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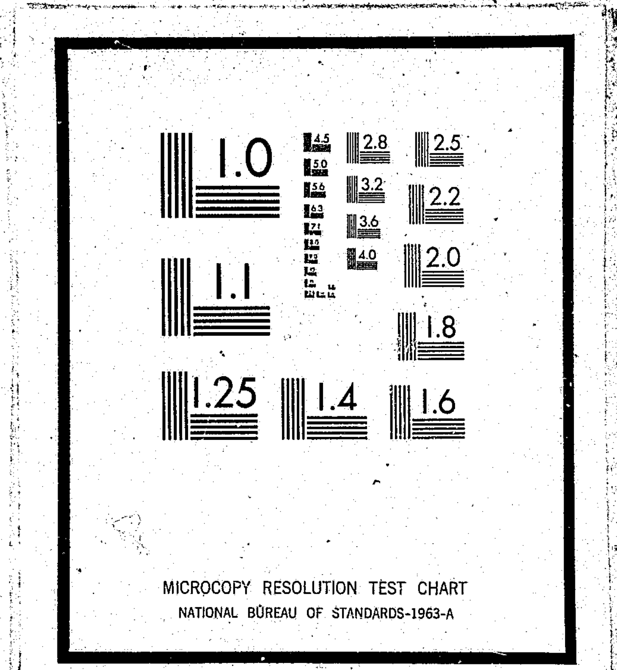

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EVALUATION OF SERVICES OFFERED BY COMMUNITY MENTAL HEALTH CENTERS AND ADAMHA-FUNDED DRUG AND ALCOHOL PROGRAMS TO JUVENILE DELINQUENTS

FINAL REPORT

to

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

Contract No. HSM-42-73-81(OP)

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ARTHUR D. LITTLE, INC.
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I. INTRODUCTION

A. The History and Purpose of the Study

This study was initiated in response to the increasing visibility of the juvenile delinquency problem and the "treatment" issue in the country and a mounting concern about the ways in which that problem is handled on all levels of government. The juvenile justice system and other public and private agencies which are involved with juvenile delinquents are trying to resolve the problem of having to respond to juvenile delinquents in two very different ways at the same time. On the one hand, the juvenile justice system deals with youthful offenders as lawbreakers in need of correction, and on the other hand, it deals with youthful offenders as wards of the court needing counsel, supervision and treatment. The argument continues to rage whether many of those now handled as juvenile offenders should have any contact with the justice system at all. Various possibilities for "diversion," including use of mental health services for that purpose, occasion this study.

The current trends in the handling of juvenile delinquents include the following:

- An increasing pressure to define and protect the constitutional rights of all juveniles who are referred into the various components of the criminal justice system. "Right to treatment" implications are among those that occasion the interest of the public mental health system.

- An increasing pressure in some states to decriminalize the juvenile delinquent and to see his behavior as an indication of his need for help more than punishment—thus, the shift of disposition responsibility from the juvenile courts and probation departments to new youth services agencies, to state welfare agencies, and to children's and family service agencies. (This is not true in all states, however, and in fact in some there is increased processing of youth through the justice system.)

In the midst of these trends, the Department of Health, Education and Welfare (DHEW) and the Department of Justice (DOJ) find themselves faced with new federal law* which will probably increase demands for services for juvenile delinquents. The Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) feels a consequent need to define better the most appropriate activities for its funded programs to carry out in juvenile delinquency in possible support of the emerging Law Enforcement Assistance Administration (LEAA) role. The initiation of this study is one of the ways in which ADAMHA is addressing that need.

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*e.g., Bayh Bill, PL 93-415

The specific purpose of this contract is to determine the nature, extent, and interrelationships of services offered by community mental health centers (CMHCs) and ADAMHA-funded community-based drug and alcohol programs to juvenile delinquents, in order to help determine the appropriate role of mental health agencies in serving juvenile delinquents in the community.

The study has four broad objectives:

(1) To survey the nature and extent of services presently available for juvenile delinquents through CMHCs and ADAMHA-funded drug and alcohol programs. Specifically:

(a) To determine the type and extent of direct services available for juvenile delinquents through CMHCs and ADAMHA-funded drug and alcohol programs.

(b) To determine the type and extent of consultation, technical assistance, education, and in-service training provided by CMHCs, drug and alcohol programs to personnel in law enforcement, the courts, probation, parole, corrections, and other related social agencies regarding issues of the mental health needs of juvenile delinquents.

(2) To provide an analytic-conceptual framework to help understand factors which promote or retard the development of programs dealing with juvenile delinquency within the setting of CMHCs and ADAMHA-funded drug and alcohol programs. Specifically:

(a) To study issues of policy formation, administration, staffing and other relevant contingencies which appear to affect whether or not CMHCs, drug and alcohol programs attempt to address the needs of juvenile delinquents.

(b) To understand better how the needs of juvenile delinquents relate or do not relate to any overall youth focus of CMHC, drug or alcohol programs.

(3) To examine the relationship between CMHCs and ADAMHA-funded community-based drug and alcohol programs with each other and with other community agencies as this relates to the mental health needs of juveniles. Specifically:

To clarify patterns of referral and extent of cooperative planning and policy formation between CMHCs and contiguous ADAMHA-funded drug and alcohol programs in the handling of juvenile delinquents.

(4) To encourage increased provision of needed services to youthful delinquents by CMHC, drug and alcohol programs. Specifically:

(a) To describe innovative, model or promising programs or services now offered by CMHCs, drug or alcohol programs which have high probability of enhancing the mental health of juvenile delinquents.

(b) Based on the experience of these promising programs, to provide a practicum of guidelines, administrative techniques, and suggestions as to how such programs may be initiated in other communities, how resources may be mobilized, and how the various ADAMHA-sponsored programs might coordinate efforts in this area.

(c) To identify a nucleus of skilled and experienced persons within CMHCs, drug and alcohol programs which presently provide services to juvenile delinquents and who will, when brought together, instruct others how to establish such programs.

B. Methodology

1. Survey of the Literature

In an effort to identify what has already been written about juvenile delinquency and mental health, we reviewed three types of literature: (a) legal doctrines, (b) the literature of juvenile delinquency, and (c) the literature of "diversion" theory and practice with particular emphasis on mental health services. Our purpose in conducting this survey was to synthesize the literature from these three different sources in order to create a more common framework for discussing and dealing with the problem of juvenile delinquency as it relates to mental health and related services. The bibliography was compiled from three principal sources: (a) the general knowledge of project team members, (b) a search of journal abstracts, indexes, and bibliographies, and (c) a subject search by the NIMH National Clearinghouse for Mental Health Information. A detailed report of the literature survey is presented in Appendix A.

2. Legislative Review

The purpose of this task was to specify existing mandates of ADAMHA for providing mental health (including drug and alcohol) or related services to juveniles in general and juvenile delinquents in particular. Available secondary materials (monographs, committee prints, reprints of speeches given after the fact, etc.) were reviewed in addition to applicable hearings, speeches, bills, laws, and regulations. Finally, selective non-directive interviews were conducted with some of those who were involved in the development of legislation. A detailed report of this task is presented in Appendix B.

3. NIMH Document Review

The purpose of this task was to review the reporting and monitoring documents of the CMHC, drug and alcohol programs to discover, corroborate or document: (a) the intent of the programs in dealing with juvenile delinquency; (b) projected if not actual activities of the programs related to delinquency; (c) already reported linkages of the programs with each other and with other community agencies and institutions -- particularly in the juvenile justice system; and (d) emphasis on juvenile delinquency services relative to overall program thrust. The documents that were reviewed include: original staffing grant applications; continuation applications; site visit reports; grant award statements; special service project grants; CMHC biometry inventory data; SRI reports from the Alcohol Treatment Centers; and other relevent NIMH documents. The detailed report of this document review is presented in Appendix C.

4. Regional Office Interviews

We conducted telephone interviews with the Associate Regional Health Directors, and occasionally one or two other staff members, of the ten HEW regional offices in order to gain information and insights into the following four areas: (a) the role of the regional offices in both stimulating and/or monitoring juvenile delinquency services among the programs in their regions; (b) the level and nature of any requirements or requests for such stimulation and/or monitoring from Washington; (c) the existence of any relationships between the regional offices and other agencies vis-a-vis juvenile delinquency (e.g., the Office of Youth Development or the Law Enforcement Assistance Administration); and (d) the perceptions of regional office staff about the various levels and types of involvement in juvenile delinquency exhibited by their programs. The results of these interviews are presented in Appendix D.

5. Questionnaire Survey

Two questionnaires were administered to CMHCs and ADAMHA-funded drug and alcohol programs. A short questionnaire was sent to all programs which became operational prior to fiscal year 1973. A more detailed questionnaire was sent to those programs which responded and which appeared to have significant involvement in services related to or indicative of juvenile delinquency. Detailed questionnaires were also sent to a sample of non-involved programs. A complete discussion of rationale, sampling plan, methodology, design, and analysis issues for both of these questionnaires is presented in Appendix E.

6. Field Visits

Visits were made to 25 ADAMHA-funded programs to gain information from key individuals in the programs and in the community on issues relating to the roles of the programs in dealing with the problems of delinquency

in the community. We made pilot visits to one CMHC, one ADAMHA-funded drug program and one ADAMHA-funded alcohol program to assure us that the field instrument and field survey strategy were the best possible. Field visits included 12 CMHCs, eight ADAMHA-funded drug programs, and five ADAMHA-funded alcohol programs (these include the three sites included in the pilot visits). Detailed discussions of site selection, rationale, methodology, and analysis issues are found in Appendix F. Descriptions of program activities for each field site are presented in Appendix G.

7. Conference

In May 1974 a national conference was held on "the role of CMHCs, ADAMHA-funded drug programs, and ADAMHA-funded alcohol programs in the prevention and handling of juvenile delinquency." Speakers and panel members were selected on the basis of their apparently successful involvement in juvenile delinquency from the various standpoints of mental health programs, drug programs, alcohol programs, and the juvenile justice system. The proceedings of this conference are published as a separate document.*

C. A Note on "Delinquency" and Other Terms

Readers will quickly notice our discomfort with the term "delinquency." We use the term quite consistently in this report, and used it extensively during the field work and questionnaire phases of the project, because it conveyed more substance more quickly than other terms. So it conveys what we actually discussed or queried people about.

Only the mental health and substance abuse experts most deeply involved in "delinquency" are firmly aware of terms such as "status offenders": CHINS, PINS, etc.(It should be noted that youth falling under these categories are not considered juvenile delinquents in a legal sense, and in many states cannot be handled under the same programs as juvenile delinquents.) Too few people turned out to recognize the term "juvenile offenders." But everyone seemed to know that a "juvenile delinquent" is "a kid in trouble with the law." Most of the mental health, ATC and drug center personnel directly concerned with "delinquents" are also aware of the significance of court adjudication in defining a delinquent. But using the concept of adjudication to bound the population of "delinquents" is often too limiting. The RFP on which this report is based is clear enough in its concern for "predelinquents," "delinquents," and persons whose behavior would make them "delinquents" if a court chose to adjudicate them as such.

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*Who Can Help? Proceedings of a Conference on the Role of the Mental Health System in Helping Juvenile Offenders. Plog Research, Inc. Encino, California. No. 5005, September 1974.

But the term has a somewhat quaint sound, reminiscent, some told us, of the 1950s. It antedates a great deal of ideology and theory: behavioral, decriminalizing, child advocating and deinstitutionalizing. These ideas affect the strategies of both mental health services and justice system leadership. They also make it difficult to be sure we are communicating what we intend when we talk about juvenile delinquents.

We are in a double bind. ADAMHA programs had difficulty distinguishing status offenders from juvenile delinquents; we grouped all under one term for communication purposes; yet it is the status offenders -- CHINS, PINS, etc. -- who are probably most amenable to help from such programs.

In addition, we have tended to invent abbreviations of our own. "JD" means juvenile delinquent. "JO" is an exact synonym, but stands literally for juvenile offender. "JJS" means juvenile justice system, the local complex of courts, law enforcement, probation, youth services, detention and corrections that is legally mandated to intervene with delinquents and delinquency. We occasionally refer to juveniles referred for service by agencies of juvenile justice as "JRJD's" -- justice-referred juvenile delinquents.

Soon after the beginning of the project, NIMH was reorganized into ADAMHA; hopefully we have been able to achieve both precision and effective communication by referring to the programs under study as "ADAMHA-funded service programs," which include the community mental health centers (CMHCs), the Alcohol Treatment Centers (ATCs), and the drug treatment programs of the National Institute of Drug Abuse (DTPs).

D. Current Delinquency Mandate of ADAMHA-funded Service Agencies and Implications for this Study

At the outset of this study, we understood that none of the agencies under consideration had a legal mandate to do anything in particular for delinquents or about delinquency. Legislative review only deepened and confirmed this impression, which is now further strengthened by the very recent passage of the Bayh Bill (PL 93-415). Because of this fact, there is no reason why any of the programs we have looked at should be condemned or even criticized (let alone praised) for what they have done or not done in the delinquency field. Because our mandate was to find out what is going on, we have developed a certain degree of empathy and enthusiasm whenever we have seen something we thought to be unusual or that in some other way impressed us. But throughout we have attempted to maintain balance and perspective. We intend to imply no invidious comparisons among programs, though mere juxtaposition is bound to suggest comparison. Furthermore, we were asked to locate and study some programs that offered little or no service to delinquents -- so there are program descriptions in Appendix G that are included to shed light on those circumstances under which relatively little juvenile delinquency activity is going on. From our point of view, these programs are inherently just as interesting as the others, and we are equally grateful to all the directors and staff members for permitting us to visit.

The further implication is that this study represents an evaluation, or at least an assessment, of the activity level in delinquency to be found nationally in the three types of programs under study. But it is not properly an assessment of individual local programs, and it would be extremely unfair to treat it as such, given that no specific mandates, or even guidelines, exist to compel attention or action in the delinquency field.

The issue of mandating cuts quite deeply, however, since the mandates that do exist can actually operate to minimize the capability of the programs under study to do anything about delinquency, or much about delinquents. A CMHC is a generic service program with its scope and range defined geographically and in terms of certain sorts of operations: inpatient, outpatient, emergency, etc. Categories of groups at risk, such as delinquents, may be selected for discrete attention, but the natural emphasis of those responsible for organizing a service operation will be on that service and not on particularistic strategies for using the service to accomplish objectives among specified populations. Similarly, the age-specific categories that have been heretofore chosen in the ATCs and DTPs have tended partly or largely to exclude persons of juvenile delinquent ages. Again, the mandate that exists seems to interfere with doing much with delinquents and delinquency.

II. SUMMARY OF FINDINGS

This section presents the major findings of fact from the work of this study. We have grouped the findings in several categories which reflect the key issues in serving juvenile delinquents.

A. Numbers and Types of Clients

- The questionnaire survey shows that fewer than 25% of the clients of CMHCs and drug programs are juveniles; for ATCs, the fraction is less than 5%, and 70% of ATCs serve no juveniles. Around half of juvenile clients in CMHCs and ATCs have exhibited delinquent behavior, and three fourths of those in drug programs have. Only 15% of the juveniles in CMHCs are justice-referred; the fraction is higher for the other two programs.

- The delinquent youth served by ADAMHA programs tend almost everywhere and overwhelmingly to be white males, whereas the demography of delinquency shows more blacks and an increasing number of females. This suggests a basic disjunction between what delinquents need and what these classes of services usually offer. The more clearly the problem is defined as delinquency, the less attracted are the purveyors of typical ADAMHA services.

B. Services: General

- Technically, any service of an ADAMHA program available to juveniles is available to juvenile delinquents, and by and large the services actually provided by ADAMHA programs are open to delinquents.

- Sixty percent of the ATCs offer no services to juveniles, and drug programs are often precluded from offering services to non-drug-using juveniles.

- The higher a program's level of involvement with delinquents (based on whether or not a program targeted its efforts toward delinquents, the level of effort devoted to delinquents, and its initiative in developing delinquency programs), the greater the variety of direct or indirect services offered to delinquents.

- Programs which were most heavily involved in therapeutic counseling with delinquents were: (a) drug programs whose reputations, clients, and staff were familiar and acceptable to juvenile delinquent clients, and (b) CMHCs which chose non-traditional, less formidable settings for counseling (e.g., street, client's home, a house, etc.).

- All three types of programs target consultation and case evaluation for courts and probation toward delinquency or toward agencies which primarily serve delinquents.

- About half the programs reporting through the questionnaire survey provide consultation and case evaluation targeted toward delinquents to courts and probation on a regular and substantial basis (several hours a week).

- Four CMHCs of 13 visited were involved in delinquency prevention. One had a day care program for pre-delinquents; one had a program for unwed delinquent mothers-to-be; one in a poor black and chicano area is heavily involved with the schools; and one has developed a most explicit program for delinquency prevention.

- Only three CMHCs and three drug programs of the 25 visited accepted "community adjustment" or "station adjustment" referrals of early, minor offenders directly from the police as an alternative to adjudication or probationary supervision.

- Only one CMHC of 12 visited had an extensive residential treatment facility for difficult and troubled youth, some of which were delinquent.

- Only one CMHC of 12 field visited provided treatment programs to parolees from the Department of Corrections.

C. Services: Direct

- CMHC, drug, and alcohol programs rarely target direct service programs toward delinquents.

- Three direct services that are actually provided to delinquents are entirely typical of the CMHC and drug program direct services; namely, counseling, psychotherapy, and evaluation.

- ADAMHA programs quite commonly provide evaluation and testing services to courts and probation offices (59% of CMHCs responding to the questionnaire said the bulk of their services for delinquents was psychiatric evaluation). Typically, these services are provided as a result of requests from the courts or probation.

- Evaluation services are needed by courts either to corroborate, justify or test a dispositional decision or to provide information on which to base a dispositional decision. Court officials find these evaluations most useful when they avoid psychological jargon and focus on a description of

the youth and his relationships with others. Discussion of types of dispositions which might be most helpful are also useful if the evaluator (1) knows what is available, and (2) respects the limits on his own knowledge.

- ADAMHA programs strongly committed to juvenile delinquency services are also strongly committed to offering services to police departments (not just courts, probation or corrections). This suggests willingness to try to deal with delinquents at a relatively early stage.

- Pre-delinquency services tended primarily to be continuing, non-psychiatric counseling by a stable person who could serve as an adult role model.

- All programs providing direct services to pre-delinquents were CMHCs (no drug programs or ATCs did so).

- All CMHCs among the field visit sample with programs for pre-delinquents were strongly oriented toward identifying services needed in their community; most were located in communities with real or severe problems of juvenile delinquency, but which the community leadership either minimized or strongly denied.

D. Services: Indirect

- Indirect services of CMHCs, drug, and alcohol programs, according to the questionnaire survey, are targeted toward juvenile delinquents more often than direct services. Roughly 15-20% of programs in all three categories offer court, police or school consultation on delinquency.

- Although CMHC direct services to juveniles are usually created in response to requests from somewhere within the juvenile justice system, most of the indirect service programs encountered in the field study were initiated by the CMHCs, not by the juvenile justice agencies.

- Indirect services provided to schools, courts, police, probation and corrections are usually intended to improve the "system" which has primary contact with and responsibility for, juvenile delinquents.

- In communities with relatively abundant social services, ADAMHA programs very frequently concentrate on indirect services to or on behalf of juvenile delinquents.

- Among the 25 programs visited, six CMHCs, four drug and one alcohol program provided indirect services to schools and other agencies; for example:

  - Consultation with teachers and psychologists on the problems of specific students.

  - Consultation with teachers on methods of dealing with aggressive, disruptive students (e.g., behavior modification).

  - Consultation to parent-teacher-student groups formed to develop drug abuse and/or alcohol abuse prevention programs.

