A Primer for Mental Health Practitioners Working With Youth Involved in the Juvenile Justice System

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Overview

Many mental health practitioners were trained in programs or at a time when very little attention was paid during the course of training to youth involved in the juvenile justice system. For a variety of reasons, general clinical training does not ordinarily equip a mental health practitioner to operate within the juvenile justice context. Practitioners who have been trained within more recently developed programs with a "forensic" emphasis may be more familiar with adults within the criminal justice system than with juveniles, more focused upon technical assessments such as competency to stand trial, than upon youth-specific developmental and functional assessments, or relatively unfamiliar with the emerging literature regarding youth with mental health needs who have had contact with the juvenile justice system or penetrated to its deeper end programs.

This paper provides an overview for mental health practitioners who provide professional services to youth who are involved with the juvenile justice system. This overview emphasizes emerging research and practices, the emerging conceptualization of trauma and its implications for youth involved with the juvenile justice

mental health diagnoses, and that some 60 percent of youth who warranted a mental health diagnosis also met diagnostic criteria for a substance use disorder (Shufelt & Cocozza, 2006).

The high prevalence of youth with significant mental health needs and co-occurring substance use disorders is a disturbing counterpart to research findings about the elevated risk of criminal justice system involvement for adults with serious mental health needs, particularly if these adults also have substance abuse problems[3]. The gradual recognition over recent years of the high prevalence of youth with mental health needs in the juvenile justice system has led to disturbing findings about the system, a system that was not designed to identify and respond as a clinical service system to meet the needs of these youth. Juvenile justice programs and facilities often lack established policies and practices, sufficient clinical and staff resources, and/or adequate training to effectively meet the needs of these youth. Youth with significant mental health needs who do not pose heightened public safety risks may be nonetheless incarcerated[3] Youth may be detained because mental health services are not available[4]. When detained or incarcerated in juvenile justice facilities, many youth will have poor or no mental health care.5 Additionally, many secure juvenile facilities are characterized by poor training for staff, inadequate clinical services, and improper medication practices.[6]

The need has become increasingly clear for:

- mindful public policy decision -

essential to achieving both public safety objectives and meeting the mental health needs of youth in the juvenile justice system. Whatever other perspectives or interests they may have, potential partners and stakeholders can ordinarily agree upon achieving common goals of (a) community, family, and youth safety, (b) supporting the positive development and success of youth involved in juvenile court, (c) positive engagement of family and community for youth at risk, and (d) cost -effective use of resources and professional expertise to meet needs, reduce risk, and support positive development over time. These collabor1(in)-2(p)-3(o)chit(i)--edc92(p)-3(-7(e)-1(8)-6(er)-3(t)-8(im)-2(e.(a)-9(c)1(b)-

providing assessments regarding the rehabilitation of juveniles should be attentive to the implications of distinguishing between rehabilitation and clinical treatment of mental health disorders (Kinscherff, 2006), [10] including:

- Assessments of youth involved with the juvenile justice system are most relevant when they address rehabilitation. The recommended services or interventions must specifically link to case-specific factors giving rise to delinquency and to factors that would reduce recidivism risk.
- The recommended services or interventions must actually be available, since rehabilitation cannot occur if the needed services cannot be accessed. The law in some jurisdictions further requires that services or interventions must be accessible through the juvenile justice system. Where the optimal services cannot be accessed, the clinician still articulates what the optimal services would be and why, but also provides an analysis of whether, or to what extent, accessible services are likely to have an impact upon rehabilitation as well as symptoms of mental health disorders.
- While solid clinical skills are essential, mental health practitioners must also be familiar with research regarding developmental trajectories of delinquent misconduct, and the psychiatric and/or cognitive impairments commonly found among delinquent populations.
- Mental health practitioners must also be familiar with and apply research regarding the efficacy of clinical assessments and interventions specifically relevant to reducing recidivism risk (rehabilitation) as well as symptoms and functional impairment arising from mental health disorders (treatment).
- In addition to the dimensions of mental health practice described above, clinicians must also be familiar with relevant law, policies, and practices of the specific juvenile justice system in which they are providing services, and the resources accessible

adolescent may reflect misguided efforts to achieve emotional intimacy while in another it may reflect calculated efforts to dominate or even humiliate the victim.

Failure to view a youth and that youth's misconduct through the broad lens of individualized developmental psychology may result in poor matching or even mismatching of interventions. For example, a youth p tth1-pw 1.0() pr 0.0et 1 [met 1 tth1-ectth1- it 1 9

forty-year old adult. Diagnosis is especially challenging when youth, such as those in juvenile justice settings, have complicated or difficult life histories and complex clinical presentations. The reliability of clinical diagnosis may be deeply compromised without

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problems associated with significant impulsivity, restlessness, and hyperactivity and so would be classified as the predominantly “hyperactive-impulsive” subtype. Another youth with ADHD may present primarily with problems with attention and concentration and lack prominent hyperactivity or impulsivity, thus classified as having the “predominantly inattentive” sub type. Most youth with ADHD have problems associated both with impulsive/hyperactive behaviors and significant impairments in attention/concentration, so are classified as the “combined” subtype.

