in the justice system have been chronically sexually abused by someone they trusted.

Girls have lost their sense of home and permanency. They've lost their trust and their faith. For my doctoral dissertation, I interviewed about 400 homeless and runaway girls who were living on the street. Each one of them shared with me that every day they prayed. Everyone of these girls had a profound belief in God. However, when society labeled them as bad girls, which meant they'd had sex, they felt they were no longer welcome in their church of origin, and they had to abandon their faith. We need to look at that as a society.

Girls have also lost their credibility by being labeled. You're not going to hear me labeling girls today. I'm going to simply talk about girls. They've lost their roles as caretakers, a critical component in the lives of girls. We've been taught to be caretakers. We've seen our mothers, grandmothers, and other women as caretakers. Girls who enter the juvenile justice system have lost that role. They've often lost their children.

I want to look at three different areas in developing programs and services for girls. One is the six developmental domains that are critical to the lives of girls. The second is the gender competency strategies put out by the Valentine Foundation that relate to each of the six domains, and the third is concrete program ideas. None of the things cost extra money.

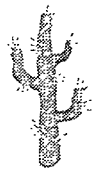
The six major developmental domains for girls that must be addressed in every program—individualized or case plan—are these: physical, emotional, sexual, intellectual, family and relationships, and spiritual.

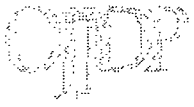
The first domain is the physical. Adolescence is a time for girls in which the body is changing. She's having extreme hormonal shifts. She's trying to understand the role of menstruation, which continues to be a mystery for adolescent girls and often for adult women. She's dealing with mixed messages from the media. Everything she's listening to—music, magazines, movies—basically say women should be on the receiving end of violence, or should be sex objects. This is very confusing for adolescent girls.

Earlier, the role of nutrition was discussed. For girls, nutrition is critical. Often girls are living on Diet Coke and potato chips, when their bodies are growing and all of these things are happening. Girls learn to self-nurture in very negative ways. We grow up in a society where we are not valued as females. So we see eating disorders, drug use, and sexual acting out. Eighty percent of all high school girls in this country are practicing unsafe dieting practices. We are given images that we must be thin and have unrealistic body types. From the very beginning we reject our bodies. We see girls using over-the-counter diet pills as well as skipping meals, which further add to poor nutrition and development.

Primary healthcare issues are critical and are often neglected as girls grow up and when they enter the juvenile justice system. Why is this critical? The leading causes of death for women in this country are cancer, heart disease, and AIDS. These all stem from behaviors that begin in adolescence, but we continue to neglect primary healthcare issues. Most of the young women that I work with in the state of Florida have never had a physical or even seen a doctor.

We recently completed some research at the National Council on Crime and Delinquency. One of the girls told us, "I got arrested again to go back to detention, because I knew I had an STD, and if I got to the detention center, they will get me to medical care."





Think about that. That shows the strength that girl has. She's learned how to manipulate a system that continues to victimize her. She can't access primary healthcare except at the one place that's been consistent in her life, the detention center.

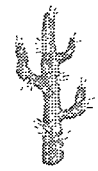
We talked before about sexual abuse and the high levels of stress that results. During adolescence, the impact of family and dysfunction within the community have extreme consequences for girls. They internalize problems and try to fix them. This has long-term health consequences on a developing body that we must address as girls go through the system.

Valentine identified the number one gender competency strategy for girls. We in the juvenile justice system must provide a space that is physically safe. Girls must be removed from those who depend on them and from the demands of adolescent males. Co-ed facilities hamper the treatment process for girls. Sound and sight separation is not enough. They know the guys are over there and the attention is over there, it's not on themselves. Girls need a place where they can simply concentrate on themselves.

I do want you to understand the role of self-medicating in the area of physical health. Girls' use of substances is very different from young men's. For young men the use of substances is risk-taking behavior. Girls use substances to self-medicate, to deal with depression, fear, and other personal issues. When we remove the substances, we have to be ready to deal with the clinical depression that girls often exhibit in our programs. Typically, we remove the substances and then wonder why the suicide ideations, attempts, or rate go up for girls. We've not replaced them.

One thing I hear when I go around the country is, "I would rather work with ten guys than one girl." Here are some reasons they tell me. "Girls are emotional." I say, "Yes we are, and isn't it a wonderful thing?" So let's own up to that. "Girls are quick to pick. They pick, pick, pick, pick at one another." I say, "Yes." As adults we need to realize who taught her that, because we did. I'm talking to the women now. We taught them well. "Girls speak without thinking." Well, sometimes we do. This is not necessarily a negative thing. What we need to do is help girls voice their emotions. We often neglect helping girls do this. "When girls feel trapped they run." Help them reframe that into, "If my life has been one of victimization and, sexual abuse, and I run, it's a healthy response for me in a world that's not giving me any other response." My personal favorite is, "Girls are manipulative." I love that. I say "Yes, yes, we are very manipulative, and what a skill that is." If we want to, we can all be manipulative. We like to say, "We have good negotiating skills." Well, I own it for what it is. We all manipulate. We need to help girls learn to manipulate or to negotiate a system, which strengthens their ability to survive.