  - Special counseling and/or education programs around issues of drugs, alcohol, and sex.

  - Consultation and education to staff of child welfare and protective service agencies around methods for handling particular emotional and behavioral problems and around referral decisions for treatment.

  - Training and consultation and education with other social service and youth agencies around various issues.

  - Catalyzing or convening efforts to mobilize other agencies to become involved in the problem of juvenile delinquency in the community.

E. Categorization of Delinquents

- ADAMHA-funded programs do not view juvenile delinquents as a category, and therefore do not keep records in ways which make identifying delinquency-related activities easy.

- A few among the large, well-staffed CMHCs are involved in juvenile delinquency programs. But even these CMHCs tend to perceive juvenile delinquents as clients like any other clients, receiving services that are by and large determined by behavior other than delinquency.

F. Diagnosis of Delinquents

- The juveniles served on behalf of juvenile justice are diagnosed appropriate to the program serving them: CMHCs receive clients most often described as suffering from "character disorders," "drug abuse" and "neurosis." ATCs receive primarily "alcohol abusers" and persons with "character disorders." Most drug program delinquent clients are diagnosed "drug abusers."

- Provisions of mental health services to delinquents can change a label of "delinquent" to "sick" or "crazy." That this is not an improvement in most places in the United States is attested to in the field visits.

G. Referral Sources

- Fifteen percent of CMHC juvenile clients are referred by the juvenile justice system; the fraction is somewhat higher for drug and alcohol programs.

- Most justice-referred delinquents come from courts and probation, not from law enforcement or corrections. Early diversion to the mental health system does not seem to occur.

H. Staff

- There is low correlation between staff experience in outreach and program involvement with delinquency; however, most reporting programs do employ staff experienced in outreach, work with juveniles, and work with delinquents. Thus, the capability exists in most reporting programs for work with delinquents.

- Roughly 25% of total staff in outreach, juvenile work and juvenile delinquency work in CMHCs are social workers -- traditionally trained personnel. In drug programs and ATCs, juvenile and delinquency workers tend to be non-traditionally trained; about one fourth are at professional levels and another quarter are at paraprofessional levels.

- Average actual numbers of trained personnel in the program studied are quite substantial (partly because some large programs skew the mean upward). For example, average number of workers trained or experienced with juvenile delinquents is reported as 14 in CMHCs, seven in ATCs, and 14 in drug programs. (Total staff size of CMHCs average under 100 in our sample; the other programs are much smaller.)

- Reported percentages of staff time devoted to juveniles are somewhat loosely allied to percentages of juveniles served. Thirty percent of CMHCs spent staff time proportionally to the client mix. Thirty-one percent spent proportionally more time on juveniles than their numbers dictate. For drug programs, the numbers are 37% and 50% respectively.

- Staff time is distributed among a variety of activities quite characteristic of the overall programs of CMHCs, drug

programs and ATCs but with relatively heavy emphasis on school and court consultation, and in the case of CMHCs and drug programs, psychiatric evaluation.

- Among just those programs offering services to juvenile delinquents, the amount of staff time allocated to delinquents is small: 100 hours a week or less for CMHCs, 50 hours or less for ATCs and drug programs.

I. Relationships with Other Agencies

- ADAMHA programs -- particularly CMHC and drug programs -- that really concentrate on youth and delinquency claim that collaborative planning, service networking and mutual referrals work well. However, limited referrals and limited collaboration tend to be the rule nationally.

- About a third of those programs reporting juvenile delinquent clients are affiliated -- apparently actively -- with other local agencies targeted toward juvenile delinquency, suggesting that they are genuinely built into local processes for coping with delinquency.

- There appears to be a low level of mutual awareness among separately funded CMHCs, drug and alcohol programs in the same locality.

J. Funding

- The overwhelming majority of programs have asked for supplemental funding (91% of drug programs, 81% of CMHCs, and 79% of ATCs). Of these, over 80% have received at least some special funding that appears relatable to juvenile programs. Funding constraints, however, are frequently noted: by 50% of all CMHC programs, 38% of drug programs, and 30% of alcohol programs. The majority of all programs were not receiving earmarked funds: 25% of the programs received juvenile-earmarked funds. Only 9% of reporting programs reported funds earmarked for delinquency services.

K. Legislative Mandate

- Legislation related primarily to youth development, the criminal justice system, or mental health revealed six mandates for ADAMHA.

  - To sponsor and promote research on juvenile delinquency as a mental health problem.

  - To fund demonstrations to apply and test research results and develop generalizable results for delinquency prevention, treatment, and related issues.

  - To see that youth in trouble or delinquents are not excluded from CMHC, drug or alcohol services if they are in need of them.

  - To offer consultation and education to agencies and groups involved with delinquents, either on a case- or program-oriented basis.

  - To offer training to mental health workers and professionals in fields involving youth and youth in trouble.

  - To encourage activities to change community social forces which may contribute to delinquency.

- Nothing in the legislation mandates any portion of ADAMHA to do anything about delinquency directly in the name of coping primarily with the complex of social problems known as juvenile delinquency.

- At the time of the legislative review, it was unclear what agency, if any, at the federal level had a clear mandate in the juvenile delinquency field. With the passage of PL 93-415 in September 1974, calling for establishment of a National Office of Juvenile Justice and Delinquency Prevention, the issues of coordination and responsibility may be ultimately controlled.

III. CONCLUSIONS

This section summarizes conclusions derived from the work on this contract related to ADAMHA program involvement in juvenile delinquency.

A. Conclusions on Factors Affecting ADAMHA Program Involvement

(1) Community attitude toward delinquency affects ADAMHA program involvement. If there is a serious delinquency problem and the local community acknowledges it to be serious, then an ADAMHA program can expect to gain support for efforts to get involved. A determination of the specific nature of how it will be involved then depends on other factors (management commitment, staff training, etc.). But if there is a serious delinquency problem which is being denied by the local community, that denial will limit and may affect the mode of involvement viewed as appropriate for the program.

(2) If there are very few other social service agencies available to provide services to JD's, then the ADAMHA-funded program may be successful in providing direct services (as differentiated from indirect services).

(3) If there is an abundance of social service agencies currently involved in, or potentially available for, providing services to juvenile delinquents, then the most effective approach may be to provide indirect services to these other agencies in an effort to enhance their services to and skills in dealing with juvenile delinquents.

(4) If ADAMHA entertains hopes of collaboration among separately funded ADAMHA-service programs in the same locality, there is a long way to go even to build mutual awareness; respondent programs, when located nearby but separately funded, often do not know details about one another, unless they are networked for a pre-existing purpose. We conclude that they will not collaborate unless actively led to do so; however, collaboration is not essential to juvenile delinquency involvement.

(5) Extensive involvement in juvenile delinquency is not really possible for an ADAMHA-funded program without the development of cooperative relationships with at least one major component of the juvenile justice system.

(6) Cooperation is most easily achieved by ADAMHA programs with juvenile justice systems that believe in diversion of juveniles into treatment programs outside the juvenile justice system. The programs that exhibited the greatest and most varied forms of juvenile delinquency involvement were those that had diversion-prone juvenile justice systems in their communities.

(7) Justice-referred delinquents came from the courts and probation more frequently than from law enforcement or corrections. We conclude that if what is happening is "diversion," it tends not to occur until a juvenile is already well-entangled with the juvenile justice system. The extent of justice system referral activities is not a major factor in determining the extent of program involvement with juvenile delinquency.

(8) We conclude that the most important internal factor affecting a program's capacity for juvenile delinquency involvement is the nature and extent of its youth services. Programs with well-developed services for youth will find it easier either to accept juvenile delinquents into those existing services or to adapt those services to the point where they are responsive to the needs of delinquents. Furthermore, programs with well-articulated youth services (e.g., drug programs) will tend to be more acceptable to delinquent youth than will programs with fewer youth services.

(9) CMHCs seem to be relatively unhampered in their dealings with delinquents, except by factors more or less within their own control. (Funding is a reported constraint, but at least limited funding can be obtained for these purposes, if we are to trust the results of the survey.) Once a CMHC has a positive relationship with the juvenile justice system, then it is a question primarily of internal management desire and competence whether the CMHC serves delinquents.

(10) Programs with staff members with prior experience with juvenile delinquency are also somewhat prepared for JD involvement. We conclude that programs which want to become involved can readily develop their capacities for that involvement simply by hiring staff members with prior delinquency experience. Program staff members who have had experience with juvenile delinquency tend to be strongly committed to staying involved; this experience prepares a program for both direct and indirect service involvement, and can override strong deterrents in the community for developing services for delinquents.

(11) But if staff experience with outreach (92%), juvenile work (91%), or work with juvenile delinquents (85%) is taken as a precondition, then almost all reporting programs have at least these minimal qualifications for taking up delinquency activities. We conclude that nearly all have a basis on which to build; certainly, lack of availability of trained staff is not a major constraint.

(12) Where staff involvement in juvenile delinquency activities occurred only on an informal basis, it was because there were constraints imposed by the juvenile justice system or from within the ADAMHA program (such as preference for voluntary treatment or age restrictions).

(13) Where informal individual staff involvement occurred, it was initiated by staff with previous experience and interest in working with delinquents. Program involvement, however, does not necessarily follow.

(14) We conclude that the greater the extent to which a program is community-oriented, the better prepared it will be for JD involvement. Community orientation requires being intimately aware of and responsive to the problems and human service needs of its community and being strongly connected to the public and private social service system in its community through strong, if informal, links.

(15) On the other hand, programs with strong orientation toward the "mental health clinic model" tend to be ill-prepared for JD involvement. Such programs focus rather exclusively on emotionally disturbed clients, with little interest in community "diagnosis," provide therapeutic services primarily through traditionally trained professionals, and prefer voluntary clients for treatment.

(16) Drug programs target more services toward delinquents, seem to have proportionately more staff competence for dealing with delinquents, and have apparently tried harder to obtain funds for working with delinquents than CMHCs or ATCs; however, they are often prevented by their charters and community attitudes from emphasizing delinquency services (except for delinquents who are drug abusers). In some cases negative community response to their reputations as counterculture agencies and the defensive program policies they develop in response may preclude their being active in delinquency or predelinquency programs, despite their accessibility to young people.

(17) Programs with a strong direct service orientation will be primarily prepared to develop a direct service involvement in juvenile delinquency, unless their model for delivering direct services conflicts strongly with the needs, attitudes and styles of the potential delinquent client (i.e., too much oriented toward psychotherapy and the "mental health" model of clinical services).

(18) Alcohol Treatment Programs relatively rarely serve juveniles, or juvenile delinquents. They were not originally focused on juvenile alcohol abusers. We conclude that as a result they are presently not well adapted to provide juvenile delinquency services. National policy changes and considerable technical guidance would probably be required to bring about significant emphasis on juveniles.

(19) Though many programs lavished hours of valuable time on completing our questionnaires, emphasis on juvenile delinquency is so slight that whatever records the programs keep do not respond well to categories concerning delinquency. Management, administration, funding and reporting requirements all are neutral or work against involvement with juvenile delinquency.

The following table summarizes the factors which tend to enable specific types of involvement with delinquency.

STRATEGIC ELEMENTS FOR PROGRAM INVOLVEMENT IN JUVENILE DELINQUENCY AND THE FACTORS THAT PROMOTE AND/OR ENABLE THEM

Strategy	Factors Generally Promoting/Enabling Strategy
1. Direct Services to Courts and Probation	• Moderate-high JD problem visibility • "Serious" problem perception • Scarce or abundant social service resources • Diversion-prone JJS • Strong program youth orientation • Previous JD experience among program staff • Strong community orientation in program • Strong direct and indirect service orientations
2. Direct Services to Police (early intervention model)	• Moderate-high JD problem visibility • "Serious" perception or denial of JD problem • Scarce social service resources • Non-diversion-prone JJS • Strong program youth orientation • Previous JD experience among program staff • Strong community orientation in program • Strong direct and indirect service orientations
3. Direct Services to JD's via Schools and Other Agencies (early intervention model)	• Moderate-high JD problem visibility • "Serious" perception or denial of JD problem • Abundant social service resources • Non-diversion-prone JJS • Moderate-strong program youth orientation • Previous JD experience among program staff • Strong community orientation in program • Strong direct and indirect service orientations
4. Direct Services to Pre-delinquents via Schools and Other Agencies (delinquency prevention models)	• Low-high JD problem-visibility • "Serious" perception or denial of problem • Scarce or abundant social service resources • Non-diversion-prone JJS or diversion-prone JJS • Strong program youth orientation • Previous JD experience among program staff • Strong community orientation in program • Strong direct and indirect service orientations

TABLE, continued:

Strategy	Factors Generally Promoting/Enabling Strategy
5. Indirect Services to JJS (police, courts, probation, etc.)	• Low-high JD problem visibility • Moderate-"serious" perception of problem • Scarce or abundant social service resources • Diversion-prone JJS or non-diversion-prone JJS • Strong or weak youth orientation in program • Strong or weak community orientation in program • Mental health clinic model orientation vis-a-vis direct services • Indirect service orientation with respect to community problems outside "emotional disturbance
6. Indirect Services to Schools and Other Agencies	• Low-high JD problem visibility • Moderate-serious perception of JD problem • Abundant social service resources • Diversion-prone JJS or non-diversion prone JJS • Weak-moderate program youth orientation • Strong community orientation in program • Mental health clinic model orientation vis-a-vis direct services • Indirect service orientation

B. Conclusions on Effects of Juvenile Delinquency Activities of ADAMHA-funded Programs

N.B. These conclusions are either impressionistic or second-hand. Our activities did not extend to true evaluation of impact, but we visited 25 programs in 16 communities, and have developed several judgments from the experience.

(1) We conclude that those juvenile delinquency services or services for juvenile delinquents that exist in connection with ADAMHA-funded programs attain results no worse than other local delinquency programs. These programs tend to be well-regarded locally. Recidivism rates where reported are no worse than those of other programs. We are quite certain that this subject would be just as difficult to study adequately in the context of mental health programs as in the juvenile justice system.

(2) Indirect services are also difficult to evaluate for results. Our impression is that the results of traditional testing and evaluation services are by and large considered to be mediocre or poor by judges and probation officers — though potentially useful. Training programs seem to be held in relatively high esteem, but this may be due to the fact that training programs are rather rare and are the result of initiatives by talented, committed people who are very sensitive to the needs of those they propose to train.

(3) We noted existence of no programs in the national survey that focused primarily on serving status offenders. We believe that there are probably no data by which to evaluate the experience of mental health programs or sponsorship for helping members of this large group. Non-criminals, in trouble with family, school or other authority figures or institutions, the status offenders would appear to be a primary target for CMHCs wishing to concentrate mental health services on an identified adolescent population at risk, but we find little indication that they are presently so regarded.

(4) The potential scale of services to juvenile delinquents by ADAMHA-funded programs is large enough that total impact could be considerable, if effective programs are developed.

C. Conclusion on the Problems Involved in Changing Institutional Relationships

The three major types of institutions of interest to this study include the agencies of the juvenile justice system (including Youth Service Bureaus), the ADAMHA-funded service delivery programs, and the public schools. All of these agencies have charters which are apparently clear: The ADAMHA-funded programs "take care of crazy people, addicts, and the over-emotional." Police arrest criminals. Courts try them. Schools teach reading and writing. But in all of these agency activities there is also a large, vague area having to do with emotional growth, "social

work," family problems and community conflict. In no case are all of these peripheral activities clear or generally accepted. It cannot be claimed that appropriate processes have been worked out or agreed to in support of their functioning. The ultimate development of such processes probably has something to do with what the mental health agencies can contribute to the whole complex of problems around youth and delinquency. What we have in mind is network-building, catalyzing of appropriate connections among service delivery agencies to get certain juveniles or classes of juveniles cared for, and leadership in changing community attitudes.

D. Conclusions on Program Evaluation Stemming from the Mandate of ADAMHA Programs to Deal with Delinquency

(1) Local grantees may choose to offer services to juvenile offenders as such. When they do, the evaluation issues are these:

- Is juvenile delinquency a consideration appropriate to a particular local project, given its strategy and its service population? To social diagnosis? To treatment? To outcome evaluation?
- How will or does an explicit focus on juvenile delinquency offset the project's chance to be effective in its own right or in overall programmatic terms (e.g., does such a focus help or hinder relating to other agencies)?
- If justice and other state or local social agencies are mounting a diversion strategy, how has the project under study responded? If the response seems inappropriate, what would probably be required to bring about an appropriate response, given a degree of local consensus on the magnitude of the problem and the resources available to cope with it?
- If the project is serving juvenile offenders knowingly, how and in what ways is it attempting to make (or keep) itself competent and current in the field?

(2) In practice, CMHCs vary widely in what they do about delinquency. The mandate is vague. Furthermore, in terms of their function the community mental health centers are in an inherently stronger position not to treat delinquents than are the drug and alcohol programs. CMHCs are not mandated to provide services to delinquents at all. They are mandated to provide consultation and education to courts, probation, etc., but have no funding specifically earmarked for these purposes, unless they have been awarded special grants. Local law and practices vary, but nothing in federal law binds the local juvenile justice system to permit CMHCs access to adjudicated offenders. The drug and alcohol programs will, however, be dealing with delinquents if they deal with juvenile abusers at all, unless decriminalization goes much further than at present. In evaluation terms:

- Do CMHCs refuse to provide C&E services to courts and probation offices?

- Under what circumstances do CMHCs reach out to treat juvenile delinquents, and when do they avoid doing so?

(3) Some clients of CMHCs, as well as some young alcohol and drug abusers, may be neither known to the juvenile justice system nor referred by that system. This has implications for program evaluation:

- Can the program legitimately deal with delinquency in an open way, or must its delinquency-oriented activities be treated as incidental? (Incidental activities can be evaluated as though they were central, but it is generally distorting to do so.)

- If the program can deal legitimately and openly with delinquency (i.e., if the courts refer delinquents who are addicts), how stable and significant are the arrangements that support openness? Under what circumstances must the program inevitably slip into the double bind with respect to delinquency: having to accept all or most juvenile abusers, whether delinquent or not; having to protect its delinquent, but unacknowledgedly so, clients from the justice system, or risk losing the reputation of being a reasonably safe place for juveniles in trouble to go for help?

- How does the program cope with involuntary referrals? Does it have an explicit, constructive approach to treating those who are patients only because of legal coercion?

(4) There are also some general issues for evaluators of CMHCs:

- Does (and how does) the CMHC reference and utilize an awareness of juvenile delinquency as an index to local mental health?

- If the CMHC is receiving federal or other public funds in any way related to juvenile delinquency, how effectively is it using those funds to cope with delinquency or delinquents?

- If the CMHC catchment area is in a Model Cities area, a poverty area, a high crime area, or is the recipient of a children's services (Part F) grant, has there been explicit and convincing attempt to cope with delinquency or delinquents? If not, why not? If so, what is the scope, duration, and relationship to the local system for juvenile justice?

- If juvenile delinquency is a major local concern recognized by the CMHC, and a diversion strategy has gone into effect, how does the CMHC relate to that strategy and is that relationship appropriate?

- If juvenile delinquency is a major local concern, what is the CMHC doing about prevention, how effective are these activities, and what is the proof of the effectiveness level asserted, whatever it may be?

IV. RECOMMENDATIONS

A. Guidelines for Establishing Collaborative Relationships with the Juvenile Justice System

RECOMMENDATION: ADAMHA-FUNDED PROGRAMS INTENDING TO BE ACTIVE IN JUVENILE DELINQUENCY SHOULD FIRST BUILD CONSTRUCTIVE RELATIONSHIPS WITH AGENCIES IN THE JUVENILE JUSTICE SYSTEM.