ADHD can compromise academic and social learning, ageappropriate decision-making, and ability to conform to behavioral expectations in school and other settings. While most youth with ADHD do not go on to develop Disruptive Behavior Disorders, developmental complications associated with ADHD (e.g., learning diffic

and co-occurring substance use and/or ADHD are associated with poor outcomes[19]

Given that ODD describes behavior that is likely to result in significant friction with

Bipolar Disorder, particularly when a significant trauma history is unknown or inadequately considered by the diagnosing clinician.

Traumatic symptoms and post-traumatic adaptations may also present developmentally "moving targets" in the same youth over time. For example, a youth who presented with prominent anxiety and clearly trauma-related symptoms (e.g., intrusive thoughts of the traumatic event, traumatic nightmares) just after the trauma exposure may present later primarily with the adaptations to the acute impact of the trauma, such as psychological numbing to dampen anxiety, avoidance of situations or persons that may trigger reminiscences of the trauma, and intense emotional dysregulation when efforts to control emotions fail or trauma responses are triggered again.

To avoid being tricked by "Chimera" of psychological trauma, screening in juvenile justice settings should include screening for traumatic exposure and common trauma-related symptoms. Clinicians working with delinquent populations must carefully consider trauma in developmental formulation, differential diagnosis, and functional assessment. Failure to do so risks serious errors in indentifying mental health needs related to trauma exposures, clinical diagnosis, case formulation, and matching youth with clinical interventions.

Prevalence of Trauma in Juvenile Justice

There is a growing body of research demonstrating that a significant number of youth with trauma histories come into contact with the juvenile justice system.[21, 22] One study (Abram, Teplin, et al., 2004) found that 92.5 percent of youth in an urban juvenile detention center had experienced at least one traumatic event (mean: 14.6, median: 6) with 11.2 percent meeting criteria for PTSD in the previous year.[23] More broadly, a National Child Traumatic Stress Network (NCTSN) study (2008) [24] determined that more than 50 percent of youth in the juvenile justice system have had trauma exposures and that over 50 percent of them had developed at least some trauma symptoms.

This should not be surprising given that many youth who come into contact with and then penetrate deeply into the juvenile justice system have known severe emotional disturbances and histories of multiple system involvement. One study (Meusner & Taub, 2008) [25] of male and female youth with these characteristics found that 28 percent met criteria for PTSD (girls: 42%, boys: 19%) and that those with PTSD were also more likely to have histories of running away, delinquent behavior, self-injury, anxiety and

Diagnostic Challenges Arising From Trauma Histories

exposed to a single traumatic episode and those exposed to chronic or multiple trauma exposures. While the diagnosis of PTSD captured one variant of response to traumatic stress, it is arguably inadequate to adequately describe persons with traumatic stress histories that were more extensive and/or began in childhood rather than adulthood.

The existing diagnostic categories related to trauma among children and adolescents are a grey area of diagnosis insufficient to capture either the acute or the enduring developmental impact of psychological trauma. As a result, mental health professionals may fail to recognize symptoms or functional deficits that are actually related to trauma exposures. For example, mood instability arising from trauma may instead be diagnosed as Bipolar Disorder, trauma-related difficulties with attention/concentration may be diagnosed as ADHD, and flat emotional states may be diagnosed as depression rather than the "emotional numbing" arising from trauma. A diagnosis of "Developmental Trauma Disorder" has been developed intended to "capture the reality of the clinical presentations exposed to chronic interpersonal trauma."[26] While not currently in the Diagnostic and Statistical Manual of Mental Disorders (DSM) system,[27] its proponents argue that youth are "ill-served by the current diagnostic system as it frequently leads to no diagnosis, multiple unrelated diagnoses, an emphasis on behavioral control without recognition of interpersonal trauma in the etiology of symptoms, and a lack of attention to ameliorating the developmental disruptions underlying symptoms."[28]

As applied to youth in juvenile justice settings, those who do not meet the full criteria for PTSD may not receive a diagnosis that reflects the trauma origins of many of the features with which they present clinically. They may receive multiple diagnoses that individually capture some portion of their clinical presentation but which are not integrated in the clinical developmental formulation of the youth as having a common origin in trauma exposures. Particularly when youth present with defiant, provocative,

Whether or not Developmental Trauma Disorder is included in the DSM -V, it is essential that mental health professionals incorporate into practice diagnosis and intervention -planning consistent with the research[30] upon which the proposed diagnosis

At its heart, juvenile justice is a form of “future victim prevention” intended to secure safety for individuals and communities by intervening with youth whose misconduct has already compromised the rights and interests of others. It is crucial that the core mission not be compromised by devoting limited juvenile justice resources to youth who can be responsibly diverted at a variety points from unwarranted penetration deeper into the juvenile justice system. This is particularly the case for youth who can be supported in positive development through community-based responses or whose significant mental health needs outstrip the capacities of juvenile justice to meet those needs. Additionally, asking the juvenile justice system to become the default mental health services system for youth who do not pose significant public safety risks or who are likely to respond to community-based mental health services may contribute to a loss of focus upon the core mission of juvenile justice.