Why do girls have these issues? This is what we see that makes us crazy. When we look behind the issues, we find girls who come to us after years of sexual abuse and victimization. They're using substances as a way to deal with this. Too often we detox them without considering the ramifications. I'm not advocating that girls use drugs. We have to be aware that girls are self-medicating as a way of survival. If we reframe that from a strength-based treatment modality, we can see girls wanting to be healthy. They want to survive. That is a strength we can build on. Girls come to us with qualifying disorders. The hardest thing that we deal with at Pace is clinical depression, even after years of dealing with gender specific issues.



Girls are often the victims of rape and date rape. Girls do not define date rape as victimization. They carry with them—"I caused it." Date rape, being raped by someone that you know and trust, is a chronic issue for girls. Another issue is sexual harassment that occurs not only on the street, but within the facilities that we're running. We don't define sexual harassment as sexual harassment.

Our staff see the emotional components for girls and often don't know how to deal with them. We're quick to label, as opposed to looking at the dynamics behind the emotional issues. Domestic violence may be one.

The strategies that we recommend differ a little from the other speakers here. We must find the healthy and lovable part of every girl we serve and reframe it. Don't stay stuck in the old mindset. Reframe the behaviors and find the part of her we can nurture to grow in a different direction.

Interventions must be strength-based rather than-deficits based. See the runaway, quick to pick behaviors as survival skills. Do not personalize. At Pace, we believe in the treatability of every girl. Trust takes time to develop. For girls, trust is a major issue after years of victimization. Girls need time to talk. I had an opportunity to do some work in a detention center. The girls would come home from court, and be out of control at dinner time. They had not been given time to talk when they got back from court. Everybody was talking during the evening and midnight shift. When we changed the schedule and gave them 15 minutes to talk with a case manager before going to dinner, the behavior at dinner changed. They need time to talk because girls use language very differently than young men.

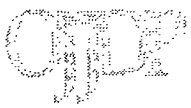
Staff and volunteers must be willing to be change agents. When we work with girls, we must be aware of our own values. We must make them explicit. We must use ourselves as a model for change. This is a key element in training staff. These are the most critical gender competent strategies.

How do these translate to a program? The first thing we do at Pace is have each girl plant seeds. They can watch the cycle of life and nurture growth. This has a parallel to their own lives. They all start with an "I'm a Girl Worth Watching" scrapbook because no one has ever told them they're worth watching. This scrapbook allows the girl to leave behind anything from the past that she chooses not to bring forward. Her life starts as of this day. What she puts in it defines who she is.

Another strategy is giving voice to emotions and modeling that all emotions are acceptable. Girls have been taught that being emotional is a negative thing. Staff have been taught to help girls give voice to their emotions.

The next domain is intellectual. Every program must deal with the intellectual part of girls and recognize that there can be abstract days and concrete thinking days. Girls come to you with an unfair perception about their academic abilities and their intelligence. We know that girls score much higher in the earlier grades on standardized tests than males do. When they graduate from high school they are scoring lower on standardized tests, because girls buy into, what society tells them: they don't fit in math and science. That's a frightening thing for women's long-term self-sufficiency.

Sexual development is also a key aspect that we all get very uncomfortable with. Girls get very mixed messages about their sexual development. We grow up in a society that tells us it's much more important to be pleasing to males than to be competent. What we



find with our girls is that sexual acting out denotes a lack of boundaries in their lives. The people in their lives who should have been setting the boundaries are often the ones who are victimizing them. What we see is high-risk sexual behaviors. From a mental health perspective, girls come to us with extreme feelings of shame about sexual development, because of the mixed messages. Staff, because we're all confused about our own sexual development and society's messages about sexuality, reinforce that shame. Staff must be trained about sexual development issues. They can unintentionally reinforce shame when they say, "Why are you acting like that?" Girls come to us who are involved in prostitution because they would rather sleep with a guy in a warm bed than die from the cold sleeping outside. In Florida, the alternative is sleeping on the beach and being eaten by mosquitoes. Staff don't understand that these feelings of shame for girls mean, "I'm flawed." The girls internalize and believe it.

As gender competency strategy, every program must provide girls with information about how their bodies work, pregnancy, contraception, and disease and prevention. We're typically really good with the last part. I call it the disease model of sexuality. We're good at it. We can tell a girl every reason not to have sex. What's equally important is giving girls the opportunity to explore the value and the pleasure of sexuality. Let's not fool ourselves; girls know that it's pleasurable. They've experimented and it hasn't all been a negative experience for them. If we want girls to learn about nurturing and committed relationships, we must be willing to talk about healthy sexuality. We must be willing to teach our staff to have a comfort level discussing this.

We're doing some consulting in staff training in the Level 10 program, the highest level in Florida adult prisons. With the first 25 girls, staff discovered the girls were sexually acting out. They had huge discussions, and expressed discomfort about masturbation. I did staff training about getting comfortable with this. Talk about it rather than reinforce issues of shame. The other issue centers around sex orientation and the values that staff bring which may further emphasize shame. Girls are masters at shame. We certainly don't need it to be part of the treatment process.