Because the development of collaborative relationships with the juvenile justice system seems to be a virtual prerequisite for substantial program involvement in juvenile delinquency, we have prepared the following set of guidelines and specific suggestions for how ADAMHA programs can approach the juvenile justice systems in their communities in an effort to achieve such a relationship, and vice versa.

In establishing collaborative working relationships it is useful for both parties to keep in mind some fundamental premises which can act as guideposts for the evolution of the relationship and also provide a sense of where the important priorities lie. As we see them, these premises are as follows:

- That both programs are there to serve juvenile delinquents, though the nature of their service is different and in each case unique.
- That each program has a specialized expertise and a specific set of responsibilities which needs to be understood and appreciated by the other program.
- That it is always necessary to establish agreed-upon ways of working, though these need not necessarily be formal. They must, however, be reasonably explicit. Otherwise misunderstandings and conflicts can occur which can undermine the development and continuance of the relationship.

1. The Basic Process

We see the process of involvement of ADAMHA program activity in the juvenile justice system as having three aspects: (1) familiarization, (2) relation negotiation, and (3) monitoring and ongoing work.

a. Familiarization: "Making Friends"

In this phase, the initiating agency is attempting to do two things: to find out what the other agency is like, how it operates, what its premises and assumptions are; and secondly, to tell the other agency who it is, what it is doing, and what it thinks it can do, in terms of providing collaborative services.

Critical in this familiarization phase is the identification of particular individuals in the target agency with whom the initiating agency feels it can work. The process of becoming and remaining credible cannot be stressed too much.

Second, and equally important, is the identification of the particular times and locations of potential involvements; that is, when and where the initiating agency feels it can best and most strategically make its input in the process. This is partly a matter of convenience, but local mores are also important. We know of some mental health-type services to delinquents that are rigidly scheduled to occur in prescribed neutral surroundings—listed lawyers' offices, Family Service Agency facilities, etc. In other communities, homes, storefronts or other locales may be appropriate. The point is to work it out, be explicit, and pay attention to the impact of particular locations and times.

b. Relation Negotiations

Once both agencies have achieved some understanding of one another, identified particular key individuals, and located those points in each of their organizational processes where they believe they can have the most impact and effectiveness, or where there is the greatest need for service, negotiation of relationship can begin. This is essentially a process of working through what each thinks it can do vis-a-vis the other, all in the light of what both would like to do. This may happen in a rather formalistic way, with people sitting down at a table and talking about what they are going to be doing, or it can happen in an operational and behavioral way, where the negotiation takes place in terms of action.

It is our sense that whatever the means, relation negotiation is most effective when at some point or other, it is embodied in a kind of contract, be that a document or a verbal agreement in which the specific responsibilities and involvements of both agencies are delineated. Such a contract should specify key people, phases and points of involvement, and the outputs of those involvements. There should also be some attempt to delineate client profiles in terms of what sorts of clients will be referred, and what sorts of clients accepted. Initially, these "client profiles" should be seen as experimental rather than definitive: they will probably change over time as each agency becomes more familiar with the capabilities of the other. There should also be a specified feedback process; that is, a periodic re-evaluation of the relationship that takes place. All of these lay the bases for the ongoing work.

c. Monitoring and Ongoing Work

As the relation proceeds through referrals and mutual service, it is important that it be monitored and that regularized feedback activities be conducted. These should be so regularized that they happen regardless of whether or not people think they ought to happen at a particular point.

In other words, a programmed periodicity in a feedback system is preferable to waiting until the crisis has erupted to such a point that people feel they need to sit down and talk about it. Often, such a crisis point may be too late for any useful healing process to be undertaken. Generally agencies are unwilling actively to maintain relations with other agencies that "take their time." Thus it is important to anticipate problems, so that time taken for their resolution is minimal.

Beyond monitoring to assure feedback, there also exists the routine but fundamental requirements normally expected from monitoring: performance management, accountability, discovery of training needs, and procedure improvement.

2. Some Operational Guidelines for the ADAMHA-funded Agency that Wants to Work with the Juvenile Justice System

- Decide to do it and assign someone the responsibility and time for developing the relationship.

- Go to the court and other agencies which handle juveniles, explain your service, try to develop an understanding of enforcement, justice and corrections processes, and explore when it would be most useful to have your agency's involvement. This may be a complex, not an easy process. There are different consequences of mental health involvement at different stages of these complex processes, and these vary from community to community. You must become aware of them, and know the consequences, if you are to make an intelligent judgement as to where you can and will be able provide services. Do not bite off more than you know you can chew. Small successes are infinitely preferable to large failures: minimally they permit the relationship to continue and expand. Failures won't preclude continuance, if they are seen as something which could be expected under the circumstances. If they seem to flow from undeserved arrogance about capabilities or just plain carelessness, it's a different story.

- Clarify and limit the kinds of youth or problems you feel your agency can handle within the spectrum of what it is or whom it is the justice system needs help with.

- Training programs for the juvenile justice system are one of your best entrees and introductions as to what you can do and how you will do it. Try to get one going early.* Shape it around the needs and availabilities of the criminal justice people you are working with. A caveat is necessary here: arrogance on the part of the mental health people that they have the knowledge that needs to be transferred will doom the effort to failure. Admonitions to learn, be modest, etc. hold even more strongly here.

*"Early" is as soon as they want it, maybe not as soon as you want it.

- Identify key individuals as soon as feasible: (1) people you can and want to work with who want to work with you; (2) people in key roles in their own system.

- Whenever possible, work on the turf of the juvenile justice system component: try to have children seen there. Attempt to get specific space allocated for your work in the JJS, even if it is temporarily loaned for two hours a week. Transporting clients complicates things immensely; staff can move more quickly and easily, and doing so may eliminate the need to report on whether or not someone is showing up, etc.

- Establish as early as possible a regular time when you will be at the juventile justice system. Keep in mind that your primary strategic job is to make less work for the juvenile justice system, not more, and to provide specialized services for juvenile justice clients. Be clear about your limitations and what you cannot do.

- Work out "treatment contracts" very explicitly, and involve everybody who can trip things up in negotiating each treatment contract. Sometimes this may include judge, probation officer, parent and juvenile—and even others. Issues of freedom, authority, voluntary treatment, discipline, and just plain fairness will be slipped over unless they are directly dealt with. And if they are missed, the treatment process is likely to be subverted.

- Establish, as early as feasible, a process and time for feedback.

- Keep a log of cases for the court, probation, or whatever element of the juvenile justice system and for yourself. It will function as a way of refining and defining your program.

3. <u>Some Operational Guidelines for any Element of the Juvenile Justice System that Wants to Work with an ADAMHA-funded Program</u>

- Get to know and understand the range of services provided by the community mental health center, drug or alcohol program.

- Go to the agency and explain your agency's processes in as great detail as possible. Familiarize them with the system and where and when their involvement would be most useful to you.

- Be as clear as possible with them about the legal consequences of involvement at particular points in the adjudicatory process.

- Ask them what they can and think they will be able to do.

- Perfect your mutual understanding of who should be referred through exchanging anecdotal cases, and getting their reactions as to which sorts of clients they think they may be able to deal with most effectively.

- Do not let them fall into the loving-mama role or push you into the stern-papa role. Almost any delinquent knows all about how to manipulate that situation.

- Be explicit about the reality of timetables and the consequences for not following them. If you need to have a report back in two weeks, you must be explicit about it.

- Establish a regularized feedback process.

- Involve other youth-serving agencies in your process with the agency. You should not only be referring to the mental health agency, but the mental health agency should also be able to refer to other useful agencies and vice-versa.

- Do not expect all ADAMHA-supported agencies to be willing to provide supervisory reporting on the client. These particular agencies are not supervising your client; what they do may turn out to be diversion from probation, but it is not a synonym for probation. Others will be quite willing and skilled in providing both supervisory and probationary services. Be sure that your contract is explicit as to what has actually been agreed.

- Press them for training programs and case consultation for your staff, once you are convinced they have anyone who can help.

- Establish a liaison person in the mental health center to whom you can relate, someone who can follow your referrals and provide you with ready access to the mental health center's organizational process.

B. <u>LEAA* and State Relationships</u>

1. <u>Funding</u>

RECOMMENDATION: ADAMHA-FUNDED SERVICE PROGRAMS WISHING TO ESTABLISH THEMSELVES IN THE JUVENILE DELINQUENCY FIELD SHOULD ARRANGE TO VISIT THE DESIGNATED STATE PLANNING AGENCY (SPA) FOR LEAA OR THE STATE CRIMINAL JUSTICE PLANNING AGENCY IN THEIR STATES, AND SHOULD OBTAIN AS MUCH INFORMATION AS THEY CAN ABOUT LEAA PROGRAMS AND THE NEWLY AUTHORIZED LEAA JUVENILE JUSTICE INSTITUTE.

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*The Law Enforcement Assistance Administration of the United States Department of Justice.

The most likely current source of funding for innovative programs and for many kinds of current technical information is LEAA. But local programs seeking funding must now approach LEAA through the states. Generally, LEAA money is dispensed through regional units within each state, so it may be necessary to get to know several people in several different offices before actually doing anything with respect to any of them.

2. Organization Relationships at the State Level

RECOMMENDATION: ADAMHA-FUNDED LOCAL SERVICE DELIVERY PROGRAMS INTERESTED IN DEEPER INVOLVEMENT IN THE JUVENILE DELINQUENCY FIELD SHOULD BUILD A VARIETY OF STATE AND DISTRICT RELATIONSHIPS IN ADDITION TO THOSE JUST SUGGESTED WITH STATE CRIMINAL JUSTICE PLANNING AGENCIES.

A number of state agencies may be of importance in building up a reasonable degree of awareness and trust on the part of local service delivery entities wishing to work on juvenile delinquency. These may include a wide variety: Mental Health, Mental Retardation, Youth Services, Children, Vocational Rehabilitation, Corrections, Attorney General, etc.

The point is to seek out all who may be involved, identify the appropriate officials, and keep in contact with a variety of officials and offices. Do not put all the eggs in one basket.

C. Collaboration among ADAMHA-funded Programs

RECOMMENDATION: ADAMHA SHOULD NOT PUT GREAT EMPHASIS ON ACHIEVING COLLABORATION AMONG THE CMHC'S, DRUG PROGRAMS AND ATC'S IN THE JUVENILE DELINQUENCY FIELD (A QUESTION WE WERE ASKED TO STUDY). IN THOSE RARE INSTANCES IN WHICH TWO OR MORE SUCH PROGRAMS EXIST CLOSE TOGETHER WITHOUT BEING ADMINISTRATIVELY JOINED, IT MAY BE POSSIBLE AND DESIRABLE TO ENCOURAGE COLLABORATION, BUT WHEN THERE IS AN ADVANTAGE, REASONS FOR COLLABORATING ARE USUALLY SO OBVIOUS THAT A RELATIONSHIP WILL DEVELOP WITHOUT HELP. IF NOT, THERE IS MARGINAL ADVANTAGE IN HAVING ONE.

1. The Differences among the Programs

a. The Alcoholism Programs (ATCs)

The treatment and prevention of alcoholism has a long and evangelical history going back as far as the temperance movements of the last century. This sense of a need for personal change and commitment lends a particular tenor of fervor and "witnessing" in alcoholism treatment programs (ATCs). Primarily, these programs are oriented toward adults, reflecting legal constraints on drinking (now shifting somewhat), social patterns of alcohol consumption in our country, and the need that NIAAA had in its beginnings to establish itself with a visible

clientele, such as those drunk in public or driving while intoxicated. There is now more awareness of the problem of alcoholism among juveniles and steps have begun to target this population. However, program clientele do not as yet reflect this shift.

Accordingly, two sorts of clients continue to be most commonly seen by the alcohol programs directly funded by NIAAA. They are the "revolving door" alcoholic; that is, persons who come back again and again, go on and off the bottle, and need periodically to be detoxified and helped therapeutically to the extent that it is possible. The other people seen most typically in alcoholism programs are the middle-class, middle-aged problem drinkers who have become alcoholics and are trying to get cured.

The orientations of alcoholism programs are medical in nature: that is, alcoholism is viewed as a disease; the alcoholic is a patient, not a sinner. The staff are frequently ex-alcoholics themselves, tend to be older persons, and act as witnesses for the benefit of kicking the alcoholic habit. These programs have two aspects:

(1) Detoxification: that is, getting off alcohol and going through the withdrawal that is associated with discontinuance of its use.

(2) Staying off alcohol through an act of will, encouraged by personal interaction with people who have also been alcoholics and who have stayed off alcohol. The treatment goal is complete abstinence. The means to achieve this goal are exhortation, group support and witnessing, and a gradual armoring of the will to resist the impulse to have a drink. This is primarily the AA model, and it is one to which all visited ATCs subscribed to a greater or lesser extent.

Frequently these programs saw their immediate goal as being first to detoxify the patient and then to provide him with some transitional therapy, and finally to refer him to AA for the ongoing, often lifelong supportive milieu to help keep him in abstinence.

b. The Drug Programs (DTPs)

Drug programs are relatively new in our country, gaining momentum in the middle and late sixties when the consumption of drugs among our youthful population blossomed into public view and concern. The programs were closely associated with the counterculture and, like the alcohol programs, they drew much of their initial personnel from the user culture, in this case, the streets. Even today, many of the professionals in the drug programs are ex-addicts, although this trend is decreasing both as the drug programs become more broadly youth-oriented and as credentialed young professionals have chosen to go into this particular field.

Like the alcoholism programs, the style of the drug programs is personalistic; that is, a person-to-person relationship is the basis for most therapy. However, unlike the alcoholism program, there is no exhortation involved, and the goal of total abstinence from drug usage is less apparent. Rather, drug programs see themselves in the role of counseling the youthful drug user and looking upon his drug usage as an integral part of a personal and social network, rather than a disease. The issue is how well the user copes with himself, his life, and his drug usage, and what effects it has on him and others.

Drug programs tend to see the youth they are serving as clients, rather than patients. This is even so when those drug programs have as their primary goals detoxification or methadone maintenance.

The style of the drug programs, in terms of their quarters (e.g., storefronts, walk-in, drop-in centers) the clothes and the verbal styles of the people working in the programs, and their general orientation to street, hip and counterculture attitudes and ideals make them very accessible to many young people. Frequently, the programs are treated as a general resource for young people in the communities in which they are located.

c. Community Mental Health Centers (CMHCs)

Community mental health centers also are a relatively recent creation, although they grew out of the classical mental health movement in this country, which began over a hundred years ago with the creation of state hospitals for the mentally ill. The CMHC concept, of course, dates to the early 1960s. Mental health centers bridge the gap between alcoholism and drug programs in terms of the kind of staff they attract. The nature of staffing grants and the medical foundation of the mental health profession has necessitated a high degree of professionalism among staff members of community mental health centers. They all have degrees of one sort or another, many of them beyond the bachelor's and master's level, and they must fit into coded descriptions of their therapeutic capabilities; that is, a clinical psychologist, a child psychologist, a social worker, etc.

The effect of this is to make for fairly strict delineation of staff responsibilities and skills, generally much more so than either the alcoholism or the drug programs. The mental health center staffs have a rather explicit division of labor and responsiblity (especially in the large CMHCs, with professional staff running above 60-80 persons).

As formally credentialed professionals with considerable affinity to the American clinical tradition in medicine, mental health professionals tend to wear suits and ties (sometimes clinicians' jackets) and to operate out of offices, whereas alcoholism and drug workers tend to be more informal in their dress and mannerisms and more comfortable on the street or in the lounge than in the consulting room. Frequently, mental health centers have offices with desks and dictating machines, diplomas on the

walls, and rows of books on shelves. None of these accoutrements are primary characteristics of typical drug or alcoholism programs.

The orientation of the mental health center is toward dealing with people experiencing serious, perhaps even severe psychological problems. While those problems are not necessarily perceived as a disease, the ideas of cure and of relief from pain are paramount in the therapeutic thrust of community mental health center activities. Frequently, mental health centers are housed in large buildings which have about them the aura of small community hospitals and are often located near community hospitals. The terminology used to delineate the various aspects of mental health services further strengthens the impression of disease and medical care: inpatient, outpatient, emergency, etc.

Community mental health center services are acceptable to a segment of the population that countenances the idea of mental illness as a disease susceptible to cure, rather than a curse of which one should be ashamed or a social symptomatology which one should fight. Generally, the populations that seek help from community mental health centers are comforable when interacting in a verbal mode or are by and large in need of only intermittent support, arranged by appointment, a one-hour-a-week therapeutic session or a semi-monthly drug clinic. Inpatient, total care is reasonably rare and kept to short periods. On the other hand, the alcohol and drug programs have tended to start with their clients at a point that is more or less mutually defined as a crisis. A client becoming seriously involved with either one of them gives himself up for a period of time to frequent and often continuous interaction with the staff and other clients of the program. All of these differences bear on the manner in which the programs make themselves available to juvenile delinquents, as well as on their modes for interacting with one another.

Individual CMHCs have historically emerged from a variety of roots. A number are based on the adult outpatient mental health clinics that were founded in considerable number following World War II in many parts of the country, but all have been somewhat influenced by them. One widespread characteristic feature of the CMHC clientele has been its age profile. The 1971 amendment to the law, authorizing special grants for children's services, has been funded, but by no means have all centers responded to this or other urgings to provide services proportionately to children. Existing service models for children still seem to draw heavily on the child guidance clinics of the 1920's and 1930's, or on the model of a specialized children's hospital. Neither of these methods for organizing children's services seems to fit into the "typical" CMHC in a way that easily leads to good organizational relationships, or swiftly results in achieving case loads sufficient to make the overall statistics reflect the profile of the service population or to convince local observers that the needs are met for a range of mental health services for children and adolescents.

Other attributes of the clientele are still harder to keep in perspective. Many community mental health centers have been established in "poverty areas," to meet state priority plans, to qualify for maximum federal funding. This should and does result in including many relatively poor persons in the CMHC clientele. However, those who use CMHCs are probably more prosperous than those who are patients in state mental hospitals, a circumstance also certainly consistent with what was said earlier about the relatively verbal inclination of CMHC clients. There is a pull on the CMHC toward being "middle class" toward serving middle class adults. To the extent that this pull is effective, it reduces the likelihood that a particular CMHC can be of great and continuing use in helping to cope with delinquency.

2. The Extent of Collaboration among the Programs

As can be seen from the above profiles, there are significant differences in clientele, style, attitudes, mode of operation, and locus of operation among the three types of programs visited. These differences do not make for easy collaboration or intensely strong interrelationships among the programs.

In our field visits, we found that the programs that seemed to have the most interrelationships were those that were in fact all operating under one umbrella or overseeing agency; for instance, a county mental health authority or a community mental health center that operated an alcohol treatment unit and drug treatment unit would tend to have more interaction among the drug, alcohol and mental health people than in a situation where each program was funded separately, or through differing sponsoring organizations. In umbrella organizations, there was easy exchange of records as needed, although the staff of each of the programs were fairly specialized and autonomous. In part this reflected a division of labor, and in part the nature of staffing grants which insisted that particular categories of professionals specifically be assigned to granting agencies' programs. Frequently, however, community mental health people interested in youth served on a part-time basis in a drug program. The umbrella mental health agency itself was frequently active in the centralized intake for all clients and referred them to particular programs, as applicable or needed. On the other hand, clients who came into the alcohol or drug programs frequently were not referred on to community mental health centers for mental health therapy; rather, they were dealt with in the specific program to which they had come.

In instances where the three programs were separated, although located in the same community, there was relatively little interaction. Each of the programs deals with a separate public, and the staff differences are significant enough that while not precluding staff interaction, they certainly did not demand it.