Despite other important differences among mental health professionals regarding policy and practice, or differences in perspective arising from their various roles in juvenile courts and juvenile justice, most can probably agree that it is best to avoid unnecessary penetration of youth into the juvenile justice system, ineffective use of scarce fiscal and human resources, and loss of focus upon the core mission of juvenile justice. Mental health professionals have

childhood experiences and adolescent onset of antisocial behavior, drug use, and depression.[40]

- Development of a trauma-informed approach to juvenile justice that recognizes the contribution of trauma to the emergence of high-risk behavior and delinquent misconduct, but which forges an alternative between the two traditional juvenile justice models of punishment or mental health intervention. Griffin, Germain and Wilkerson (in press, 2011)[41] thoughtfully describe a trauma-informed approach which places this alternative within current jurisprudence such as the US Supreme Court decisions of Roper and Graham, and which finds middle ground between punitive approaches and mental health approaches.

  The trauma-informed approach does not hold the youth responsible for the traumatic experiences but holds the youth accountable for learning how to manage perceptions, emotional reactions and behaviors when an acute trauma response is triggered or when maladaptive attitudes, beliefs, and behaviors emerge in response to trauma. It takes a strengths-based rather than a punitive approach, teaches specific alternative skills as the youth is held accountable for how they choose to manage their trauma-based perceptions and reactions, and "relies more on the use of supportive adult relationships in recovery."[42]

- Mental health professionals providing services to youth involved in the juvenile wla(h)-1(e0.2f6(en2t4f A Tw [(al)-8-13(d)-13(d T* [(wl)-71 9n r19(n)-3((a(g)-5gs)-2(i)-1)-3(azn)-3(ag

Notes

1 In her presentation at the National Leadership Forum on Behavioral Health/Criminal Justice Services (Washington DC. April 5, 2001), SAMHSA Administrator Pamela S. Hyde noted that more than 80 percent of adult state inmates, 72 percent of federal inmates, and 82 percent of jail prisoners meet criteria for mental health or substance use disorders. She also state that more than 41 percent of state inmates, 28 percent of federal inmates, and 48 percent of jail inmates meet criteria for both.

2 See, for example: Report of the Texas Juvenile Probation Commission (2003) indicating that 67 percent of incarcerated youth with high mental health needs were committed for non-violent offenses.

3 See, for example: Congressional Committee on Government Reform (2004) reporting that approximately two-thirds of surveyed juvenile detention facilities indicate that they hold youth because of lack of available mental health services.

4 See, for example: Congressional Committee on Government Reform (2004) reporting that some 25% of juvenile detention facilities have poor mental health treatment or no mental health services for youth.

5 See, for example: Report of the US Department of Justice (2005) reporting on a series of investigations of secure juvenile facilities and documenting poor staff training, inadequate clinical services, improper medication practices.

6 See NCMHJJ's Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System (Skowyra & Cocozza, 2007). The critical intervention points identified by the Blueprint For Change: (a) Initial Contact and Referral; (b) Intake; (c) Detention; (d) Judicial Processing; (e) Probation Supervision; or alternatively (f) Secure Placement; followed by (g) Re-Entry.

7 See, for example: SAMHSA's Helping Young Offenders Return to the Community , (Newsletter, 16(3): May/June 2008) for descriptions of model programs for community re-entry of juveniles, such as those funded by the Young Offender Reentry Program of SAMHSA's Center for Substance Abuse Treatment.See also: Resource Kit: Improving Services for Youth with Mental Health and Co-Occurring Substance Use Disorders Involved with the Juvenile Justice System. Available on the National Center for Mental Health and Juvenile Justice website.

8 Center for Mental Health Services (CMHS), SAMHSA. Comprehensive

Treating the Behavior Problems of Children and Adolescents Pacific Grove, CA: Brooks/Cole Pub Co.

19 Kinscherff, R. T. & Tobey, A. E. “Forensic Assessment in Juvenile Transfer Proceedings: Effects of Traumatic Stress and Chronic Violence.” Expert Opinion (Newsletter of Division of Forensic Mental Health of the Massachusetts Department of Mental Health. Law and Psychiatry Program (University of Massachusetts Medical Center) &1-12(e)-1(r)-4(s)-12(i)-1(t).s/21 57(E2:l)1(3-4(o)-4(b)-3(ep)1(i

probation violations, incarcerations, increasingly severe offenses and other legal difficulties.

29 Ibid.

30 See Pelaprat, M. Complex Trauma Among Court-Involved Youth . Doctoral Project, Massachusetts School of Professional Psychology, 2009. Of particular interest, this preliminary investigation relied upon assessments which did not include routine screening or assessment for dimensions of Developmental Trauma Disorder/"complex PTSD" and yet found that approximately 66% of the 41 youth whose cases were studied had experienced two or more forms of trauma exposure, and that dimensions of "complex" post-traumatic adaptation wtnadrenauteriencetnadr