The next area is family and relationships, a critical domain for girls. Girls often take on the role of caretaker within their families. When they're removed, especially to institutionalized care, guilt feelings become critical. They feel they are neglecting their responsibilities.

Absence of family also plays a role. Staff need to be trained to understand the importance of family. Too often, I see staff intentionally or unintentionally reinforcing that the families must be no good, because they don't show on Sundays, or never come to visit. The staff get angry at those families. You're further victimizing girls by being so negative about their families. We need to help girls define where they fit within their families. Girls also need to understand peer relationships.

One of the critical strategies is safe space for girls. We have to provide programs for girls that deal with self-mutilation, suicide, etc. Girls need to be safe from other girls. This is very sad to me. Girls do hurt other girls. They must be safe from staff—not in terms of abuse, neglect, or safety—I'm talking about the most subtle level. You, as administrators, must be committed to making sure your staff are not reinforcing what we accuse girls of doing—scapegoating, shunning, and all those quick to pick sorts of behaviors. This is also a

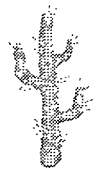
safety issue in a facility. When we have staff who gossip about one another, shun one another, scapegoat one another, sit in treatment sessions and roll eyes and do all the behaviors that we accuse girls of doing, we're being negative role models. When I do staff training, this is where I spend the most time. If girls only see the images on the Rikki Lake Show or the Jerry Springer Show of how women treat one another, and we as staff subtly reinforce that by the way we treat one another, how else are we going to teach them about women's relationships to women? Where are they going to see women that lift one another up instead of pulling one another down? Too often we subtly reinforce that. This is not a safe environment. And in the same place, men and women need to model how men and women get along. If we're not modeling an equal relationship in the workplace, then we're simply reinforcing what girls are learning from the messages society is giving them.

Girls need programs that reinforce their relationships with other women. This is critical for any girls' programming. Females need to be the majority of staff in that facility, trained in gender competency strategies. If you have a girls' program with all male administrators, it simply reinforces that girls can't measure up. They do not have leadership skills. They can't run their own programs. This is not a gender competent program. As women, we must be willing to share our stories with girls. It's not easy. It's not easy being a female, holding a job, and being pulled by family. We have to be willing to make that clear to girls, and to help them learn to manage.

Next is the families and relationships. Your staff need to help girls know who their families are and where they fit within that family, even if both parents are incarcerated. You can help develop family trees and histories. Our girls interview people in their families about the faith of the family. We have our girls, collect favorite recipes of the family. It's just been a wonderful way for girls to figure out where they fit and to explore the values. Our girls also develop friendship chests. In these friendship chests they put the qualities that they would like to have in their friends, if their friends do not currently have these values, it helps girls see why they need different peer relationships.

The last domain is the spiritual domain. I have to tell you my visit to New Mexico four years ago made me a fanatic about the spiritual domain of girls in our program. Prior to that we had been neglectful. Pace developed the National Girls Caucus about five years ago to bring people together who are working with girls. Girls were included also. The girls told us that we told them about everything except their spirituality. We said we were uncomfortable with that. Now isn't that strange? I can stand up here and talk with you about masturbation but I'm uncomfortable with spirituality. I had an opportunity to vacation here in New Mexico and visit a number of the reservations. The one thing that I saw was the attention to spirituality. I went back to figure out how to implement this critical domain in the lives of girls. It is critical to development. It is not built on a specific religious denomination. It helps girls see where they fit in the greater scheme. They know they are part of something outside of themselves. When girls are spiritually empty they cannot stand the quiet. They fill it up with noise, the self-nurturing behavior that is often eating disorders or sexual acting out. Too often the girls we serve are cut off from their families, their faith, and their roots. Any program working with girls must address the spiritual domain.

The Valentine strategy advocate for reaching out and advocating for a girl is very powerful. Every Pace staff member is trained to think, "If that was my daughter being talked



about, what would I want to be said around the table?" We say, when we're discussing a case, if there no advocate for the girl at the table, then we've failed that girl.

We must tap into the personal and cultural strengths girls bring into the program, and acknowledge their souls. I promised a counselor I would tell this story. She was working in a residential program. The girls were cursing, screaming, yelling, and fighting with one another. They had done well in group and wanted to go outside, so she agreed to take them. As they were going outside one girl was still cursing and threatening to beat up another girl. As they were walking, the counselor's dress came unzipped a little. The girl who was still causing havoc stopped, zipped her dress, and said, "Your dress was unzipped." Then she went back to "You M-f'n blah, blah, blah." When staff got back together, this counselor asked, "Which is the real girl? Is it the girl who was the caretaker? She took care of me because she probably didn't want me to be embarrassed." Without thinking, she zipped her dress and took care of her. Is the real girl the caretaker or the angry girl that we see screaming and yelling and causing problems? The real girl, that sacred part of her, is the girl who took time to be a caretaker. If we reframe and see this part of the girl, we'll be able to develop programs to meet her needs.