Frequently, both the alcoholism program and the community mental health center referred problem-disturbed youth to the drug program which in such a situation was seen as a generalized helping resource for youth in the community. The police generally referred alcoholics to the alcohol program, young people not obviously psychotic to the drug program, and others, as necessary, to the community mental health center.

The results of our questionnaire survey suggest that the questionnaire respondents were not clearly aware of one another's programs unless they were under common sponsorship, knowing neither the funding sources nor the auspice of other programs located nearby.

What is the implication for juvenile delinquency services?

- For ADAMHA-sponsored programs to co-exist in nearby areas is uncommon (one chance in three, in our sample of programs, but more like one in ten in all such programs). Therefore, the issue of collaboration is not very significant.

- The differences among the programs, while over-simplified in our description above, are still real. Juvenile delinquency is a complex phenomenon peripheral to all three types of programs. Unless some form of administrative umbrella exists these differences seem to preclude a lot of interaction in terms of delinquency, which isn't "naturally" a shared concern. Exceptions are on the simple, almost mechanical level, as when an ATC refers all juveniles to a nearby drug program because the ATC simply serves no juveniles at all.

- The complex interactions among programs and the subtle networks that are possible offer opportunities for many sorts of collaboration, including both ADAMHA and non-ADAMHA programs. The reader is referred to Section V.G. and Appendix G for program descriptions of Escambia County, Florida, and Rockland County, New York as examples.

- The concept of collaboration among ADAMHA-sponsored programs is valid in its own terms, where such programs do co-exist. However, the crucial factor is probably the attitude and desires of the responsible local leadership of the juvenile justice system, in particular, judges, chief juvenile probation officers, local directors of Youth Services (if such exist), and police officials responsible for juvenile matters (as well as state level LEAA and Criminal Justice Planning Agencies where this is possible). If these persons are open to services by and interventions from the local mental health and substance abuse programs, they can easily create an atmosphere in which collaboration in juvenile delinquency services becomes just one aspect of a joint effort to revise and revitalize the treatment accorded juveniles in trouble with the law. See Appendix F, Field Visit Data Analysis, pages F-37 to F-39, for evidence that suggests the over-riding importance of

the attitude of the juvenile justice system leadership to all aspects of ADAMHA-service program participation in juvenile delinquency affairs (regardless of who causes these attitudes to be negative).

3. Relations among ADAMHA Programs, the Juvenile Justice System, and Other Social Service Agencies

Historically, there exists a rather strong relationship between alcoholism treatment programs and the courts and police. An emerging and more positive relationship is seen to be occurring among drug programs and the police, Although in some communities mutual suspicions still prevail.

The community mental health center is seen as a possible resource by the police and sometimes by corrections, though not one they are apt to call upon unless in clear-cut cases of mental disturbance. Probation departments and courts, on the other hand, may frequently call upon the mental health center as an additional source of input to help them with the determination for a particular juvenile or adult with whom they are working. Over half of our questionnaire respondents maintain these kinds of relationships, and court-probation consultation is the most common delinquency service provided by CMHCs.

The alcoholism programs seem to receive few referrals who are juveniles or youths. They reason that alcoholism is a more difficult problem to identify in youths than it is in adults. Frequently, the youths have many other problems, and alcoholism is simply one of them. Referring agencies in the justice field tend not to identify alcoholism in youth as a particular problem, even though this is changing, and consequently they do not refer them to alcohol treatment programs but to an agency able to cope with a variety of conditions at once.

With respect to drug programs, social service agencies in the community will frequently refer youth with whom they do not know what to do. While in some senses the drug programs are suspect by other social service agencies in the community, they tend more to welcome youth whether referred, coerced or voluntary, and seem to be able to engage young people in relationships that the young people find strengthening. This is perceived as minimally useful or unique, though not necessarily as trustworthy, by most other community social service agency representatives. (The issue for many traditional agency and law enforcement people is whether drug programs introduce young people to drugs, which may also be a metaphor: Do drug programs reinforce young people in counterculture values?)

The experience of community mental health centers is perceived as more specific and limited primarily to the mentally ill. Confronted with a "delinquent" client whom they have reason to believe is mentally ill, social service agencies will frequently refer that client to the community mental health center. But the criteria and bases for the determination of possible mental illness are somewhat subjective, and certainly variable. The center almost always responds, accordingly, by itself evaluating

the client and deciding whether or not the client is appropriate. If the mental health center determines that in fact the client is not mentally ill, but is either sociopathic or manifesting retardation or deprivation of some sort, it will frequently refer the client back to the originating source or elsewhere. This defensive response to perceived "dumping" tends to reinforce the impression among many social and justice agencies that the community mental health center in their community is unwilling to deal with delinquent clients, though such a judgement at least partially reflects their own unwillingness to deal with the same client in the first place. What seems to be the case is that nobody knows how to cope with the dull (and/or hyperactive), impoverished, antagonistic, drop-out, uncooperative, troublesome juvenile. More than that, few agencies are prepared to try, but there are just enough such youngsters to create super-abundant opportunities for accusations about mutual dumping and rejection.

D. Strategic Models for Establishing a Role in the Juvenile Delinquency Field

RECOMMENDATION: SERVICE DELIVERY PROGRAMS WISHING TO ESTABLISH THEMSELVES IN THE JUVENILE DELINQUENCY FIELD SHOULD WORK OUT A STRATEGY APPROPRIATE TO THEIR CIRCUMSTANCES, REMEMBERING THAT STRATEGIES DO NOT ARISE FULL BLOWN, BUT REQUIRE A PERIOD FOR DISCOVERY, REFLECTION AND ADAPTATION.

1. Preconditions

In addition to establishing functional relationships with the local and state agencies involved in juvenile justice (as suggested in a preceding recommendation), a number of other preconditions for a successful strategy can be readily listed:

- Hire new staff or develop existing staff members already experienced in work with delinquents (and at least mildly committed to addressing delinquency and delinquents).
- Build up overall program for youth (delinquent or otherwise).
- Support community and agency-oriented consultation and education (C & E) (especially in communities served by many social agencies).
- Make sure the entire staff is skilled and effective in giving feedback (on cases, on meetings, on relationships, on referrals) and that feedback and good linkages are stressed in all inter-agency dealings.
- Stress direct or indirect services depending on adequacy or abundance of local agency services.

- In setting up for program planning and implementation, space the milestones according to:

  -- Perceived openness of juvenile justice system to outside collaboration in the diversionary mode.

  -- Extent of local delinquency problem, and whether it is an admissible problem or is denied.

2. Types of Models

The variety of approaches to juvenile delinquency on the part of existing ADAMHA-funded local service delivery programs is already very great and is obviously affected by a local program style of management and organization, the type of community, the services to be provided, etc. Appendices F and G give considerable detail. In this discussion we present only selected outlines and parameters.

a. Direct Services to Juveniles

These services are characterized by outreach, utilization of former delinquents or other non-traditionally trained professionals as front-line counselors, and a step-by-step progression through the hierarchy to people who are much more establishment-oriented. To protect and develop the program, its sponsors should be well accredited to local opinion leaders and power brokers. To acquire clients, the counselors must be acceptable to delinquent youth. Translation among the different sorts of staff people involved at various levels of the program hierarchy may be required, and the working out of tacit but real trust relationships will be essential. Thus, the organizational model is that of a chain composed of unlike links that stretch all the way from the downtown area (service clubs, mayor's office, school superintendent), into the neighborhoods and cultures within which young people live. The end links on the chain represent persons whose work is largely outside the program and whose working "colleague" contacts are primarily with persons other than program staff. But the types of people they work with are obviously very different ("hippies" vs. "straights," the powerless vs. the powerful). The connecting links represent persons whose working colleagues are more likely to be other members of the staff of the program. More than one intermediate link may well be required, in order to provide sufficient translation in communication along the chain.

Connectedness of the chain is the emphasis:

- To maintain coherence internally, despite a range of values, needs and styles that is unusually broad.

- To maintain the external contact necessary to maintain a clientele (contact with young people, contact with juvenile justice agencies), and to maintain a viable program (contact with funding sources, sanctioning agencies, and avenues of legitimacy).

Direct services models are most viable when they fill a service gap that is more or less universally perceived to be a gap. This is why we believe we found direct services programs to juvenile offenders in greater number in areas poorly supplied with social services.

b. Indirect Service Model

The simplest indirect service model is based on one person: a C & E director or his analog, skilled and committed to working on behalf of juveniles to prevent delinquency, to habilitate juvenile delinquents, or to alter the attitudes and practices of the juvenile processing agencies. Such a person clearly profits from the support of a somewhat like-minded program director. But there are considerable benefits in a situation in which the C & E director can take risks authentically on his own, without necessarily committing or compromising his boss. Effective C & E occasionally becomes somewhat upsetting to its immediate beneficiaries. A program director rarely, however, can be the direct instigator of such upsets without making his entire program vulnerable. So we do not recommend that the program director be the operating head of a C & E program in juvenile delinquency, even if he has the time (rare), or the skills (somewhat less rare).

The C & E director or his staff needs to be sensitively effective in two principal areas, which suggest the remaining major elements of the model. He must be able to choose or develop persons to do the work who are both acceptable and effective (implying the freedom and flexibility to experiment and to search outside the program staff itself). He must be active, discerning and persistent with respect to a strategy. How is the consultation or training program supposed to help juveniles? How (and when) will its success be demonstrable?

Many of the indirect services programs observed are the results of ADAMHA-funded program initiative. We speculate that their viability derives largely from the gradual emergence in people who know what they want to do of a genuine capability for knowing what they are doing. It is this combination that enables an explicit strategy to be developed. Managerially speaking, the existence or evolution of a good strategy is often the earliest sign that appropriate dedication and skill are at work: It is what a program director (i.e. a center director) can look for as a test of whether anything is or could really happen in an indirect services program.

c. Diversion Model

Many of the direct services programs observed may be interpreted as attempts at diversion either within or away from the juvenile justice system. Some receive juveniles early (from the streets, schools or police adjustment). Some receive juveniles in the midst of adjudication processes (from court, probation, or youth services). A very few take juveniles who would be otherwise headed for corrections. But they don't often make claims about conducting diversion projects, a reticence we find commendable.

We would propose a model keyed to status offenders (CHINS, PINS, MINS, etc.), children who have committed no crime, but are brought before the court by parents or others as ungovernable, uncontrollable, "impossible to deal with" in one way or another. For the present, the process of petition and adjudication identifies more of these children than anyone can handle, but one of the purposes of the model would be to achieve means for identifying them when, where and if the "status offender" laws are stricken. Alternatively, the effect of widespread community mental health attention to this broad class of children might be to preserve the essence of the legal identification process but to alter drastically and improve the process that ensues.

In either case, the point is to provide families, schools, and children with more dignified means for admitting that there is trouble, that it involves a juvenile and that they would like help. A "status offender" petition is in fact such an admission, but it preserves the self respect of the petitioner only at the price of heaping all the responsibility on the child, thus labeling and denigrating him ("this uncontrollable child . . . ").

What we imagine as a first step toward action is involvement of a mental health-type outreach worker in the investigation (if there is one) that takes place concurrent with or prior to the hearing and disposition on the petition. The purpose would be:

(1) To forestall the petition by working out a generally acceptable alternative that actually addresses key issues in addition to "ungovernability," when these issues exist.

(2) To develop constructive relationships with members of agencies (schools, police) whose procedures can be either part of the problem, or part of the solution, in order to help maximize progress toward a solution.

(3) To identify children with major emotional difficulties and see to it that they are treated, or at least have a genuine opportunity to be treated.

What we propose is less formal than the psychiatric evaluations that generally take place now. It would not be conducted at the mental health (or drug or alcohol) center, but among the agencies of juvenile justice and wherever possible in the neighborhood the adolescent or child came from. It presumes a special perspective, unusual skills, and ready acceptability by judges and probation officers. None but a group of mental health professionals already well established with juvenile justice agencies could hope to succeed. For anyone else to try would be likely, and perhaps rightly, interpreted as arrogance. What we are suggesting is, therefore, a model to work toward on the part of some of those already acknowledged as useful, rather than a plan to be imposed on the mass of CMHCs, ATCs and DTPs.

Later steps could be in various directions, depending on circumstances and on what turns out to work:

(1) Toward facilitating among social service agencies on behalf of individual children for whom an alternative to "status offender" disposition is being worked out (brokerage and child advocacy).

(2) Toward developing one agency (e.g. a youth services bureau) into primacy in the actual practice of working with these children (children who in 1974 would be adjudicated as status offenders and put on probation, institutionalized, etc.). Some CMHCs, at least, do have the capabilities necessary to help another agency establish those kinds of relationships and internal processes that could make it acceptable, effective, able to minimize labeling, or to turn it into a constructive process. Other issues include sensitivity to the agency's being drawn too close to the juvenile justice system, and ability to help the chosen agency avoid becoming too diffuse or fragmented. (The CMHC function would be to provide community and organization development consulting.)

(3) Toward building up some of the capabilities of mental health programs themselves for providing direct services to status offenders (as presently defined) and their families.

There are tentative steps, or perhaps strong movement, in the direction indicated, in those juvenile courts and probation departments now or recently negotiating contracts with CMHCs for services of mental health counselors to be carried out at the court and in the community. What we're suggesting, however, would be full-fledged, deliberate attempts to concentrate on a particular class of minors—the status offender—and to try to develop an effective diversion for them outside the juvenile justice system. But we must emphasize that the model can work only in mental health programs already judged by the agencies of the juvenile justice system to be sophisticated, effective and knowledgeable about juvenile offenders and delinquents.

E. Suggestions for National Program Administrators

1. Areas of Activity vis-a-vis Juvenile Delinquency: "Positioning" the Mental Health Programs

RECOMMENDATION: IF ADAMHA DECIDES TO ENCOURAGE LOCAL PROGRAMS TO WORK IN THE JUVENILE OFFENDER FIELD, IT SHOULD NOT NOW PRESS FOR DIRECT FULL-SCALE EFFORTS TOWARD DIVERSION SERVICES. MOST OF WHAT THE ADAMHA-FUNDED LOCAL SERVICE PROGRAMS CAN READILY DEVELOP AND DO (BASED ON WHAT HAS BEEN DONE) IS BELIEVABLE AND MAY BE ACCEPTABLE AS SUPPORT AND IMPROVEMENT FOR THE JUVENILE JUSTICE SYSTEM, OR AS DIRECT EXTENSIONS AND APPLICATIONS OF WHAT THE ADAMHA-FUNDED PROGRAMS HAVE ALREADY LEARNED TO DO, BUT NOW APPLIED TO DELINQUENCY PREVENTION OR HABILITATION. THE MISTAKE LIES IN LABELING THESE ACTIVITIES AS DIVERSION, THOUGH MANY OF THEM MAY RESULT IN DIVERSION BEING ACCOMPLISHED. TOO MUCH IS STILL TO BE LEARNED AND TOO FEW ADAMHA-FUNDED LOCAL SERVICE DELIVERY PROGRAMS HAVE BROAD AND DEEP CREDIBILITY WITH JUVENILE JUSTICE AGENCIES TO MAKE THE CLAIM OF CURRENT DIVERSION CAPABILITY SUPPORTABLE.

What is the utility of mental health program involvement in juvenile delinquency?

We have not been asked this question but we cannot avoid thinking about it, nor can we see how ADAMHA policy can be made in the absence of theory, as well as factual information, bearing on the point. We came to no categorical conclusions during our field visits. Our impressions are basically positive, however:

- In some cases mental health professionals and workers are more skilled than juvenile justice people in "finding people where they are" (although in some cases the reverse is true). They can offer valuable help to many probation officers, policemen, and youth service bureau counselors. In some cases what these juvenile justice people need to know is how to come across to juveniles squarely and straight, while at the same time discovering and conveying an accurate understanding of "where the juvenile is at" to the juvenile. Unless we want everyone in the juvenile justice system to be selected from the ranks of the formerly delinquent, this kind of training is certainly essential——and training by mental health counseling trainers could still be useful in a probation department entirely composed of former juvenile offenders, since not all are automatically sensitive or skilled in relating to these clients.

- Really significant evaluative material is produced for the courts and probation departments by mental health professionals when they focus on analyzing and reporting the facts of a juvenile's family situation, and how he interacts in various other contexts and situations important to his particular troubles and life style. Well done, these materials help immensely in deciding among available alternatives for disposition. (Poorly done, late, full of diagnostic jargon, or too full of unsupported recommendations, it is a different story.)

- Mental health may have a service role and certainly has a shared developmental role in coping with the presently most ignored problem area of them all: How to positively influence, educate, cure, or change the behavior of the assaultive, disruptive, dull or retarded delinquent and (often) abused, neglected or rejected juvenile who is a failure or an annoyance in virtually every situation he gets into. These persons may or may not be psychotic or neurotic. Even if they are mentally ill, they tend to be terrible patients, frequently being utterly unwilling to relate to any identifiable mental health professional or worker on a voluntary basis, and often acting in very destructive ways. They are the young people on whom everybody has already given up. They now end up in wrecked cars, in prisons, and (especially if female) just disappear from the view of the establishment into the hidden cracks and crannies of society.

- Mental health and drug programs and personnel are doing excellent work with "predelinquents" in several different settings:

  - In-school group rap sessions ("nonpsychiatric counseling") with school counselors and probation officers. This is done with students mostly on the verge of dropping out, often in many kinds of trouble at home and school (if not with the law).

  - Outreach street programs in which "alternative adult role models" are demonstrated by the living and interacting of the street workers.

  - Sponsoring and building up voluntary programs of such types as "Big Brother," "Big Sister," "Volunteers in Probation."

  - Working collaboratively with local police forces.

The ADAMHA-funded service programs are functioning far below potential and capacity in most of these categories (assuming that planned expansion of existing and new CMHCs continues, and realignment of drug programs continues without cutbacks that are lethal). We found relatively few examples of these kinds of activities in our questionnaire survey data. Their presence, of course, was a criterion for visiting some of the field sites chosen. We saw impressive examples in the field. Ten are summarized later in this document. We are sure that mental health, drug and alcohol treatment programs can in certain circumstances be active and effective in juvenile offender programs. There is a great deal to be learned, explored and accomplished in all four of the kinds of activities just cited (improving the interpersonal skills of juvenile justice personnel, doing useful psychological evaluations, coping with the assaultive and disruptive delinquent, working with "bad kids" who are not formally involved with juvenile justice). We believe learning and exploration in these areas should be encouraged.

In certain other categories, the ADAMHA-funded programs are probably doing all there is to be done (where they are effective). What is known if it is used and applied at all, tends to be relatively well-understood. It may not "work," it may be done with less than optimal skill, but at least there is a reasonable degree of common awareness of what is involved:

- Treating emotionally disturbed, adjudicated delinquents or offenders, or offering case consultation on their behalf (persons very similar to other non-offenders in the case load);
- Furnishing technical advice, including detoxification supervision, to police and others in dealing with young persons apprehended "high."

In one other category, we see little activity, little inclination to pick it up, and no advantage: the proposal that mental health-type programs try to take an overall role in serving directly as a diversionary alternative for a wide range of juveniles otherwise headed for various experiences within the juvenile justice system or diversion alternatives outside it. The preceding section on program models suggests a limited and bounded experiment in diversion.

2. Future Funding by ADAMHA, or Encouraged by ADAMHA

Should ADAMHA funds be allocated to juvenile delinquency service activities?

What the ADAMHA-funded programs do best, in our impression, is still only incidentally concerned with juvenile delinquency. What is happening at the federal level seems in any case inconsistent with giving ADAMHA significant operating authority (or funds) in the juvenile delinquency field. But the activities of the ADAMHA-funded local service programs that go well seem to us to deserve support and to deserve and require federal stimulus.