We have a number of program ideas which provide opportunities for girls to reclaim their spirituality. We bring volunteer projects into the institution, so that girls can learn they have something to contribute. We also help our girls to take an active role in government. Government is one way to teach girls self-determination. They are reading materials through a spirituality book club sponsored by Oprah Winfrey called Spirity Girl. A curriculum introduces girls to meditation, prayer, and daily positive affirmations. Their self-talk always says, "I'm no good. I'm a slut. I'm all those horrible things the world has said I am." Our goal is to replace these with positive affirmations—the use of prayer, regardless of whom you define as your higher power. The girls are taught to write and visualize how they would like their lives to be. With these aspirations it will happen. Please, listen to girls and honor them. Thank you.

Identifying Mental Health Needs in Juvenile Sex Offenders

Dawn Lovelace Klemann, Psy.D.

Senior Psychologist, Beaumont Juvenile Correctional Center, Beaumont, VA

Overall, I'd like to give you a sense of the sex offender population that I work with in the Virginia Department of Juvenile Justice. I'll present a case that captures or drives home the complex issues of dealing with sex offenders. In summary, I'll explain the interventions we use which are targeted to the sex offender. I'll compare the diagnoses of sex offenders and the non-sex offenders.

To begin, let's talk about female offenders. In 1998, we had a little over a thousand female offenders out of a population of 9,000. Out of the 1,059 females, nine of them had committed a sex offense, and six had prostitution charges. In prostitution the victim is probably the female herself. In terms of rape and forcible sodomy, there is a victim out there that they've created. Ten of them had some prior sex offense on record. We don't have a good picture of how many female sex offenders there are. We have this idea that, "woman don't do that sort of thing. They would never victimize their own children or any other child." That incest is taboo, and the idea that female offenders are rare have kept us from having a real picture of the number of female sex offenders. One author estimated that 3.1 million children have been victimized by female sex offenders. That's a huge number, but we don't have a good picture of the actual number.

Because of the small number of females, I'm going to focus on male offenders. In 1998, 10% of our population had a prior record of committing sexual offenses. There were more white than black sex offenders. There was a drop in the middle of 1996, but both populations were steadily increasing, up to 1998. There was a increase between 1993 and 1998, to one out of every 10 offenders being a sex offender. That's significant. The problem was just growing and growing. We had to throw some resources at that population.

Aggravated sexual battery is the most frequent offense, followed by forcible sodomy, rape, and sexual battery. As sex offenders grow into adulthood, we see the severity of the offenses escalate. They start with hands-off offenses—peeping, exposing themselves, and obscene phone calls. Then they go to penetration or hands-on offenses. As their ages increase, so does the age of the victims. They're more likely to engage in penetration. If we can

target these offenders as juveniles, we're going to make a big difference in the number of victims created by adult offenders.

Now, we'll compare the diagnoses of sex offenders to those of non-sex offenders. Sex offenders also have multiple diagnoses. About the same number of non-sex offenders and sex offenders have one diagnosis. About 30% of our sex offenders have co-occurring psychiatric disorders. Overlapping diagnoses make their treatment needs very complex. To provide effective treatment for them, you've got to nail down the mental health issues and the sex offending behavior.

We know males typically have behavior disorders such as attention deficit hyperactivity disorder (ADHD), oppositional defiance, or conduct disorder. The occurrence of ADHD and conduct disorder is very high for sex offenders. The existence of ADHD is not surprising and may limit participation in outside activities, so their social skills are very limited. Their self-esteem is low because they've had such negative experience in school. The horrendous social skills help explain the kind of offenses they commit. Conduct disorder is violation of the rights of others and violation of societal norms or rules. Isn't that exactly what a sex offense is? It's not that surprising that we see conduct disorder in our population.

The occurrence of mental disorders, psychosis, and mental retardation is about the same for the non-sex offenders and sex offenders. The juvenile sex offenders who present with mood disorders seem to be completely untreatable. There's nothing we can do for them because they have self-injurious behavior, don't know how to handle their anger, and have very low self-esteem. All of this interferes with their ability to even begin treatment, much less complete it. These are the juveniles who look untreatable. If we can address these mood disorders before they enter offender treatment, success is more likely.

We do see more psychosis in our sex offenders. Psychosis does not create or promote sexually deviant behavior. That behavior is symptomatic of some underlying disorder, but not descriptive of that disorder. The mentally retarded are housed in another facility and receive modified sex offender treatment. This is a very high risk population. They have severe deficits, especially in their social functioning. They're incredibly impulsive and do not have a good sense of how their behaviors affect other people. They might be sitting on a park bench masturbating and not think anything about it. They do not realize that's completely inappropriate behavior. It's a tricky population.

The existence of substance abuse and dependence, personality disorders, and anxiety is huge in both populations. Some blame their deviant behavior on the substance they were

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using. You have to counter these distortions and defense mechanisms. They explain the substance abuse saying, "Well, I'm better when I'm high. You know, I'll be cool when I do it. I mean, she'll like it. It will increase my enjoyment of what I'm doing. Breaks down my inhibitions. Builds up my nerve to do it." You hear a lot of that from substance users.

The borderline personality disorder group is difficult to handle. They are irrational, impulsive, and unstable in terms of their relationships with other people. If you look at these characteristics and those of sex offenders, they fit together very well.

Anxiety disorder has an interesting role in sex offenses. Obsessive compulsive disorder (OCD) causes fantasies to become incredibly sadistic. The fantasies are more excessive than they might be otherwise. The offenders perseverate and may start compulsively masturbating, or act out other sexual behaviors. If you appropriately medicate, and use adjunct treatment that focuses on the OCD, you'll be able to break part of the cycle. They will not be able to move forward, actually offending somebody. They won't be as sadistic and obsessive.

A large number of psychopaths have a suicide ideation. These behaviors begin with incarceration. You should expect to see some depression symptoms. They've lost complete control of their environment. They have no idea what they're walking into. They don't know if they're going to be raped in the course of their stay. They have a lot of grief about the fact that they will no longer be able to engage in sexually deviant behavior. Isn't that something? Just like any other addict, they want to quit. They know it's bad. They know it's wrong. But the idea of letting go is frightening. "What am I going to have? Why do I have to cope with everything else? You mean I've got to deal with my family problems?" You'll see some of them decompensate when they think about letting go. The other stage at which you'll see a lot of suicidal ideation is when they start to take responsibility for what they have done. They start to really understand the impact of their actions on their victims. They realize how much they've hurt this 3-year-old child by penetrating him. All of the defenses they built to justify their behavior and protect their self-esteem are being torn down. They have nothing left, as far as they are concerned. They have to look at how bad their behavior was. At this point be aware of suicidal ideations. You should assess for suicide all the way through treatment.

What about the number of sexual abuse victims among sex offenders? Don't we assume that sex offenders must have been sexually abused? What the numbers actually say is, those who have been physically abused or experienced neglect are equally or even more likely to be arrested for a sex offense. To me this means, "Yeah, sex abuse is a contributing factor to sexually deviant behavior, but physical abuse and neglect are contributors as well." We have to look at all of these. For some sex offenders, sex abuse is not an issue. Don't assume that they've been sexually abused.

How do you deal with it? I want to give you the details of a case I am working with now. He was committed when he was about 16 for non-forcible sodomy, possession of marijuana, and disorderly conduct. His non-forcible sodomy was a result of having so-called consensual sex with another peer in his group home. At 13, he was charged with raping his 7-year-old sister. This abuse went on for about a year. He was incredibly violent and aggressive. He physically abused her by pressing her face against a heater until it would burn. He put her in a dryer, and turned it on. He wasn't committed on this charge. He was put on

suspended probation, required to do outpatient service, and was separated from the home and the victim. Over the years he was hospitalized about 15 times for suicidal behaviors. He himself had been molested by a peer in the community when he was about ten. At the age of five, over the course of at least a year, he was physically and sexually abused in every way you can think of by his 15-year-old uncle. In addition to that, he found out when he was about ten that he was the product of a rape. His mother had been raped by his uncle by marriage. Instead of putting him in therapy, the family verbally abused him, let him know he was worthless and a curse to the family. His whole existence was disgusting. When he was molested at ten, he was also exposed to a lot of homosexual pornography. So, there is a lot of confusion for him in terms of his sexuality. He had 40 sex partners, male and female, using no protection whatsoever. It looked like a death wish. He was engaging in self-destructive behavior: "Just let me die. Just let me die." He, as I said, was very suicidal, and had a lot of command hallucinations to kill himself and other people. He has multiple diagnoses, and an IQ of 76. Okay, what do we do with a boy like that?

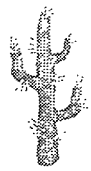
We used the cycle of offending which was discussed before in terms of non-sex offenders. This cycle is specific to the sexually abusive behavior. The first purpose of the cycle is for them to understand the dynamics of, what led up to, what was going on during, and what was going on after their sexual acting out. The second purpose is to identify the ways this child can intervene. There's no question of a cure for this boy. But, if he can identify ways to manage his behavior, to change his way of thinking, to decrease his arousal level, and to have more pro-social behavior, then he'll be able to cope rather than compensate through power control over his victim. We can almost predict how they're going to feel at different points in treatment. We can predict the risky situations for them, when they are out in the community. We know the things they need to avoid and what interventions need to be in place to help this boy be successful.

We start the process by asking, "What are the traumas that this boy has experienced? What are the things that have influenced his acting out behavior? What are the things that have led him to feel powerless, and out of control? What are the things that have led him to feel afraid, to hate?" There were several events for this child. We talked about him finding out he was the product of a rape. We talked about the sexual, physical, and verbal abuse. There were disruptions in his care. He was shuffled among his grandmother, aunt, the group home, and hospitals. All of those were events for this young man and significantly influenced his negative behavior.