- "Community-oriented" programs should be stimulated, particularly CMHCs that accept a mental health service responsibility toward coping with social problems, have begun to develop potent C & E capabilities, and are able to function effectively as community catalysts, as facilitators among the public and private agencies working on delinquency, and as trainers and skill-builders for juvenile workers (police, probation, voluntary parent substitutes, etc.). ADAMHA, through NIMH, might specially fund on a supplemental basis the C & E functions of those CMHCs (and other programs) that are effectively undertaking these kinds of activities, for at least a portion of the cost of convening, consultation, and curriculum-building. In some cases, specific training programs for school personnel, police, probation officers, YSB counselors and community volunteers may need subsidizing too, at least

at the outset. But these programs should either be dropped or become valuable enough to their recipients that most of the financing could eventually come through channels in other social and governmental systems. Such funding would also couple accountability and utility judgements as closely as possible.

Sponsorship and supervision of each-one-teach-one voluntary networks is, however, a partial exception to the requirement for seeking alternative funding. Where these networks develop on the basis of voluntary, experienced (but noncertificated) counselors delivering direct services to juveniles (and families) (volunteers usually working under the supervision of certificated* professional volunteers) it may be highly appropriate and necessary for the CMHC to share with the court or the YSB in paying for group training sessions, for administration, and for the developmental costs associated with these activities. (See the Rockland County CMHC write-up later in this document for a description of a program which serves as a readily expandable network, able to accept court and probation referrals quickly either to maintain a counseling relationship or to arrange for a more appropriate placement, and which works partly because of its training function for professionals and the dynamics associated with the training function).

RECOMMENDATION: ADAMHA, PROBABLY IN COLLABORATION WITH LEAA, SHOULD INSTITUTE A KIND OF "PERFORMANCE PAYMENT," A SUPPLEMENTAL GRANT OF $25,000 TO $250,000 ANNUALLY, FOR A LIMITED NUMBER (10-50) OF THOSE ADAMHA-FUNDED PROGRAMS THAT DEMONSTRATE THAT THEY ARE USING AT LEAST THE YOUTH-ORIENTED PORTIONS OF THEIR C & E BUDGETS EFFECTIVELY.

The objective is to provide an incentive for these relatively successful and effective programs to continue to evolve their internal capabilities for conducting C & E. This would depend on: (1) Federal policy with respect to future C & E activities of ADAMHA-funded service programs (2) the steadily evolving role of LEAA-funded state operations as a possible source of funds and stimulus for arranging for local groups to carry out much of the community catalyzing function included here; and (3) the growing capability of ADAMHA central office and regional office personnel to gather and apply the results of local success appropriately to other communities in programs of the kind described in the next recommendation.

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*MDs, PhDs, or others actually already licensed to do treatments, and qualified in law to supervise (and train) others who are not entitled to the same independence.

RECOMMENDATION: ADAMHA, THROUGH THE NIMH CENTER FOR STUDIES IN CRIME AND DELINQUENCY, AND IN ASSOCIATION WITH THE NATIONAL INSTITUTE OF JUVENILE JUSTICE WHEN AND AS IT IS FORMED, SHOULD UNDERTAKE DEVELOPMENT OF A TRAINING STRATEGY OR PROGRAM (INCLUDING TRAINERS) TO BE MADE AVAILABLE THROUGH THE HEW REGIONAL OFFICES TO STATES OR TO VOLUNTARY GROUPINGS OF CMHC'S AND DRUG PROGRAMS, AND PERHAPS TO ALCOHOL TREATMENT PROGRAMS AS WELL.

This technical assistance effort should offer cognitive and experiential aid toward coping with the following processes:

- How to develop constructive relationships with agencies and personnel in all parts of the juvenile justice system: what these persons do, the backgrounds they come from, the concerns and suspicions they may have about mental health services, the actions that can be taken to build credibility with those in the juvenile delinquency field, evaluation of the relationship, etc.

- How to develop and carry out evaluations useful to juvenile courts, probation agencies, and youth service bureaus: negotiating mutually acceptable content, working out deadlines and cost factors, agreeing on the uses for which case evaluation documents are appropriate, coming to grips with differences in "treatment" objectives.

- How to work out effective relationships with probation officers (or judges) and with nonvoluntary clients referred by juvenile justice as emotionally disturbed offenders: "contracts," responsibilities of each party, appropriate treatment processes, outcomes, reduction of role conflicts to manageable differences.

- How to develop a C&E activity among community agencies involved in delinquency: community diagnosis, specific problem identification, mobilization of community effort, role(s) of juvenile justice system, role(s) of private agencies, role(s) of CMHCs, creation and financing of acceptable coordinating processes, developing an adequately flexible set of direct services for juveniles that function in the diversion mode.

- How to develop a street, school, or other outreach program for "predelinquents": accessibility to juveniles; side-tracking the mental health stereotypes; protecting the necessary levels of activity from each other--these include variants from conservative/establishment/law-and-order to counterculture, all of which have to be involved; financing outreach programs; monitoring and evaluation; measuring progress and justifying outcomes; risks necessary and unnecessary.

Without considerable work to develop and test such a training program, it is uncertain whether it should be a few days, short term, serial, single

shot, etc., how its actual costs of implementation should be borne, who should be encouraged to take part, or whether it would be sensible to offer it as one package or several. We believe this is something which could be developed immediately, for offering to interested users in 1975, as a step toward enabeling local programs to become better able to build capabilities in juvenile delinquency or to discover if they can meet the prerequisite conditions for undertaking work in this field as new funds become available for diversion through LEAA.

Essentially, the curriculum would be derived from the experiences of the programs that have already become heavily involved in juvenile delinquency. The users, for the most part, are presumed to be programs not involved heavily at this stage.

RECOMMENDATION: ADAMHA AND/OR NIDA SHOULD CONSIDER HOW TO MAKE INDIVIDUAL STAFF MEMBERS OF THE DTP'S MORE AVAILABLE FOR DELINQUENCY SERVICES. IN MANY CASES THIS MEANS SOME KIND OF INDIVIDUAL PARTICIPATION, SINCE THE DRUG TREATMENT PROGRAMS THEMSELVES MAY NOT BE CAPABLE OF ACHIEVING READY ACCEPTANCE IN THE DELINQUENCY FIELD.

The future national attitude towards drugs and drug treatment programs remains somewhat in doubt; federal policy may have to be equally tentative. We note, however, that where the NIDA-funded drug programs have community support to do so, they tend to become active in reaching out to troubled young people, whether addicted or only tempted by drugs. They often receive juvenile referrals from nearby alcohol treatment programs because they have the experience with youth and acceptability among young people. They are generally located in neighborhoods and in quarters in which young people in trouble feel comfortable. In many communities we heard the claim that "the kids have nowhere else that they can or want to go of an evening."

The problem with supporting predelinquency or delinquency services in these drug programs is a value problem:

- They may be viewed by law enforcement and juvenile justice officials as being beyond reach—in several ways "out of control." The ideological differences between more or less counterculture drug program counselors and more or less law-and-order-oriented juvenile justice and enforcement officials lead to this judgment.

- They may be seen as unconscious or accidental recruiters to drug use, which becomes an important matter if "drug experimentation" is seen as natural and rather unimportant by the drug counselors, but represents a likely permanent fall from grace by others.

If the competence of drug counselors is to be used more broadly among juveniles whose drug problems are incidental at most, these counselors should be helped to function separately from the existing community drug treatment programs. This may mean loan, transfer, or "seconding" of staff to other

agencies. It may mean converting some of the present drug rap houses to youth rap houses, probably with funding from non-NIDA sources growing over the months and years ahead, and additional pressure on the drug programs to seek such funding.

The general conclusion, however, is more weighty than the specific recommendation we make for dealing with its implications: (1) The common American attitude toward drug use is still one that makes unthinkable either a direct conversion of "drug programs" to "youth programs" or a generalizing of the function of the drug programs; (2) the skills of many drug counselors with young people are badly needed, and not only with respect to drug addiction. If the drug programs face cutbacks, let us be sure to find a way to use these skills constructively.

We recommend that NIDA management, the NIMH Center for Studies in Crime and Delinquency, and appropriate LEAA officials work out mechanisms and plans for meeting the varied contingencies that could arise out of decreased drug program funding and increased federal focus on juvenile justice and delinquency prevention.

3. "Mandating"

RECOMMENDATION: WE SEE NO ADVANTAGE IN EXPENDING ENERGY IN STRIVING TO CHANGE THE CURRENT MANDATE. MORE MEANINGFUL SUPPORT THAN MANDATE CLARIFICATION IS DESCRIBED IN SUBSECTION 2 JUST PRECEDING.

Should ADAMHA mandate particular activities in the juvenile delinquency field?

The question almost answers itself in terms of current activities, federal trends, and professional preferences of local program leadership. A mandate would be merely disruptive if unaccompanied by extensive funding and technical assistance. Congress seems to be clarifying the law. A new juvenile justice institute is on the books and at least beginning to be implemented.

The present "mandate" to CMHCs to seek funds for permanent support is about all that is required to permit programs that can, should, and want to become active in juvenile delinquency to learn how to do so.

4. Evaluation Issues and Suggestions about Evaluation

RECOMMENDATION: UNDER CERTAIN CIRCUMSTANCES ADAMHA PROGRAM EVALUATION AUTHORITIES SHOULD EXPECT THE LOCAL SERVICE PROGRAMS TO EVALUATE THEMSELVES AND BE EVALUATED IN TERMS OF DELINQUENCY ACTIVITIES.

So long as there is no federal mandate for mental health and substance abuse treatment programs to do anything in particular about delinquency, it may be fatuous to expect delinquency to figure in the periodic evaluation of these programs. But under certain circumstances, it would be appropriate to include delinquency considerations in program evaluation:

- in high crime areas;
- where delinquency is recognized as a problem;
- where the C&E function in a CMHC is weak or is limited to case consultation and "mental health education";
- where social services are scarce, except for the CMHC, drug or alcohol program; and
- where the program is funded to cope with delinquency problems.

Evaluation questions for program planners or administrators to answer include the following:

- Why and how is delinquency appropriate to the program's overall strategy? Should delinquency be overt in program strategy?
- How does (or would) focus on delinquency affect the program's chance to be effective in its own right and in terms of its major charter?
- How effectively does program management relate to the juvenile justice system and the agencies of general government behind the juvenile justice system?
- How well are services provided to the agencies of juvenile justice? In whose opinion? With what shortcomings? At what cost?
- How skilled and effective is program management in fronting for and training youth or delinquency workers who are credible to youngsters in trouble with the law?
- With what effects (and on whom) are the juvenile delinquency activities of the program being carried out?
- How and with what effectiveness has the program dealt with the issue of "voluntariness" vs. "coercion"?

V. SUMMARY OF TASKS

Section I, B briefly describes the methodology for the various tasks which made up this study. The purpose of this section is to summarize the major content of each of the tasks. Detailed reports for each task are found in Appendices A through G of this report.

A. Literature Survey

The literature survey was an attempt to blend inputs from three fields: legal doctrine, the literature of juvenile delinquency, and diversion theory as related to mental health services. It is divided into three sections:

1. The Parens Patriae State, Diversion and Youth Service Bureaus

The courts have become increasingly clear in defining "treatment" for children to satisfy the requirement to "the right to treatment." But the functioning of the juvenile court system itself is both a violation of civil procedural rights now more or less completely accorded to adult offenders, and appears to be relatively ineffective. Furthermore, the so-called status offenses provide the least debatable instances of juvenile court actions in disregard of basic civil rights and include a high incidence of dispositions that discriminate against broad classes of juveniles.

The efficacy of the parens patriae juvenile court has, however, not really been tested by any research we have found, nor has the potential efficacy of proposed juvenile judicial and rehabilitation systems of civil rights advocates. Nor have labeling theory and differential association theory literally been proved.

Diversion is still another ambiguous concept, seeming to call for reform but not so far implemented intensively, except by the very officials of the courts and probation departments who are accused of causing much of the existing problem. Furthermore, not only are services suitable for functioning in a diversionary mode in very short supply, they also tend to operate in social service networks quite isolated socially and even geographically from juvenile justice networks and are therefore hard to establish. Diversion, however, turns out most commonly to take place in an informal probationary status and is not in fact diversion from juvenile justice. Youth service bureaus may be on the way to becoming another back-door intervention agency in the lives of children, but neither function, accountability, staffing, anticipated results, target populations nor financing of the youth service bureaus is clearly established. Their ultimate effect is uncertain.

Only three central findings clearly emerge from the legal and criminal justice literature:

- diversion has either not really been tried, or it has been used as a device for informal probation; and in neither case is it well understood or adequately studied.

- the function, role, financing and relationships of the new youth service bureaus are unclear; thus their role with respect to diversion and general reform of the juvenile justice system is far from demonstrated

- the doctrine of parens patriae is under severe challenge. If it falls, so may the juvenile justice system as we know it.

2. Dilemmas in Defining and Treating Dangerousness

The strategy of the Juvenile Justice Standards Project is to decriminalize the status offenses, thus reducing the burden on the juvenile justice system simply by redefinition and reduction in the numbers of juvenile offenders. Those who remain will be tried as equals to adults before the law and entitled to counsel and to determinate sentences. Sentences will, in theory, be for the purpose of rehabilitation or overcoming potential dangerousness.

However, dangerousness is a predictive category, related to but not plausibly based entirely on past behavior. It will in all likelihood be left to mental health professionals to decide who is dangerous. The question is whether these professionals can take the risks and responsibilities in making their judgments other than cautiously. Can one take chances with "dangerousness"?

Reversion to the concept of dangerousness is advocated as one aspect of juvenile justice reform, surrounded as it will be with procedural safeguards. Whereas mental health code reform challenges the predominance of the medical profession and psychiatric practice, juvenile reform thinking embraces the mental health professional as the lesser of two evils in relation to court personnel, and just as the criminal justice model, complete with current civil rights, comes to be applied to juvenile justice itself. Behind current research and advocacy to refine and apply the concept of dangerousness therefore lurks the risk that all that was arbitrary, capricious, punitive, and negatively labeling of juveniles committable under the juvenile justice model will be simply perpetuated under a mental health treatment model built around the concept of dangerousness.

3. Community Alternatives to Incarceration

The concept of de-institutionalization leaves those offenders who are dangerous to others still in the institution. It also abandons to the institution those acting-out, rather uncontrolled juveniles who show up as recidivists, incorrigibles, intractables. When retained in the community these persons are really being confined in mini-institutions, even when called "residential treatment centers," another concept for which there are no standard criteria, nor programmatic content, nor agreed set of purposes or types of patients. Regardless, group homes are less costly than institutions to operate, even though the literature shows no clear results except that intensive one-to-one supervision seems to be better. Apart from such considerations, the real question is whether any treatment strategy should be tolerated, except as another means for bringing about basic reform of juvenile justice, since none are demonstrably effective. But there is no guarantee of effective reform in what has been written into the literature so far.

B. Legislative Review

We reviewed the legislation and resulting programs related to juvenile delinquency, mental health, and youth development to ascertain what guidance the legislation offers for ADAMHA programs. Under what circumstances has ADAMHA the mandate or the opportunity to offer services to delinquents or pre-delinquents? Under what circumstances has ADAMHA a mandate or opportunity to offer services related to preventing or reducing delinquency?

This investigation was intended to serve the juvenile offenders evaluation project in certain specific ways:

- To familiarize project staff and ultimate users of the study with mandates in law, as these might constrain the services to juvenile offenders offered by ADAMHA-funded programs. (There is no use in expecting programs to do what is forbidden to them; there is no use in requesting further legislation in a complicated field if authority exists to do what the ADAMHA-funded programs may competently do already.)

- To establish what specific program evaluation questions (if any) flow from the nature of existing legal mandates and associated material.

In this review we sought not only those mandates which affect ADAMHA directly but those mandates affecting other federal agencies dealing with youth development, delinquency and criminal justice. We wanted to become explicit about the possibilities and constraints under which ADAMHA can work without overlapping, duplicating or encroaching on the mandates of other federal agencies.

In our review we examined legislation and programs which were of

(1) historical significance -- illustrated trends in emphasis on youth and delinquency or mental health;

(2) current significance -- programs presently operational which include service delivery;

(3) future significance -- pending legislation which may provide an expanded or shifted focus in the future.

Immediate action, of course, comes only through currently operational programs and presently effective legislation.

The following table lists the legislation selected from our review and the basic purpose or problem intended to be addressed by this legislation.

LEGISLATION SELECTED FROM REVIEW

Public Law	Title	Agency Created or Affected	Purpose or Ameliorative Strategy
79-487	National Mental Health Act	NIMH	Reduce the incidence of mental illness through research, demonstrations and training.
84-182	Mental Health Study Act	NIMH	Create the Joint Commission on Mental Illness and Health to study U.S. mental health needs and resources available.
87-274	Juvenile Delinquency and Youth Offenses Control Act of 1961	HEW/Welfare	Mount demonstrations and provide information and technical assistance to states on control and prevention of delinquency.
88-164	Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963	NIMH	Assist in construction of facilities for offering mental health services to individuals in their own community.
88-452	Economic Opportunity Act of 1964	OEO/Labor	Reduce poverty through federally sponsored programs and thereby reduce social problems caused by poverty.
89-97	Social Security Amendments of 1965	NIMH	One amendment established the Joint Commission on the Mental Health of Children to focus on youth to an extent which the Joint Commission on Mental Illness and Health was unable to do.
89-105	Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments of 1965	NIMH	Provide funds for staffing support in the early years of CMHC development to increase ability of communities to offer mental health services to individuals in their home environment.
89-197	Law Enforcement Assistance Act of 1965	Justice	Provide training for law enforcement and related personnel in an effort to better control and prevent crime.

Public Law	Title	Agency Created or Affected	Purpose or Ameliorative Strategy
89-793	Narcotic Addict Rehabilitation Act of 1966	NIMH	Treatment and rehabilitation of the narcotic addict; viewed addiction as a sickness rather than a crime.
89-754	Demonstration Cities and Metropolitan Development Act of 1966	HUD	Deal with the problems of the inner city with appropriate redevelopment and social programs.
90-31	Mental Health Amendments of 1967	NIMH	Extend funding for staffing and construction of CMHCs.
90-351	Omnibus Crime Control and Safe Streets Act of 1968	LEAA	Established LEAA in the Department of Justice to encourage state planning for improving law enforcement and fund research directed on crime reduction and control.
90-445	Juvenile Delinquency Prevention and Control Act of 1968	OYD (YDDPA)	Companion act to 90-351; authorized HEW to assist local agencies and offer research and training support to prevent and control delinquency.
90-574	Alcoholic and Narcotic Addict Rehabilitation Amendments of 1968	NIMH	Remove alcoholism handling from the criminal justice system and place it in the CMHCs as a mental health problem. Provide network of community-based treatment facilities for narcotic addicts.
91-211	Community Mental Health Centers Amendments of 1970	NIMH	Increase support of mental health activities in designated poverty areas; provide special funds for children's mental health services.
91-513	Comprehensive Drug Abuse Prevention and Control Act of 1970	NIMH/Justice	More focused attack on drug control and rehabilitation; adds abusers to the target population (heretofore only addicts were targeted), and identifies high use areas for concentration of effort.

Public Law	Title	Agency Created or Affected	Purpose or Ameliorative Strategy
91-527	Drug Abuse Education Act of 1970	HEW/OE	Authorizes educational activities for preventing and controlling drug abuse.
91-616	Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970	NIMH (NIAAA)	Establishes a federal agency to mount a focused attack on alcoholism as a mental health problem.
91-644	Omnibus Crime Control and Safe Streets Act Amendments of 1970	LEAA	Emphasizes community-based treatment and rehabilitation programs for offenders — a deinstitutionalization thrust.
92-381	Juvenile Delinquency Prevention Act of 1972	OYD (YDDPA)	Extends 1968 legislation and focuses YDDPA on youth and delinquents outside the criminal justice system; emphasizes prevention.
92-255	Drug Abuse and Treatment Act of 1972	NIMH	Requires CMHC seeking new funding to provide drug treatment and rehabilitation programs.
93-45	Health Programs Extension Act of 1973	NIMH +	Extends funding for 12 expiring health programs (CMHCs are one).
93-83	Crime Control Act of 1973	LEAA/Justice	Requires provision of narcotic addict services by the criminal justice system and, where they do not detract from narcotic rehabilitation services, provides alcohol treatment services. Delinquents are included in target population.

According to the legislation reviewed, the ADAMHA mandate with regard to juvenile delinquency emerges as follows:

Mandate	By whom
Sponsor and promote research on juvenile delinquency as a mental health problem.	NIMH
Fund demonstrations to apply and test research results and develop generalizable results for delinquency prevention, treatment, and related issues.	NIMH
See that youth in trouble or delinquents (insofar as they are part of the eligible population in a catchment area), if they are in need of such services, are not excluded from CMHC, drug or alcohol services.	ADAMHA through regional offices. By CMHCs, ATCs, and drug programs.
Offer consultation and education to agencies and groups involved with juvenile delinquents, either in conjunction with specific psychiatric evaluations or as a more didactic, issue-oriented independent activity.	CMHCs, etc., under NIMH/regional office monitoring
Offer training to mental health professionals and paraprofessionals in fields including youth and youth in trouble.	NIMH
Encourage activities to change the social forces in a community which might contribute to delinquency (community development activities). These activities also may include consultation and education, as well as nationally set policies such as giving priority to poverty areas in funding.	CMHCs, etc., with regional office/ NIMH monitoring

ADAMHA has no mandate to do anything about delinquency directly (i.e., in the name of coping primarily and explicitly with the complex of social problems known as juvenile delinquency). However, its activities interface with:

- the delinquent or pre-delinquent through direct mental health services;
- those in contact with or responsible for dealing with the delinquent through indirect services;
- the environment impacting on the delinquent and affecting delinquency through community development activities.

Nothing in the legislation enables ADAMHA to take over any of the traditional functions of the juvenile justice system at a federal, state, or local level. Any services it delivers to delinquents in contact with the justice system must either be with the sanction of a criminal justice or juvenile justice agency if one is affected, or have been removed from the jurisdiction of such an agency by legislation, state judicial administration ruling, or specific court action in particular cases.

C. Document Review

For various reasons it seemed unlikely we would find many programs that would appear to be relatively "heavily" or specifically involved in juvenile delinquency work. Informed observers told us in advance that only a handful of the CMHCs were working actively with juvenile offenders. Furthermore, many mental health professionals allegedly shy away from juvenile offenders (or at least shy away from categorizing youth as "delinquent" or "pre-delinquent"). Drug programs have clientele that by definition are offenders. For them to report delinquency programs might be superorogatory and also viewed as an invitation to notoriety. The alcohol programs were founded, like the CMHCs, with none but the most general intentions to serve youth, and in some cases with deliberate focus on other alcohol problems and at least tacit exclusion of juveniles.

Accordingly, the distribution of the ratings from our document review was as anticipated. At the very least, our common-sense rating scheme was shown to produce common-sense results. At most, the judgmental criteria enable a good empirical basis for identifying those programs that tell headquarters they serve juvenile offenders, and ultimately allowed a strongly suggestive comparison between what they tell headquarters, what they told us, and (in those programs we visited) what the programs seemed to be doing. In general, correspondence was good.

This review showed a correlation between direct services and referral sources; indirect services and referral sources; and direct and indirect services. The association of these correlations produced a set of hypotheses for the remainder of the study:

- Without explicit referrals of offenders from the juvenile justice system, ADAMHA-funded programs can have and will obtain almost no juvenile offenders as clients and will have limited or no opportunities for delivering "indirect" services. (Important to service strategy, as it appears to deny the possibility that a CMHC could "get into delinquency" merely by offering a program for delinquents.)

- ADAMHA-funded programs do not often add the label "juvenile offender" or "delinquent" to a client's description. They are so labeled only if the label arrives with them. A corollary: they remain labeled only if it's important to the original labelers to be able to continue to identify them as "offenders" or "delinquents." (Important to the evaluation of what ADAMHA programs actually do when they serve delinquents.)

- Direct services and indirect services are not mutually exclusive -- they are inexorably linked. Programs which deal with delinquents deal with delinquency. (Important to program strategy.)

D. Regional Office Interviews

No documentation is known to exist at the regional level regarding youth or delinquency which was not also available in Washington. None of the regional offices appeared to focus to any extent on delinquency, with the exception of Region I which actively encourages program involvement in various aspects of delinquency. These factors helped us reach the conclusion that visits to the regional offices would not be economically justified for the purposes of our contract.

The regions are in the throes of reorganization, as is DHEW. All regions except III and IV (Philadelphia and Atlanta) are reorganizing their health activities among three subdivisions: (1) family health, (2) health systems, (3) ADAMHA.

Regions III and IV, however, are reorganizing around a Division of Health Services, lumping health and mental health together in multi-program geographic teams. In Region III, for example, there will be two geographic teams: one serving Pennsylvania and the District of Columbia; the other serving the rest of the states in Region III.

E. Questionnaire Survey

Results from the total sample of programs surveyed showed the following: Fewer than 25% of the clients of CMHCs and drug programs are juveniles; for ATCs, the fraction is less than 5%, and 70% of ATCs serve no juveniles. Reported percentages of staff time devoted to juveniles are somewhat loosely allied to percentages of juveniles served, suggesting an attempt on the part of informants to show concern for juveniles. 30% of CMHCs spent staff time proportional to the client mix. 31% spent proportionally more time on juveniles than their numbers dictate. For drug programs, the numbers are 37% and 50% respectively. Around half the juvenile clients in CMHCs and ATCs have exhibited delinquent behavior, and three fourths of those in drug programs have. Only 15% of the juveniles in CMHCs are justice-referred; the fraction is higher for the other two programs. Reported staff time percentages are more consistent with these figures: 61% of CMHCs and 43% of drug programs spent time proportional; 20% and 33%, respectively, spent more time than their numbers dictate.

Very few programs consult with juvenile justice agencies except those that are actually providing services to juvenile delinquent clients.

CMHCs seem to be relatively unhampered in their dealings with delinquents, except by factors more or less within their own control (at least limited funding can be obtained for these purposes, if we are to trust the results of this survey). If a CMHC has a positive relationship with the juvenile

justice system, then it's a question primarily of internal management, desire and competence whether the CMHC serves delinquents. Drug programs, however, may be much more hampered by "community attitudes" -- i.e., their reputations as counterculture agencies and the defensive program policies they develop in response may preclude their being active in delinquency or predelinquency programs, despite their accessibility to young people. Nevertheless, one in seven drug programs targets direct service programs for juvenile delinquents; about 7% of CMHCs do so, among our sample. (Roughly 15-20% of programs in all three categories do offer court, police, or school consultation on delinquency, however.) The services they do provide are open by and large to delinquents; they just don't see many.

Those programs reporting more detailed information showed the following results: There is no or very low correlation of staff experience in outreach programs and involvement in juvenile delinquency: "outreach" capability is used for something else than delinquency or predelinquency programming. But if staff experience with outreach (92%), juvenile work (91%), or work with juvenile delinquents (85%) is taken as a precondition, then almost all reporting programs have at least these minimal qualifications for taking up delinquency activities -- a basis on which to build, should it be desired to do so, an indicator of competence and experience to support what's already being done in these programs. Typically, traditionally trained personnel are social workers (roughly 25% of total in CMHCs, in outreach, juvenile work and juvenile delinquency work). In drug programs and ATCs, juvenile and delinquency workers tend to be nontraditionally trained, about one fourth at professional levels and another quarter at paraprofessional levels. Average actual numbers of trained personnel are quite substantial (partly because some large programs skew the mean upward). For example, average number of workers trained or experienced with juvenile delinquents is reported as 14 in CMHCs, seven in ATCs, and 14 in drug programs. This doesn't tell us that all these workers specialize in delinquency; what we learned about time spent in the effort is encapsulated elsewhere in this summary and is consistent with generally low-level activity.

How is juvenile work funded? The overwhelming majority of responding programs have asked for supplemental funding (91% of drug programs, 81% of CMHCs, and 79% of ATCs). Of these, over 80% have received at least some special funding that appears relatable to juvenile programs. (It should be noted, however, that funding constraints are frequently noted: by 50% of total CMHC programs, 38% of drug programs, and 30% of alcohol programs). The majority of all programs were not receiving earmarked funds: 25% of programs received juvenile-earmarked funds. Only 9% of reporting programs reported funds earmarked for delinquency services.

If ADAMHA entertains hopes of collaboration among separately funded ADAMHA service programs in the same locality, it looks as though there's a long way to go, simply on the level of building mutual awareness: our respondent programs, when located nearby but separately funded, don't know each other, or don't know details about one another, unless they are networked together for some pre-existing purpose.

About a third of those programs reporting juvenile delinquent clients are affiliated -- apparently actively -- with other local agencies targeted toward juvenile delinquency, suggesting that they are genuinely built into local processes for coping with delinquency. However, these ADAMHA-funded programs themselves apparently tend to offer their own services to delinquents on a non-targeted basis. As earlier suggested, they serve delinquents in the course of normal business, not by labeling, sequestering or "targeting" for them.

The majority of the delinquents served in all programs are reported to be white males. We speculatively suggest that only relatively privileged delinquents ever reach (or remain with) the ADAMHA-funded local service programs, but there may be other explanations, including errors in the spotty and loose data we have to rely on.

The juveniles served on behalf of juvenile justice are diagnosed appropriate to the program serving them: CMHCs receive clients most often described as suffering from "character disorders," "drug abuse" and "neuroses." ATCs receive primarily "alcohol abusers" and persons with "character disorders." Most drug program delinquent clients are called "drug abusers." These justice-referred delinquents came from the courts and probation more frequently than from law enforcement or corrections. If what's happening is "diversion," it tends not to occur until a juvenile is already well-entangled with the juvenile justice system.

Even taking these programs offering services to juvenile delinquents as a special class, the amount of staff time allocated to delinquents is small: 100 hours a week or less for CMHCs, 50 hours or less for ATCs and drug programs. This time is distributed among a variety of activities quite characteristic of the overall programs of CMHCs, drug programs and ATCs, but with relatively heavy emphasis on school and court consultation, and in the case of CMHCs and drug programs, psychiatric evaluation. Court consultation for CMHCs and drug programs, and partial day care for ATCs are the only services that could be considered targeted for delinquents. Once again, those staff who work with delinquents tend to be social workers (more than psychologists or psychiatrists among the traditional mental health professions).

At least three general patterns are important, though a bit difficult to tie down on the basis of the questionnaire data alone:

- A few among the large, well-staffed CMHCs are involved in juvenile delinquency in complex ways, such that they can be said to have "juvenile delinquency programs." But even these CMHCs do not often look at their work in this way, tending (as do the smaller CMHCs) to perceive juvenile delinquents as clients like any other clients, receiving services that are by and large determined by behavior other than delinquency.

- Drug programs target more services toward delinquents, seem to have proportionately more staff competence for dealing with delinquents, and have apparently tried harder to obtain funds

for working with delinquents than CMHCs or ATCs. But they are handicapped by their charters and community attitudes from emphasizing delinquency services (except for delinquents who are drug abusers).

- So far as targeted services to juvenile delinquents are concerned, the questionnaire responses emphasize indirect services (mostly case consultation). "Diversion" of delinquents from juvenile justice to mental health services has clearly not gone far enough in many places to be even discernible in our questionnaire results.

F. Field Visits

During the course of our site visits, we discovered that the 25 programs were providing several different "types" of services to juvenile delinquents. Some of these services were provided directly and some indirectly. Some were provided through relationships with the courts, some through the police, some through the schools, and some through other social service agencies. Some services were provided reactively in response to a request for services, and some were provided proactively through the program taking the initiative to develop a special activity or referral arrangement in order to deal with a particular aspect of the juvenile delinquency problem. A few programs were delivering services to persons they categorized as predelinquents instead of, or in addition to, juvenile delinquents. A few more programs had only informal involvement with JD's through the efforts of individual staff members who had previous experience in dealing with juvenile delinquents and who personally wanted to stay involved with them. Finally, one program had no JD involvement at all.

For purposes of analysis and comparisons across programs, we categorized the variety of services we encountered into 11 "types" of JD involvement. There are three basic dimensions of difference between the categories: (a) reactive vs. proactive JD involvement; (b) direct vs. indirect service delivery; and (c) the organization through which contact with JD clients is made or to which indirect services are provided (e.g., juvenile justice system, schools and other agencies outside the juvenile justice system).

The first distinction (reactive vs. proactive) needs a bit more explanation. By reactive JD involvement, we mean that a program is primarily responding to some other agency's request for services. In other words, the initiative for becoming involved with JD's comes from outside the program, rather than from inside. For example, several CMHCs were involved in providing evaluation and testing services to the juvenile court because the juvenile court requested these services from them. Without this initiative from the juvenile court, the program might never have become involved with JD's. By proactive JD involvement, we mean that the program itself took the initiative for becoming involved and decided for itself what the involvement would be. A good example of proactive involvement is the special program initiated by one CMHC to take all the community adjustment referrals from the local police station in an effort to prevent these early juvenile offenders from escalating into hard-core JD's. The

police did not ask the CMHC to develop this special program; the initiative came from within the CMHC. Furthermore, the CMHC developed the program in ways that far exceeded the police's experience with, and expectations for, agencies to which they had made community adjustment referrals in the past. As a result, the program turned out to be far more effective in dealing with community adjustment referrals than any program preceding it. Therefore, the distinction between proactive and reactive JD involvement implies significant differences in program concern with JD's and the JD problem, in the quality and quantity of effort which is committed to dealing with the JD problem, and in the impact of those efforts on the JD's they serve, as well as in whose initiative is involved.

The 11 types of JD services are listed in the following table, with descriptive examples of the kind of service or program that would be included in each.

TYPES OF JD INVOLVEMENT

A. Reactive Provision of direct services to JJS (courts and probation).
Example: Evaluation and testing services for courts, as requested.

B. Proactive Provision of direct services to JJS.
Example: Special treatment program for court referred JD's only.

C. Reactive Provision of direct services to police (via community adjustment referrals).
Example: Acceptance of community adjustment referrals as police make them.

D. Proactive Provision of direct services to police.
Example: Special program which takes all community adjustment referrals from one or two police stations.

E. Reactive Provision of direct services to JD's via schools and other agencies outside JJS.
Example: Simple acceptance of referrals for testing or treatment as they are made.

F. Proactive Provision of direct services to JD's via schools and other agencies outside JJS.
Example: Special programs targeted at drug abusing JD's in junior and senior high schools.

G. Proactive Provision of direct services to predelinquents via schools and other agencies outside JJS. (Delinquency Prevention).
Example: Specially targeted program for working with tough, acting-out kids in elementary schools.

H. Proactive Provision of indirect services (C&E, training) to JJS (police, courts, probation).
Example: A training program in family therapy to probation officers.

I. Proactive Provision of indirect services to schools and other agencies outside JJS.
Example: Active consultation with teachers in how to deal with tough kids who act out.

J. Informal Individual Staff Involvement in JD activities with specific people in JJS or outside JJS as opposed to formal program involvement in JD activities.
Example: Psychologist who once served as probation officer provides consulting services to Probation Department informally.

K. No JD Involvement At All.

Findings and Conclusions from Field Visits

- According to our definition of "high" JD involvement, the higher a program's level of JD involvement, the greater the variety of services offered to JD's (either directly or indirectly). Of the six "high" involvement programs, one program exhibited six different types of JD involvement, four programs exhibited five different types of involvement, and one program exhibited four different types of involvement. Of the 14 "low" involvement programs eight programs exhibited only one type of involvement, two programs exhibited three different types of involvement, and one program exhibited four different types of involvement. The reason that this last program was judged to have a "low" level of JD involvement is the fact that all of these types of involvement were carried out in only one of the ten, loosely connected affiliates which comprise the CMHC. The CMHC as a whole had a "low" involvement.

- 80% of the 25 programs were providing direct services to the juvenile justice systems in their communities: 6 programs provided these services both reactively and proactively; 12 programs provided them just reactively; and 2 programs provided them just proactively. 9 of these 20 programs providing direct services to the JJS also provided proactive indirect services to the JJS. Therefore, the provision of services to theJJS, particularly direct services, is clearly the most frequent type of JD involvement exhibited. Furthermore, the five programs that did not provide direct or indirect services to the JJS exhibited only a "low" level of JD involvement. Therefore, it appears that any substantial program involvement with juvenile delinquency requires, or implies, an involvement with the JJS. Any other finding would shatter common sense expectations: those who would work work with juvenile delinquents of course must work with the juvenile justice system. The surprising thing is not the fact, but the depth and variety of involvement it is possible for a CMHC or drug program to have with courts, law enforcement, and corrections

- 4 programs (2 CMHCs and 2 Drug) also provided direct services to the police by accepting Community Adjustment Referrals. Two of them accepted these referrals on a reactive basis only, and the other two had developed proactive programs with individual police stations which handled all of the Community Adjustment Referrals made by those police stations. Three of the programs providing direct services to the police exhibited a "medium" level of involvement. Therefore, direct service involvement with the police appears to be an expression of strong program commitment to dealing with juvenile delinquents. It also reflects some degree of programmatic decision to become involved with JD's in the early stages of their delinquency since Community Adjustment Referrals pertain to early juvenile offenders who have committed only minor offenses. The two proactive programs clearly are

oriented to delinquency prevention. They provide early offenders with a continuing non-psychiatric counseling relationship with a presumably stable adult who can offer an alternative adult model for juveniles who live in a world of unstable, often criminally-involved, adults either in their families or their surrounding neighborhood or both.

- Again by definition the proactive types of JD involvement occur primarily in programs which exhibit a "high" or "medium" level of involvement in juvenile delinquency. The specific nature of the service (direct vs. indirect) and the specific client organization that the service is provided to or through (JJS, police, schools and other social service agencies) will depend both on the orientations and capabilities of the program and the nature of the community's resource system (Open JJS vs. Closed JJS, Scarce Social Service Resource vs. Abundant Social Service Resources, etc.). The point is that proactive provision of services reflects a stronger, more active programmatic commitment to dealing with juvenile delinquency than does reactive provision of services.

- The provision of indirect services either to the JJS or to schools and other social service agencies always appeared to be done on a proactive basis, and in most cases seemed to reflect concern with the ways in which juvenile delinquents are dealt with by the organizations that are most involved with them (police, courts, probation, schools, etc.). This does not mean that the receivers of these indirect services are merely "reactive." In many cases, they are collaborators with the program. For example, one CMHC was providing indirect services to a school counseling program which involved equally proactive efforts from drug, probation, and school counseling people as well. The indirect services provided to these organizations represent program efforts to improve the "system" which has primary contact with, and responsibility for, juvenile delinquents. Furthermore, the provision of indirect services tended more frequently to be an expression of "high" or "medium" JD involvement. Six of the 11 high and medium JD involvement programs provided indirect services to the JJS compared to only 3 of the 14 low JD involvement programs. Seven of the 11 high and medium involvement programs provided indirect services to schools and other agencies compared to only 4 of the 14 low involvement programs.