Next, we look at his cognitions—the way he thinks about those traumas in his life. How does he perceive these events? When he thinks about himself in relation to the event, he may have thoughts like, "I'm unlovable. I'm worthless. I'll never have anybody. I'm going to be alone for the rest of my life." These are some of the ways that he could interpret these situations cognitively.

The next piece is feelings. He will think about an event a certain way which will lead him to have feelings, which then would lead to some particular behaviors. This boy might feel rejected, abandoned, unloved, afraid, and out of control.

Next, we look for the triggers that are pushing this young man through his cycle. Triggers are the things that put him in a dangerous place. They signal to him and to us that it is time to pull him back. He's on his way through the cycle. One trigger may be substance



abuse or other escaping behaviors such as self-isolation and excessive sleeping. If he sees himself doing that, he needs to get some help. He needs to talk to someone and let them know, "I'm in my cycle." Imagined rejection may be a trigger. When this young man perceives you are rejecting him, he's going to react. It's not going to be pretty. Other things that might trigger him are feeling out of control, pornography, or the availability of a potential victim. If an opportunity is present, watch out—that's going to be the next victim.

Fantasies play a part in his behavior. The fantasies are sadistic and homicidal as well as sexual. He ties aggression and sex together. Isn't it likely that he has flashbacks of the times he was abused? He'll also remember his offenses against others. Many offenders don't know the difference between consensual sex and rape, so we don't know if any of his 40 sexual encounters were rapes. The details are revealing: "Yeah, I pushed her down on the bed and I had sex with her and she loved it, she was making all these sounds." Excuse me, you pushed her down on the bed. All of those sounds she was making might have been her telling you to stop. Offenders don't hear that. When they say they've had a lot of sexual experiences, you need to ask very specific questions. You don't know if your definition of consensual sex is the same as theirs.

His fantasies juice him up. Now he wants to do it. He has made a decision that, "I'm going to act out on somebody." He hasn't figured out who it will be or how it will be done yet. His thoughts are, "They deserve it. If I'm going to be hurt, you're going to be hurt." These are cognitive distortions and defense mechanisms he uses to justify his decision to act out.

Planning and grooming are the next step. The plan may be, "as soon as my Aunt So-and-So leaves, there's my chance. You don't have any babysitter tonight. And all I have to do is wait until she's asleep, and even if she's not asleep, all I've got to do is, I'll force her. So here's my chance, and this is how I'm going to carry it out." His plan is more than coercion and force. He will precede his offense with a lot of verbal abuse, to punish the victim in every way he can. He was incredibly jealous of his sister. He felt that she was loved and everybody hated him. He wanted to punish her for that. He wanted to punish his mother and grandmother by hurting the thing they cherished the most. At this stage, he's going to commit his offense. He also may exhibit self-injurious behavior.

In a secure setting, an offender may not have easy access to a victim. But, if you see him reach this stage you know he will act out in some way. He could attack someone on the dining hall staff when no one is around or upset a peer in the classroom.

After the offense, the thoughts and feelings will be about the same as those at the beginning of the cycle. "Oh, my God, I'm worthless. Oh, my God, I'm the worst person. I deserve to die. I can't believe I did this. No one can possibly love me. There is no chance that anybody would care about me, given the kinds of things that I've just done." He feels useless, hopeless, helpless, alone, and rejected.

How do you deal with multiple mental health issues? To break the cycle, treat the psychotic disorders first. These disorders, such as OCD, DTSD, and paranoia, trigger the decision to offend again. The appropriate individual treatment will enable him to interpret his flashbacks and his environment more realistically. The fantasies will not be severe enough to push him into another offense. The key is to address the psychiatric needs before you begin sex offender treatment. Too often these young people appear hopeless because the

mental health issues were ignored. A discussion of victim empathy may trigger PTSD. Stop and deal with this, and you have a chance of breaking his cycle.

The first step in our program is to screen everyone for major mental illnesses, substance abuse, and suicidal tendencies. Anyone who presents with acute mental illness or is actively suicidal is transferred to a facility where he can receive the appropriate care. Make him safe first and then deal with the psychiatric needs before the sex offender treatment.

The young man in question had 15 hospitalizations before he was committed. The diagnostic center hospitalized him twice because of suicidal behavior. He was transferred to our facility after the second 30-day treatment and placed immediately into the special needs unit. This is a six-bed unit with one psychologist responsible for providing individual and group therapy for these juveniles. The therapy is specific to the individual psychiatric needs. The psychologist works to stabilize the child and consults with the psychiatrist to be sure the medications are appropriate. As he is becoming stable, the sex offender treatment provider arrives to work with the special unit psychologist. My goal for this young man is to make him stable enough to enter the general population, or at least stable enough to tolerate treatment. We worked together to get him there. Every single day he had two contacts. The psychologist and I agreed that she would meet with him if he'd engaged in inappropriate behavior; I would not meet with him. She would address the inappropriate behaviors—He would not get reinforcement from me. After a month, we were able to decrease the number of contacts. When it appeared he was able to engage in appropriate behavior for a reasonable length of time, we were able to move him into the sex offender program. It took him about a year to become stable and consistent in his behavior.