- The provision of indirect services to schools and other agencies tends very strongly to be a response to the existence of <u>abundant</u> social service resources in the community. Eight of the 11 programs which provided indirect services to schools and other agencies were located in communities with abundant social service resources. This reflects a frequent acknowledgement on the part of the ADAMHA-funded programs that schools and other agencies may be better suited (or at least as well suited) to provide direct services to JD's than the program itself. It also reflects a programmatic

decision to tap, catalyze, increase, or improve the ways in which that system deals with juvenile delinquents. Basically, however, if there are no services, a new relatively well-funded CMHC may be a reasonable supplier. If there are lots of services, a new reasonably well-funded CMHC may be a good source of consultative support in making the programs better.

- Four programs were involved with the provision of direct services to pre-delinquents, and all four of these programs were CMHCs. Drug programs tend to serve adolescents and young adults and alcohol programs tend to serve only adults. The fact that <u>no</u> drug or alcohol programs were involved with pre-delinquents reflects the more narrow age-orientations of those types of programs. All of the CMHC s which had programs for pre-delinquents were strongly oriented towards identifying services and the needs of their community and three of them were located in communities where the problem of juvenile delinquency was either strongly or moderately denied. A program for pre-delinquents is a sensible way to deal with a denied juvenile delinquency problem because such a program is more acceptable to the community. This is even more true if denial means that the community is permitting youth to become delinquent and then stay that way without actively facing the situation. Helping a juvenile delinquent break out of his or her pattern of delinquent behavior is difficult enough when the community is concerned about or even involved in trying to deal with the problem. Like the programs that were developed to deal with the police referrals of early offenders, these pre-delinquency programs tended to take the form of providing a continuing non-psychiatric counseling relationship with a stable adult who could serve as an alternative model for youngsters surrounded by older adolescents and adults involved in lives of crime.

- Informal individual staff involvement in JD activities occurred in four programs (3 drug and 1 alcohol), all of which had only a "low" level of JD involvement. In all four cases, formal program involvement was constrained either by a juvenile justice system that was not prone to diverting JD's into treatment programs, particularly mental health treatment programs, (2 drug programs) or by internal program constraints, e.g. a strong program preference for voluntary treatment (1 drug program) or age constraints (1 alcohol program). In all four cases, the informal individual staff involvement in JD activities was initiated and carried out by staff members who had previous experience in working with juvenile delinquents and a continuing interest in the problem of juvenile delinquency. In two programs, this informal activity was the only form of JD involvement exhibited, in one program it was coupled with some referrals from the local juvenile court, and in the last program it was coupled with some direct service involvement with drug abusers in the public school system.

These four programs illustrate how program staff with previous experience in working with juvenile delinquents can promote the development of JD activities in the ADAMHA programs, even when other factors are strongly deterring their development.

The following table shows the factors in the 25 programs field visited which affect delinquency involvement.

FACTORS THAT AFFECT JD INVOLVEMENT ACROSS ALL 25 PROGRAMS

PROMOTE/DETER FACTORS	PROMOTE	NEUTRAL	DETER
High Visibility/Problem Perception	7	3	
High Visibility/Denial			4
Low Visibility/Problem Perception		2	1
Low Visibility/Denial			8
Scarce Social Service Resources	7	5	
Abundant Social Service Resources	3	8	2
Open, Diversion-Prone JJS	13	4	2
Closed, Conservative JJS			6
Community-Orientation	12	2	1
Medical Model Oriantation		4	6
Direct Service Orientation	4	9	6
Indirect Service Orientation	9	1	
JD Staff Experience	12	1	
No JD Staff Experience		5	5
Strong JJS Linkages	15	1	
Weak JJS Linkages		4	5
Strong Linkages with Other Agencies	10	1	
Weak Linkages with Other Agencies		13	1
Strong Youth Orientation	13	1	
Weak Youth Orientation		1	9
Funding Constraints	1		9
Voluntary Treatment Preferred			3
Age Constraints			3
Mental Health Stigma			2

In summary, the results of the field visit analysis show the following:

- Drug programs tend to exhibit the highest levels of JD involvement, mostly because of their strong youth orientations and because drug abuse and delinquency are often related activities.

- Alcohol programs exhibited the lowest levels of JD involvement, primarily because they were heavily oriented toward adults due to the widespread perception that alcoholism is an adult problem.

- The provision of services, particularly direct services, via the juvenile justice system, is the most frequent type of JD involvement exhibited. Furthermore, substantial involvement with juvenile delinquency (high or medium) either requires or implies involvement with the JJS.

- Direct service involvement specifically with police (four programs) seems to be an expression of strong program commitment to dealing with juvenile delinquents (3 high, 1 medium involved program). Involvement with the police also reflects a possible orientation to delinquency prevention.

- The provision of indirect services to schools and other agencies tends to be a response to the existence of abundant social service resources in the area, and may also reflect an explicitly preventive strategy.

- Involvement with pre-delinquents was found only in CMHC s (4), probably because the drug and alcohol programs have more narrow age orientations. Pre-delinquency involvement also tends to occur in communities where the problem of juvenile delinquency was being denied.

- Informal individual staff involvement in juvenile delinquency occurs where external constraints (e.g., closed, conservative JJS), or internal constraints (e.g., strong mental health clinic model orientation) prevent more formal program involvement, and where some staff have had previous experience in working with JD's.

- The combination of high visibility of the problem of juvenile delinquency and a high perception of the problem in the local community tends to promote a program's involvement in juvenile delinquency, but it is not an essential ingredient.

- Community denial of the problem of juvenile delinquency tends to strongly deter program involvement regardless of whether the "visibility" of the JD problem is high or low.

- A scarcity of social service resources in the community tends to promote program involvement in juvenile delinquency when other internal programs and/or external site factors also support that involvement. Furthermore, a scarcity of social service resources tends to promote a direct service involvement rather than an indirect service involvement.

- An abundance of social service resources tends most frequently to have a neutral effect on program involvement in juvenile delinquency, primarily because it means that there are other resources to fill the community's need or demand for JD services. However, in the three programs where an abundance of social service resources did promote JD involvement, it promoted an indirect service involvement.

- The attitude and behavior of the juvenile justice system is a highly critical factor affecting a program's JD involvement. An open, diversion-prone JJS tends to strongly promote JD involvement by ADAMHA programs and a closed, conservative JJS tends to be a strong deterrent to involvement.

- Strong program linkages with the juvenile justice system tend to be strongly associated with high and medium program involvement in juvenile delinquency and are either a prerequisite for, or a reflection of, those levels of involvement, or both.

- The extent of a program's youth orientation is also a highly critical factor affecting a program's JD involvement. However, the development of high or even medium JD involvement appears to depend on the coincidence and interaction of a "strong youth orientation" inside the program with an "open, diversion-prone juvenile justice system" outside the program. If either one of these conditions exists without the other, the extent of program involvement in juvenile delinquency will probably not develop beyond a "low" level.

- As would be expected, drug programs tend to have the strongest youth orientations and are therefore the most likely types of ADAMHA programs to become highly involved in juvenile delinquency when the external conditions are right.

- A strong community orientation in a program also tends to promote JD involvement when the external conditions are right because juvenile delinquency is a "community" problem that may or may not be perceived as a "mental health" problem.

- The exact nature and extent of a program's involvement in juvenile delinquency is determined not by any single factor but by the coincidence and interaction of several internal program factors and external site factors. The strongest positive combination includes a juvenile justice system open to interaction and seeking diversion alternatives, a strong community orientation on the part of the ADAMHA-funded program, and a strong orientation toward youth.

G. Programs Field Visited

Program descriptions were developed for each field site visited. These are found in Appendix G. Here we present descriptions of program elements which are of particular interest. First, they represent most of the program entities in sites we visited which were truly focused on delinquency or delinquency prevention.* Second, except for the police training program in Rockland County, all are illustrative of direct services and are used in ways which exemplify diversion.

1. DTP: Drug Abuse Program, CMHC of Escambia County (Pensacola, Florida)

The Drug Abuse Program frankly takes advantage of the "drug abuse shield" and the legal privilege of drug counselors to treat known addicts and those in imminent danger of becoming addicted. Florida law permits the Drug Abuse Program to treat children without their parents' consent. The combination of legal authority, available funds and outstanding personnel have made this segment of the center program until now the heart of what Escambia County CMHC has offered in the way of direct services to and for delinquents.

At the current time roughly 38% of the youth in treatment at the drug program are adjudicated juveniles who have been ordered to seek treatment by the judge. DYS** has no statutory authority to force children to undergo treatment prior to adjudication, although it may recommend that they do so. It will, however, refer children for evaluation to the drug center and may use the detoxification unit in the initial phases of its involvement with any youth. DYS and the drug program are currently attempting to work out an agreement whereby DYS could assign legal responsibility or guardianship for the child to the center and thus have him treated by the center prior to adjudication.

The general opinion of people we talked with in Pensacola was that the Drug Abuse Program was doing an excellent job: re-entry rates run as low as 5%. Follow-up evaluations of the program are done at three, six and twelve months through the mail, and they are voluntary. 35-40% of those sent out are returned, and this high return rate is felt to be yet another indication of the program's success with clients.

The program originally began as a pilot project in drug abuse prevention funded by LEAA. Since then it has acquired additional funding by NIDA and has developed third-party payment sources through local agencies and DYS. At an early point in its development, a strategic decision was made by the administration of the center for the program to de-emphasize voluntary clients obtained through outreach clinics in favor of working more closely with the criminal justice system in the community and developing a service-provider stance with respect to that

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*Many other programs were serving delinquents but not in as specifically identifiable programs as these.

**"Division of Youth Services," a rather recent consolidation of juvenile justice agencies from both state and local levels. It operates through regional offices and local representatives.

system. A member of the staff was hired who was familiar with the criminal justice system and had worked extensively with it in a previous halfway house endeavor. These two factors allowed the program to develop a close working relationship with the criminal justice system.

A primary concern that emerges from that close relationship is a need for the drug program to maintain some sense of distance and autonomy. The program desires to maintain itself as essentially an agent of the individual rather than an agent of the court. Issues of confidentiality and voluntary treatment are much involved in this concern.

Major program components include the following:

- A drug hotline open 24 hours a day.
- School treatment groups which offer group therapy in conjunction with guidance counselors in schools themselves, in nearly every high school in the county. As mentioned before, they work as co-leaders with school guidance personnel and sometimes DYS counselors. About 150 young people were estimated to be served in this way in 1973.
- Residential treatment, available to 51 long-term clients at a time. Intensive therapy features peer pressure, value clarification, decision-making, family therapy and other modalities.
- Outpatient services of the traditional therapeutic modality offered to families, groups and individuals.
- The drug program receives juvenile referrals from the alcohol program, though only occasionally. It also collaborates with the city police in offering a school program intended to cut down on driving while intoxicated.
- Some of the activities of the drug program in teacher training, consulting to DYS, and to other agencies have earlier been mentioned or discussed.
- Two youth advocates who assist clients obtain vocational and educational training and plan toward eventual employment.
- Youth advocates for follow-up and after-care work with former clients.
- A detoxification unit.

2. CMHC: Volunteer Counseling Service (VCS), Rockland County CMHC (Pomona, New York)

The Rockland County Volunteer Counseling Service is one of four demonstration projects originally set at the instance of the family court judges of New York State who, in 1966, clearly foresaw that court clinics and other agencies would never suffice to meet the growing load. The Ford Foundation subsidized these demonstration projects for several years. Now they run on money from Probation, from county appropriation (direct appropriation, not through the Mental Health Authority), and from miscellaneous gifts and grants. Total budget in 1973 was on the order of $40,000.

The mental health center offers technical assistance and counseling to the VCS. The VCS regards itself and is seen by the mental health center as quite a strong link between the family court and the mental health complex. VCS needed the professional credibility it has gained from its increasing relationship with the mental health center, and is willing to use some of its own high credibility with the court (based on its responsiveness and willingness to take on at least for referral any case the court entrusts to it) in further improving court-CMHC relationships. The crucial VCS function, however, is that of an "overflow tank" whenever court and probation have to process cases faster than existing agencies can handle them.

The Volunteer Counseling Service specializes in meeting the needs of the court and Probation Department for life counseling and family crisis counseling in a very responsive mode. When the court calls, VCS answers. Approximately 40% of referrals by Probation (without formal adjudication) go to VCS. Some aspects of their counseling are rather highly stylized. Counselors work in one or another of 15 neutral settings. While half of the counselors are already professionals, all are under continuous professional supervision (by volunteer supervisors from the fields of social work, psychology and psychiatry). VCS counselors are trained to work with the whole family or with individuals. What they offer is life counseling, not psychotherapy. The counselors are obviously often responding (in part) to an ambition to improve their consultation skills. Supervisors must in many cases be responding to largely analogous motivations. The director, assistant director, and supervisor or counselors are paid; other professionals receive no payment from VCS.

In 1973, about half of the clientele was primarily or exclusively receiving marriage counseling. Nearly all the others were in counseling primarily because of parent-child conflicts. Many of the children involved were 16 years or over, thus having reached an age at which the Juvenile Probation Department had no discretion over them as ungovernables; the schools no longer had to cope with them and didn't want them; their families weren't capable of handling the situation. VCS clearly represents an attempt to fill what is perceived as a large gap.

VCS believes it has a unique mission. It services the court. It also deals with clients that don't or won't get help from such other service providers as the CMHC. In some cases this is because clients just don't like the mental health stigma; in others it is because they don't have transportation to the center or a satellite, but can reach a VCS location (and often it is not easy for people with anti-social problems to get into the center due in part to a degree of staff resistance to treating such clients). A second part of the mission is to aid in the development of many people otherwise without adequate resources to improve themselves professionally. Somewhat incidentally, VCS also provides training and education for some of the other agencies involved with juveniles. Some of this is from casual contact in the course of casework; some occurs because the volunteers themselves are members of departments of police, probation, or the schools.

3. CMHC: Police Training Program, Rockland County CMHC (Pomona, New York)

The police training program is quite famous. It has its origins very early in the life of the CMHC. Nobody else was pressing for additional training for police, but the center saw a community need (and a center need) and found a way to exploit the fact that New York requires mental health training for police. The director of the police training program got this requirement made mandatory, which provided the leverage she thought she needed to begin enlisting police participants in what has grown to be a very successful program. Center personnel reason that police, as front-line community caregivers, must have names and faces for mental health professionals in particular. Police are just as important to the mental health center as clergymen and school people. CMHC personnel also reasoned that police didn't want to be psyched out: "Don't make no social worker out of us, lady."

First efforts were with the county sheriff's patrol. Four years ago the patrol had been directed to protect the property of the county social services complex, including the mental health center. Seeing recognized drug addicts coming and going, patrol members adopted the practice of wholesale arrest. Accordingly, mental health center personnel felt they needed to change their relationship with the sheriff's patrol, or no patients would be willing to come to the center.

The local community college was persuaded to give three college credits for successful completion of the training course. Originally, the sponsors were willing to accept veterans as well as rookies; but they discovered they could learn more than they could teach to 25-year police veterans, so they have made the course a requirement for recruits in the first six months of membership in police forces.

Mental health has now reserved the last week of what has grown to be an eleven-week training program. This one-week program starts with a marital marathon, to recognize and begin to cope with the fact that many of the police have serious marital problems (with a 90% divorce rate in

some departments). This is in part due to social isolation, the impact of repeated shift changes, and simply not being at home enough on holidays. Much of the rest of the course is devoted to role playing with "stress modules," listening exercises, and experiences in humiliation and anger, all calculated to make police more sensitive to the elements of crisis intervention and to build police skills in coping with crises. The police recruits also receive a limited amount of sensitivity training to make them better able to cope with the consequences of the typical policeman's usual attempt to hide his feelings. There are also several crucial cognitive elements in the curriculum: problems of adolescence, mental health law, an inventory of community agencies, materials on drugs and alcohol, and a discussion of the changing role of the policeman from the days when police were hired to protect baronial property to the present, when their primary job seems to be emerging as the protection of society from sociopaths.

This program continues to develop from one presentation to the next. It operates twice a year. By now it has reached a significant fraction of the policemen of Rockland County, and it seems to have changed the attitudes and understandings both of the police professionals and of the mental health professionals involved. The program is both considered valuable enough and is well enough known that other counties contract for its use.

4. DTP: Youth Services Project, Northwest Youth Outreach (Chicago, Illinois)

The North River Youth Services Project, partly funded by LEAA, is a subunit of Northwest Youth Outreach. The section they serve is a heavier ghetto area than the rest of the target area with a more racially mixed population. It is an area of greater delinquency, and the juvenile police in the area have more Community Adjustment Referrals than the other parts of the target area. The major responsibility of the project is diversion of juveniles who come into contact with the 17th District Police Station. 50% of their caseload must come from this police station through Community Adjustment Referrals. Currently they receive all the Community Adjustment Referrals from this Police Station——approximately 50 per month.

The project has five full-time staff members: a director, two counselors, and two outreach workers. Referrals to the program come from the 17th District Police Station, public schools in the area, self-referrals or walk-ins, and other agencies.

The project deals with Community Adjustment Referrals somewhat differently than other programs in Chicago in that it initiates contact with the referred juvenile and his family rather than waiting for the family to contact the project. In fact, they frequently go down to the police station at the time of arrest to meet the referred juvenile and his family, conduct an initial interview, and set up another appointment for some time within the following few days.

Project staff members work with their clients for 10-12 weeks on the average. If a client needs more than 12 weeks of counseling they generally refer him to a program which is set up to deliver longer-term care. Project staff work very closely with the police who make the referrals and provide them with feedback on referred youth two weeks after the referral is made and again 30 days later. At the moment they are not officially informed by the police when one of their clients is re-arrested, but they tend to hear about re-arrests from the youth themselves, their families, or through their outreach contacts in the community and schools.

Like the rest of the Northwest Youth Outreach Program's target area, the North River Youth Services Project's subsection, with a population of 120,000 people, has few or no other social service agencies to deal with the needs of adolescents. The project's director sees a strong need for youth services in this area to be coordinated. For the state-level agencies and institutions that deal with youth in this area as well as the rest of the city (Department of Corrections, ILEC, Department of Children and Family Services, etc.), he strongly feels that this coordination should be worked out at the state level so that youth do not continue to get shuttled around to different fragments of an uncoordinated system of social services.

5. CMHC: Inpatient Treatment for Juvenile Delinquents, University of Illinois CMHC (Chicago, Illinois)

This 15-bed inpatient treatment program for juvenile delinquents was started in 1969 based on the belief of its director that "any child or adolescent who behaves as a delinquent can be proved to have psychological or family psychological problems." Consequently, the only necessary criterion for acceptance into this program is that a child be a delinquent. In addition, they will not take psychotic, mentally retarded or brain-damaged youths. The program is long-term with the average length of stay being eight months. The program is not restricted to serving the CMHC's catchment area. In fact, since the program's start in 1969 only 2-3 of the patients who have gone through it have come from the catchment area. Referrals to the program come from the Juvenile Court. The mode of treatment combines structured milieu therapy with individual, group and recreational therapy. Ward meetings are held every day and the staff also conduct parents groups. Their impact data are sketchy, but they did have some data on 21 patients who left the program in 1969-70. Of these 21 patients, 50% had been re-arrested since leaving and 25% had been re-incarcerated. We do not know the end-point of their data collection period, so we do not know how long a period of follow-up time is covered by these figures.

6. CMHC: Youth in Action, University of Illinois CMHC (Chicago, Illinois)

Little Village, a CMHC neighborhood outpost, has attempted to help local community members set up their own recreational and social programs to meet the needs of the community. A youth-oriented example of this is the Youth in Action program which was first formed three years ago with the help of Little Village staff members. This program was developed to respond to the needs of the so-called "bad kids" who were being excluded from the traditional youth recreation programs in the community, like the Boys' Club and the Little Village Gospel Center. Youth in Action was started by an indigenous volunteer group and they are now spinning off from their affiliation with the Little Village Outpost to become a separate program in their own facility. The primary problems are gang violence and drug abuse in a community rapidly shifting from middle European to Latino.

7. CMHC: Hathaway Home, Golden State CMHC (Lake View Terrace, California)

Hathaway Home is the largest and most autonomous of the major CMHC entities; it has a staff of 200 for both its inpatient and outpatient facilities.

Hathaway Home began 50 years ago as a kind of orphanage. In its early years it also served partially as a detention home for "dependent child" cases due to insufficient county facilities for these cases. Their historical roots are, therefore, embedded in a child welfare service background, but over the years they have moved into the provision of therapeutic services for emotionally disturbed children. It is also part of a state association of 65 residential children's facilities, half of which handle delinquents and the other half of which treat emotionally disturbed children up to age 18. Hathaway Home is the only such facility with outpatient services.

They do not take mentally retarded or autistic children, and they also tend to turn away older adolescents who act out in extreme ways. All the children in their inpatient facility (capacity = 85) are there on a voluntary commitment basis. Parental involvement in both the commitment and the treatment is key. The program takes a family-oriented approach to treating its clients' difficulties, and referrals to the inpatient program come primarily from the Department of Public Social Service (DPSS), partly because DPSS has responsiblity for dependent, neglected and/or abused kids and partly because they have funds to buy this kind of residential treatment. Referrals also originate within the Los Angeles public schools, but these referrals tend to go through DPSS because DPSS has the money to pay for them at Hathaway Home. Occasionally, a referral will come from a private doctor, but at the moment there are no private patients in the Home. The final source of referral is the Department of Probation. Families frequently call the Home and say that counseling or treatment is a condition of their child's probation. The Hathaway Home discourages this kind of required referral on the part of the Probation Department because they believe that voluntary commitment is essential to a successful experience at the Home. Consequently,

less than 5% of the inpatients at the Hathaway Home are involved with probation.

The average length of stay for a child at the Home is 11 months, and during that time the staff try to work closely with the entire family of the child. The actual treatment varies from child to child and according to the severity of the disturbance. Once the Home admits a child, they do not categorize him as delinquent or non-delinquent. Once a child leaves the inpatient program, there is no formal process for sustaining contact with him, although the program's Community Workers often keep in touch with former patients. Sometimes a child will maintain contact with the outpatient facility as part of his transition out of the inpatient program.

The inpatient program is not rigorously oriented to the CMHC's catchment area and it takes children from all over LA County as well as from other parts of the State. The outpatient program, on the other hand, places highest priority on catchment area walk-ins or call-ins. The outpatient program is also primarily oriented to crisis intervention, and people are seen almost as soon as they call in. Adolescent walk-ins are seen once if they walk in by themselves, but if they are under 18 they must obtain parental consent before a second visit is arranged. The outpatient program also emphasizes the involvement of the child's entire family in the treatment. There are 21 outpatient staff members, of which 8 are interdisciplinary professionals, 3 are mental health workers, 7 are educational rehabilitation specialists, and 3 are outreach workers. The outreach staff are focusing their efforts on very young children and work in the nursery and elementary schools in the catchment area. In addition, the outreach workers are trying to work with the Probation Department to identify early offenders and provide them with supportive relationships.

8. CMHC: Social Rehabilitation Service, Golden State CMHC (Lake View Terrace, California)

The CMHC's SRS program was developed in July of 1973 out of a concern of the community mental health workers who were discovering that both adults and youth were having serious difficulties adjusting after going through the criminal justice system. The program was thus developed to focus on both adolescents and adults who come into contact with the court system.

The program is administered by the Los Angeles County Mental Health Department. It is set up on the social service model rather than the medical model, and social work backgrounds have been emphasized for staff members. The program is split 50/50 between adults and adolescents, and for each half of the program there is a director, a social worker, and four community workers.

SRS is one of three agencies which has a contract with the Mental Health

Unit of the LA County Court System. This contract provides SRS with a flat monthly sum of money for which SRS is required to provide services to a specified number of people. In the beginning they were supposed to get referrals of people who had already been sentenced by the court, but they also started to receive referrals of people who were waiting to be sentenced. Now they can even go to correctional institutions where catchment area residents have been incarcerated and are about to be released.

The total current caseload of the program is 93 people, 40 of whom are adolescents from 12-18 years old. While SRS began as an adult program, it is now the only social rehabilitation agency in the county that serves adolescents. Adolescent referrals come primarily from the schools (50%) for reasons which include teacher assault, drug abuse, and alcohol abuse. The adolescent program's community workers are deep in active contact with school personnel to facilitate these referrals. SRS will refer an adolescent to the Hathaway Home only if his problem is primarily psychiatric and only if long-term therapy is needed. In fact, they have referred fewer than 10% of their clients to Hathaway Home. In return, the outpatient facility of the Hathaway Home will refer kids on drugs to SRS because of its reputation for taking, and effectively handling, rough adolescent cases.

In their work with clients, SRS de-emphasizes "mental health" so as not to stigmatize people who come to them for help. An adolescent who comes to SRS will work almost entirely with one community worker who will form a trusting relationship with the adolescent and who will coordinate the provision of whatever services the adolescent needs. The community workers also work with adolescent gangs when their clients turn out to be gang members. Their work with adolescents is primarily crisis-oriented, and the contract they have with the County Court's Mental Health Unit states that client problems are expected to be resolved by SRS within six months.

Each client served by SRS must be screened and certified by an evaluator from the County Court Mental Health Unit, supposedly to ensure that SRS serves the type of population it was set up to serve rather than people who are more appropriately served by some other social agency. In order for an individual client to receive services from SRS for more than six months, this same evaluator must "certify that patient for an extra six-month period of treatment." In addition to this individual client screening and evaluation, SRS must also go through an annual evaluation of its program by the County Court Mental Health Unit. Consequently, it is a Golden State CMHC program which functions as a tightly monitored arm of the County Court System.

9. CMHC: Juvenile Rehabilitation Services, Golden State CMHC (Lake View Terrace, California)

This program was clearly targeted toward dealing with juvenile delinquency in the catchment area. Unfortunately, this program closed down in February 1974 due to drying up of funds.

The program began in the summer of 1970 with Federal money under the Omnibus Crime Bill.

JRS was designed as a limited scope project to work with juveniles when they first started getting into trouble with the police. They decided to work exclusively with the Foothill Division of the LA Police Department in order to concentrate their efforts on developing a strong and responsive referral relationship with them, based on a belief that an important reason why the police did not refer to social agencies was that these agencies were not responsive to the Police Department's needs.

Their goal with the police was to get them to refer young first offenders to JRS instead of just "counseling and releasing" them or sending them through some harsher route, like voluntary probation or even adjudication. They first had to convince the police of the skill of their staff members, of the clarity and goodness of their intentions, and of their willingness not to interfere with the police's decisions about what kids to refer to JRS. In order to convince the police of their sincerity in wanting to be responsive to police needs in a referral relationship, JRS had staff members on call 24 hours a day to respond to referrals. When a referral call came from the police station, a JRS staff member would go down to the station immediately to meet with the police officer, the juvenile, and his parents. Usually, the JRS staff member would then take the juvenile back to the program facility (located in a bungalow) to begin the process of establishing a trusting relationship. Meetings were scheduled frequently until a sustainable relationship had been formed. They spent time with their clients wherever their clients wanted to spend it (e.g., at McDonalds, on the street, wherever).

As follow-up with the police who made the initial referral, they would continually give feedback over time about what and how the juvenile was doing and these police officers began to make favorable comments about JRS to other policemen.

In addition to providing services to their clients themselves, JRS tried to get services from other social agencies in the catchment area. These agencies turned out to be less responsive than JRS had hoped perhaps because of competitive hostility toward the program.

Staffing of the program was critical to its effectiveness. They knew they would need excellent, dedicated staff members who "knew a lot, cared a lot, had a lot of guts and energy, and would be willing to be on call 24 hours a day, 7 days a week." As anticipated, staff workloads did turn out to be enormous and the young staff members were

burning out after one year. The director figured this was inevitable and replaced them once they had burned out, but just before leaving the program he was considering other alternatives, like doubling the staff or providing sabbaticals. During the 3-1/2 year life of the program, the staff numbered six, and they called themselves "counselors" to eliminate the stigma carried in their clients' minds by the term "therapist." When the money ran out at the end of their third year they spent six months working the political process to get continuation funding for the program. They were successful for a time but the program eventually closed due to lack of funds.

10. CMHC: Anchor Worker Program, Tufts CMHC (Boston, Massachusetts)

The Anchor Worker Program functions with an explicit strategy of delinquency prevention. Each worker operates more or less independently of the mental health center and develops his or her own caseload, advocacy and counseling interventions, relationships to school personnel, court personnel and agency staff. They develop these relationships in ways that fit their own personalities, styles, professional perspectives, energies, moods and opportunities. The children in their caseloads and "peripheral children" for whom the anchor worker assumes some form of responsibility usually are not involved with the law and the courts when they first become involved with an anchor worker. Generally, however, they do get in trouble with the law and penetrate the justice system at some point. The Anchor Worker Program, therefore, does not "prevent" delinquent behavior or labeling, but rather, helps to prevent its becoming worse, through a combination of counseling, intervening in every possible way with existing justice agencies, and attempting to make referrals for the child they are working with.

Over time, the worker's involvement increasingly is with the child's family, both nuclear and extended. Some of the family may reside in other neighborhoods with children attending other schools. The anchor worker visits these families as frequently as possible and follows them when they move.

Put at its simplest, the anchor worker concept is in effect a one person treatment "team," a person able to gather information, organize appropriate services and provide direct person-to-person service to his client and to the families in a continuous, reliable, readily available way over a period of several years. The designation "anchor worker" was also chosen to avoid the stigma of the words "mental health," which were found through a community survey to be anathema in the local community.

Each anchor worker is assigned to a school in the community. The school functions as his base of operations. He must establish relations with the teachers and the administration of the school. If these relationships are successful, they will begin to feed children to him. At the end and the beginning of each year, each teacher is given a form which he or

she can fill out, which identifies children with persistent learning disabilities, children who have difficulty in relating to other children, children who are isolated, children who are management problems, children who have difficult home situations, children who are disruptive in a group, children who have a poor record of attendance. The clients the anchor worker will work with are culled from these submissions from teachers.

The mode of working with the child is an eclectic and informal one. Frequency of contact around a variety of life issues is the major thrust. The worker very quickly becomes involved also with the family of the child. In some instances he sees more than one member of the same family. Each week he submits a weekly summary form on each of the major children he is seeing, which notes the number of contacts with the child, with his parents, and with others concerned with his development. Negative incidents are checked as well as positive events.

The program's quarterly progress report to HEW's Office of Youth Development for the first three months of 1974 indicated that 212 youth were in the caseload by March: 143 boys and 69 girls. Each caseworker carried an active caseload of 8 to 10. Those 8 to 10 were mostly the same children since the project started, with the additional youth being siblings, friends or peripheral contacts. Only two of the youths served by the project were court referrals. Over half were from the schools. 13 out of 20 were 12 years old or under, and five out of 20 were black. 13 had no previous involvement with the law, and five had a record of arrests. Children were seen an average of nine times per month, and parents an average of six times per month. Teachers and others were contacted more than five times per month regarding each case.

Selection of the anchor workers themselves was a primary concern. They are action-oriented people, all in their middle twenties, with a demonstrated ability to relate to and work with difficult-to-relate-to children. All of them have master's degrees in fields such as special education, educational and vocational rehabilitation counseling, social work and sociology. None have had any formal training in a clinical setting such as a child guidance clinic. Most of them have been with the program almost three years. Anchor workers were not given office space, and only one of them had space available in his school for use. Others gradually had to find their own space in the community agencies they were attached to. As a result, each anchor worker became used to spending most of his time in the school and on the streets. Thus the worker not only came to know who the child was dealing with in the area of his school life, but also came rapidly to know with whom and what the child was attempting to cope at home and in his neighborhood. The anchor worker is a full-time (average 50-hour week) worker. In addition, he or she carries a beeper connected to the medical center switchboard which makes him or her accessible on a 24-hour-a-day basis to family, client, school officials and other agency people.

VI. INTERPRETATION OF THIS STUDY

A. Candidate Interpretations

What are the interpretations that can be placed on the findings and analyses presented in this report?

- The theory of essential incompatibility

Community mental health and drug programs are doing as much as should be asked of them with respect to minors in actual or likely trouble with the law. Doing more through these programs would increase the risk of stigmatizing large numbers of minors as unstable or crazy - minors already highly susceptible to adverse labeling. It would also force the CMHCs and DTPs to change quite drastically, which is never easy to accomplish in any human services agency and is not often successful. Although it is possible sometimes to work around the requirement that the clientele of a mental health agency have to want to get better, basically the motivations of a person forced to receive therapy by the threat of imprisonment are wrong for receiving maximum benefits from mental health services.

This interpretation emphasizes the reluctance of many traditionally trained mental health professionals to transcend their backgrounds. It assumes that no adequate means exists to minimize labeling, nor to make labeling into a positive experience. It also assumes that CMHC and DTP capabilities interact with the need for treating many types of persons in a way that establishes a constant priority for treating "delinquents" and "offenders," a priority not lightly or easily to be changed.

We would contend that this interpretation places too little emphasis on available examples of programs in which higher priorities have been given to coping with the problems of youthful offenders and the family or social background they bring with them.

- The theory of appropriateness

According to another interpretation, mental health programs are demonstrably almost ideally equipped to conduct triage on behalf of the juvenile offender. Some offenders are "out of control" because of psychopathology. No service agency is in fact better equipped to discover and identify these persons. Some offenders behave as they do because of self-image and interpersonal relationships. This, too, is a spectrum of behavior and contexts that mental health professionals are better equipped than almost any other occupational group to sense and to comprehend accurately.

Some offenders are responding to power relationships in their lives, to the need for being tough in a tough world, or wily, cautious and withdrawn in a too-tough world. Mental health professionals vary in their sensitivity to these phenomena. But several centers in the sample visited have incorporated street-wise, untraditional, variously accultured, slum-reared or other poverty-wise counselors with relative ease. So there is skill available

for learning to interpret these kinds of behavior accurately, too. Finally, mental health professionals, at least at their best, have skill in building on chosen aspects of a person's behavior. They should accordingly make fewer errors of the kind that reinforce just those aspects of a person's behavior that lead society to experience those persons as destructive. What a few can learn, many others can also learn.

This interpretation is consistent with an idealized view of the mental health professional and potential of the centers based on a handful of exciting programs in particular kinds of centers that are oriented to social problems. But it doesn't quite square with the record the mental health centers have established when doing court evaluations - the process that comes closest to triage. If the evaluation work is good, it is obviously not routinely expressed well enough to penetrate vocabulary, ideological, or institutional differences between the juvenile justice system and the psychological evaluators. Furthermore, the results of mental health professional triage and treatment have not yet been established as clearly superior, even in a number of treatment programs in which the mental health professionals have had reasonably free hands. This interpretation is either too idealistic or premature.

- The theory of the take-over of the punitive functions of the juvenile justice system

A third interpretation of the evidence compares the authoritarian and arbitrary features of the mental health model and of the juvenile justice system, because it finds them very similar. The increasing willingness of CMHCs, DTPs and justice agencies to collaborate is said to be leading to the same relationship that so frequently exists between local judges and state hospital superintendents. "Mental health" or "drug treatment" is just another mode of social control, a method for confining people or keeping strings on them, when powerful leaders decide that these persons are different and somehow dangerous. The welcome with which "diversion" to mental health treatment is greeted by some juvenile justice system leaders is a reflection not of their being humane, but of their recognizing compatibility. As ordinary procedural and substantive civil rights are more and more applied to the juvenile justice system, it will be harder to treat juveniles in the same arbitrary way, except by slipping them over into the mental health system a few jumps ahead of the civil rights advocates.

This interpretation fails in omitting to notice that civil rights advocates are about as interested in mental patients - and perhaps in children - as in any other groups they know to be dependent and who may therefore rather easily be treated arbitrarily. It also neglects to notice that mental health professionals have rather consistently placed high priority on building internal controls by moral suasion, insight, the expressive relief of tensions, or by modifying physiological balances. Deterrence by punishment has never in modern America been given equal priority by mental health professionals, and has usually been denied overtly though sometimes effectuated in practice. In contrast, punishment and retribution have been given considerable priority by corrections officials, whatever academic penologists may have urged.

The common ground has lain beneath the doctrine that "some people just can't be left to live freely in society." But even this proposition takes a restricted meaning among community mental health practitioners, who sometimes claim to know that a little bit of punishment by confinement (ten days or so) is more effective than a lot.

So far as the data gathered in this study are concerned, we found little that either proves or disproves this theory. Some CMHCs may prescribe psychotropic drugs to some patients in quantities that result in a special kind of imprisonment for their users, but others are much more cautious about drugs. Some of our informants seemed blase and over-forceful about sending juveniles into institutions or "residential treatment," a few others seemed over-determined to avoid all institutionalization. We conclude that this theory is also less than adequate.

B. <u>Concluding Note</u>

Like theories in so much of the corpus of the social sciences, these interpretations are tremendously useful as correctives of one another. They may be unconvincing as descriptions of fact, but they are powerfully accurate criticism, each of the others. The risk that "mental health-ism" could substitute for "juvenile justicism" without at all changing the outlook for juveniles is real enough to make us very cautious about advocating major juvenile diversions into ADAMHA-funded programs. The reported interest of most programs in juvenile offenders is weak, and their inhibitions about grappling with adjudicated offenders and the justice system strong. Idealistic extrapolation from the enthusiastic accomplishments of those already committed to working with juvenile offenders is accordingly unwarranted. But there are a committed few; they know what they are doing; they are usually realistic in their expectations; they have developed skill and experience in working with the system and with young people caught in it.

If the attack on the <u>parens patriae</u> system of juvenile justice succeeds, the likelihood is very great that the so-called status offenses will disappear from law. Youngsters now in trouble with the law because they are really in trouble at home, in school, or in the neighborhood, will no longer be subject to the same sanctions, nor the same relatively easy identification. At this point, however, the juvenile justice apparatus can be looked at as a vast and expensive case-finding mechanism for the CMHCs (and to a lesser extent the substance abuse treatment programs). The sanctions of law notwithstanding, young people called "status offenders" are in trouble: with authority figures, with self-image, with educational processes, with peers, with life and their ability to cope, or with the conditions of life in a particular kind of society in which they have a particular status. These, or many of these problems, are on the agenda of mental health. If the CMHCs and community clinics generally do not become progressively more skilled and involved in locating and assisting these troubled young persons and their usually troubled families, who will? Who can? If the CMHCs do not, what will happen if the legal practice of creating "status offenses" and "status offenders" is declared to be inconsistent with minimal civil rights? Probation can offer a certain kind of supervision and may provide shrewd and useful

counseling. Detention rarely is able to offer as much. But supposing that the status offenses simply disappear. Do the problems of the former status offenders - hundreds of thousands of new ones each year - disappear as well?

We suggest that the possible elimination and present wide-spread utilization of status offenses represent opportunity and prospective apparent need to begin working more intensively toward a most genuine process of diversion from (rather than within) the juvenile justice system, and toward the mental health agencies. But right now we are only at the stage of identifying relevant examples, guidelines, and prototypes. "Diversion" is not something that the programs studied in this project are ready to be plunged into, but something that a few local programs, suitably supported from ADAMHA and LEAA, are now in a position to learn how to do. The time for this learning is ripe, if deinstitutionalization, decriminalization, and a more self-conscious attempt to minimize destructive labeling is to continue. Even beyond this, the need for deeper exploration is urgent if the status offenses are to be eliminated altogether, for their elimination cannot eliminate the problem of troubled children in troubled families.

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