We worked with him in terms of his sex offending behaviors, and his deep depression. This adjunctive treatment dealt with the psychiatric needs and the sex offender behaviors. Now, there is no suicidal behavior and no sexual acting out with his peers. He does complain of voices, but he's learned how to manage. The voices don't have to push him onto behavior. A child like this is going to take a long time to get through treatment. You've got to slow down and allow him to stabilize.

Our program uses a multi-disciplinary team approach. The treatment team consists of a psychologist, a clinical social worker, counselors, the correctional officer, and the teacher. We meet once a month to address treatment needs. We have a proscriptive program and a self-contained program. The proscriptive program is shorter. Offenders are allowed to remain in general population, but they still participate in individual and group sex offender treatment. The self-contained program separates the offenders from the rest of the population. They have their own unit and attend school with only themselves. The juvenile correctional officers (JCOs) are trained to deal with sex offenders, which maintains the treatment milieu. We have one sex offender treatment provider for every 15 juveniles. The provider deals with every issue. How are they doing in school? How are they getting along in the pod? How are they functioning psychiatrically? Are they acting out? Are they victimizing somebody?

It typically takes about 18 months to finish the program; offenders who have mental health issues take longer. We try to have a male and a female on each group therapy team. We role model appropriate interactions, conflict resolution, etc.

In summary, we need to deal with all of the treatment needs of the sex offender. We need to help him understand the dynamics of his cycle, so he can learn personal intervention strategies for each stage. Do not forget to address the concurrent psychiatric disorders through individualized treatment and/or medication. He must be able to tolerate the benefit from the treatment to prevent future offenses.

If you can deal with the underlying issues, the juveniles that look like they could never make it may very well be successful. And we've decreased the likelihood of another person being victimized.

Closing Remarks

Emily Martin

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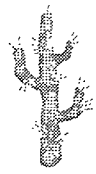
I'd like to bring this conference to a conclusion with several observations. I've been taking prodigious notes throughout the forum and I've learned a lot. This subject took me back to the days when I was a counselor in a family services agency. Counseling was a very productive and rewarding experience for me, but I burned out early. It takes a lot out of you to give the amount of support that dysfunctional families and their children need. I admire tremendously people who are engaged in psychotherapy and direct counseling with youth. I admire those of you in facilities who work with these young people day in and day out, give your best, and then hope for the best when they leave you. You are indeed in a noble profession. The challenges to juvenile justice professionals are probably more significant today than they've ever been. We're dealing with the lowest societal toleration for normal youth behavior that I've ever seen in my entire life. My grandparents and parents would be appalled at some of the things that are identified as offenses and subject matter for the juvenile justice system and the police today. My grandparents had a good sense of what adolescents needed. They understood maturational events, could read potential danger signals, and intervene when necessary. Now, we send them to detention for "normal" offenses. Once they get into our system, they enter a different life. It's almost like being in a maze. Once you put your foot in it, getting out is a major feat. This lack of toleration has increased the numbers of juveniles we're getting. The offenses these children commit seem increasingly absurd. We see many who have no business in our system. Yesterday, the youth we saw at the diagnostic center and the girls' center were the kinds of children you would see anywhere on a residential campus in a middle class school setting. These children, for the most part, were not a danger to themselves or the community. The statistics show girls are most often incarcerated because of assaults and encounters with parents, teachers, and others. Typically, parents bring a girl into the police station saying, "Take this girl, I can't do a thing with her." Unenlightened police officers process these children into the system, particularly if they have no other resources. We know these juveniles are there because of society's inability to accept their effort to try to grow up in a complex world.

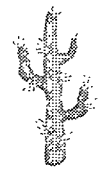


We're currently working on a juvenile offender program. A recent focus group could come to no consensus on a definition of the juvenile sex offender. Much of the data and treatment methodology has come from working with adult sex offenders who are very different from juvenile sex offenders. Professionals also acknowledge the lack of data to clearly establish effective treatment methods for this group. They said, "We have been wrong in defining juvenile sex offenders the way in which we have. The result is community hysteria over the fact that the number of juveniles is increasing." There are a lot of young people being identified as sex offenders who are not sex offenders. They are simply youth who are experimenting with sex, as all children do as they grow up. One person said a two-year-old had been identified and adjudicated as a juvenile sex offender. This child was playing with another 2-year-old, but was actually identified and referred for treatment as a juvenile sex offender. We also remember the six-year-old who kissed a girl. He was adjudicated for sexual harassment. Children do this. There was the girl who was suspended from school for a year for a fight. All of these behaviors would have been considered fairly normal 25 years ago. The family, teachers, and nurses would have dealt with them within the context of the events with supportive responses.

You don't have much control over the adolescents you get. Once you get them you must provide the best possible experience for the period of time you have them. You have a greater impact on who comes back to you than any other part of the system. The activities you develop through the diagnosis and assessment processes allow you to engage the staff, the child, the family, and the community in providing treatment, direction, and support. Follow-up after care will reduce the number of young people who come back. This is particularly critical with minority youth. You recognized the disproportionate number of minority juveniles coming into your system. You also recognized that the offenses don't vary much. You can't control their coming to you, but you can control or influence their re-entry. It's easier to come back than it was to get there the first time. Once you've been there you've been labeled.

I want to underscore the fact that your diagnostic processes, immediate treatment, and follow-up aftercare services are critical. You can make a more significant impact on recidivism rates than any other part of the system.

I'd like to comment on the suggestion someone made yesterday that there are sufficient resources to address the mental health needs of juveniles. I would caution you not to market that concept. Even if it seems true in your community, you need to examine the type of resources available. You need to know resources are adequate to meet the needs you confront. It is not useful to suggest there are sufficient resources. Mental health resources are expensive. I'm a firm believer in the University of Chicago's position that everybody in an institutional setting should be trained to support every child. Very often the cook has more influence on a child's behavior than the psychiatrist. Everybody should be a part of the treatment team. The people who provide the kind of treatment we heard about this morning are high-level skilled professionals, well grounded in the methodology. The diagnosis needs to be based on sound psychological and psychiatric principles. These are expensive services. It is better to err by taking the position that are insufficient resources. We should seek increased resources from state legislatures, county officials, and the federal government. Use the suggestion to combine mental health and juvenile justice requests. Combining your



expertise gives you a stronger selling point. Legislators are not sophisticated in terms of understanding our needs. They have enough knowledge base to understand that some of these juveniles are potentially dangerous. You have experience dealing with these behaviors and mental health has experience dealing with the psychology. It makes sense to combine your resources. A joint program should be more cost-effective. I encourage you to seek out your mental health counterparts and look for alliances. Get rid of the turf issues.

Substantive research needs to be done in the areas of juvenile mental health, their substance abuse, and their brain structures. We need to identify patterns. A lot of work needs to be done. We need to encourage that it be done in a credible fashion.

One of the things I missed seeing is a collective discourse on what works in juvenile corrections. What treatment modalities work? What references can you use to structure, improve, and modify your treatment programs? This is an area which needs some work. We need to pull together, as we did with graduated sanctions. We collected a series of program models which were identified as effective. Juvenile corrections people need to identify what works. Then there will be substantive information available to you.

There's no question that the cognitive approach is a very solid one. There are other treatment modalities that could have significant impact on youngsters. I urge you to construct a treatment modality which focuses on the role of the environment. The environment plays a significant part in response patterns and the ability to modify behavior and sustain new behavioral patterns. We're seeing more dysfunctional families than ever before. Child welfare workers will say a child's home is the best place—you only get one set of parents. You know some of these children have zero parents. To return these children to these families is probably the most destructive thing you could do. All of your work will go down the drain when you put them back in the milieu in which the patterns were developed. I'd encourage you to develop models and approaches that look at the environmental contexts on which these young people operate. I recall the Colombian village where children off the streets structured and ran their entire environment. They created a world in which they could function. The Civil Air Patrol is an example of a youth-driven, youth-managed program that builds leadership skills. The experiences and confidence gained by our young people when they structure their own environments will be invaluable in adulthood. The timespan for developing these skills is short, and dealing with dysfunctional youth is difficult. I think we can make a significant difference. Forty years ago when I was working in the City of Chicago, I can remember the Commissioner of Youth Welfare saying, "What we need is kibbutzes for urban kids." I thought it was a good idea to create a youth village in Chicago, where youth would have the support to develop independently.

Your acceptance that your system must be the default mental health system is testimony to the good people you are and to your commitment to youth. Don't let the mental health system off the hook. In other words, you need to provide the best services you can and you need to structure the services so that they are as responsive as possible, but I don't accept being the default system for mental health quietly. They have a major responsibility in responding to the needs of our youth.

It was also clear to me that we need to support training our staff. Turnover among your staff is extremely high. The salaries that you are able to pay contribute to that turnover. The middle management staff are the glue of your operation. The military has been con-

cerned about the captains, the majors, and the lieutenant colonels who are leaving the military. One reason they give for leaving is loss of confidence in the commanding officers. These are the people who hold the military together. Losing them is very serious. The line supervisors and middle management people in your institutions and in your agencies are critical. Look at ways to support those people, pay them better, help them avoid burnout. These are the people we can't afford to lose. These people have a career investment. If there are things you can do to enhance that sense of investment, they are worth doing. At the other end of the spectrum, try to find monies to raise the salaries of the entry-level folks. You will build a more competent staff.

Finally, we should support replication of the models that work in juvenile corrections. I was tremendously impressed with the program we saw at the girls' center yesterday. My hat is off to New Mexico for innovative things they are doing. I felt good when I saw the enthusiasm and creativity of the director. I felt sad seeing a number of girls who clearly do not belong there. This fact is recognized, and staff response is very nurturing, even at the discussion level. We need to look at the replication of what works.

Our mission is to help young people be the best that they can be and we're the last opportunity they have. I was really heartened because this resonated in all of the questions and discussions during these three days. It's just a pleasure to be associated with you.

It's been great being with you. Have a safe trip home.