

Critical Factors in Mental Health Programming For Juveniles in Corrections Facilities

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Abstract

Juveniles with mental health and other specialized needs are overrepresented in the juvenile justice system, and while juvenile corrections have not historically provided standardized and evidence-based mental health services for its incarcerated youth, the demand is evident. The reality is that juveniles with serious mental illness are committed to youth corrections facilities and justice systems generally do not have the capacity to provide effective mental health care. However, juvenile corrections are aware of the serious refractions involved and are exploring effective interventions. This involves examining the critical components of treatment and implementing promising youth correction programs for juveniles who are incarcerated. The authors review critical treatment factors involved in the mental health care of youth and provide recommendations to the field to further develop promising institutional programs.

Keywords: Juvenile, Mental Illness, Dialectical Behavior Therapy (DBT), Mode Deactivation Therapy (MDT), Family Integrative Transition (FIT), Aggression Replacement Training (ART), Thinking For a Change (TFAC), Motivational Enhancement Therapy (MET)

Introduction

Juvenile offenders with mental illness are a serious concern for juvenile correctional systems. There has been a steady increase of this population throughout the decade of the nineties (Teplin & McClelland, 1998; Timmons-Mitchell, et al., 1997). In 2003 about 2.3 million youth under the age of 18 were arrested and over 130,000 were placed in detention and juvenile correctional facilities (Cocozza, Trupin, & Teodosio, 2003). Concurrently there has been a significant increase in the number of juvenile offenders who have been diagnosed with mental illnesses and substance use disorders (Cocozza, 1997; Faenza & Siegfried, 1998; Libert & Speigler, 1990; Timmons-Mitchell, Brown, Schulz, Webster, Underwood, & Semple, 1997; Teplin, Abram, McClelland, Dulcan, Mericle, 2002; Villani, 1999 & Wasserman, Ko & McReynolds, 2004). Between 50 to 75 percent of all juvenile who enter the justice system has diagnosable mental health issues (Coalition for Juvenile Justice, 2000).

The minority population in the juvenile justice system has gone unnoticed. Juvenile offenders who are at risk to maltreatment and negligence among those with mental health disorders are females and African-Americans. Females in the justice system have had their treatment needs overlooked and minimized. Females have higher rates of mood disorders, substance use, sexual abuse, and physical abuse (Timmons-Mitchell, et. al., 1997 & Teplin, et. al., 2002). Furthermore, African-American youth are twice as likely to be arrested and seven times as likely to be placed in youth corrections facilities compared with Caucasian youth. There is a minority overrepresentation, a disproportionate minority confinement, and an under utilization of mental health service identification and implementation. The former refers to the harsher treatment of minorities in comparison to their corresponding Caucasian by the juvenile justice system. The latter is a subset involving only the harsher treatment of minorities detained at secure facilities during pretrial and post-dispositional stages. It is clear that all juveniles with mental health and other specialized needs are overrepresented in the juvenile justice system (Otto, 1992; Teplin, et. al., 2002 & Timmons-Mitchell, et al., 1997).

Juvenile justice administrators are faced with the multifaceted problems that arise when dealing with juveniles with serious mental illness. Although the literature on dealing with juvenile offenders with mental health issues is limited, juvenile justice administrators and mental health providers must be flexible in their responses. There has been a shift in the delivery of mental health services from

residential and community-based care to the treatment of the serious mentally ill juvenile offender. Thus, there is an even greater reliance on the juvenile justice system. Juvenile courts now expect that mental health treatment will be provided for youth while in juvenile correctional facilities. This creates a burden on the juvenile justice system as these administrators are hampered by inadequate approaches and practices for managing and treating this population (Altschuler, 1996; Burns, 1999; Butterfield, 1998; Hartman, 1997). Risks to youth have included retraumatization, difficulty reintegrating with the family, and acquiring antisocial behaviors as a result of exposure to negative peers (Veysey, 2003, Dishion, Thomas, McCord & Poulin, 1999).

Juvenile corrections play a significant role in coordinating the juvenile justice and mental health systems of care in the provision of treatment services for these youth. The reality is that juveniles with serious mental illness are committed to youth corrections facilities, and these facilities must develop the capacity to provide effective mental health care. Efficient mental health care requires the application of empirically supported casemanagement and treatment interventions; however there are few empirical studies on how to use the juvenile justice system's limited resources. Providers working with these youth must look deeper into specific individual issues, strengths, and problems. Along with many other skills, they must also be competent in providing appropriate interventions for the management and treatment of this population.

The purpose of this article is to review critical factors in mental health programming for juveniles in youth corrections facilities. This article is divided into six segments. Section one provides information on the prevalence of mental illness among juveniles. Information on population characteristics consisting of demographic data and other key trends in the juvenile justice system will be presented. Section two classifies mental health disorders. A categorical approach to address the disorders often diagnosed among juveniles will be discussed. Section three describes the relationship between youth characteristics and risk factors of juveniles involved in the justice system. Integrating risk and protective factors in treatment is the major emphasis. Section four provides information on the standard components of mental health care for juveniles in youth corrections facilities. Section five describes model facility programs, and section six discusses community programs and interventions based on promising practices. A listing and description of these programs will be provided.

Prevalence of Mental Illness Among Juvenile Offenders

The prevalence rate of mental illness is significantly higher in juvenile justice populations than those detected in the general population (Grisso & Barnum, 2000; Teplin & McClelland, 1998). In the general population, almost 21 percent of U.S. children between ages nine to 17 had a diagnosable mental or addictive disorder associated with at least one minimum impairment. Eleven percent, or roughly four million adolescents suffer from a major disorder that results in significant impairments at home, at school, and with peers (Report of the Surgeon General's Conference of Children's Mental Health, 2000-reference). Similarly, Friedman, and Glickman (1987) found the prevalence rate of serious emotional disturbance among adolescents in the general population to also be between nine and 13 percent.

Otto (1992), and Coccozza and Skowrya (2000) assert that mental health needs and services for youth in the juvenile justice system are consistently found to be at least twice as high than in the general population of adolescents. The estimates of afflicted adolescents are also much higher in the juvenile justice system (Davis, Bean, Schumacher, & Stringer, 1991; Grisso & Barnum, 2000; Teplin, et al., 2002; Ulzen & Hamilton, 1998). Estimates of mental illness are even higher for those youth confined in youth residential corrections facilities (Coccozza, 1997; Faenza & Siegfried, 1998; Libert & Speigler, 1990; Otto et al., 1992; Teplin et. al., 2002; Timmons-Mitchell, et al., 1997; Villani, 1999), ranging from 20 to 60 percent (Stewart & Trupin, 2003). Youth in the juvenile justice system are at a significantly high risk for

mental health issues that may have contributed to their criminal behavior (Wasserman, Ko, & McReynolds, 2004).

In Ohio's youth corrections facilities the Diagnostic Interview for Children (DISC) and the Millon Adolescent Clinical Inventory (MACI) were used to establish estimates of mental health diagnoses (psychopathology). Twenty-nine percent of the total population and 84 percent of the females manifested symptoms of serious mental illness. Eighty percent of the total population had substance use problems. Eighteen percent of those with serious mental health disorders had previously been admitted to inpatient mental health and/or substance abuse facilities, and 13.5 percent had attempted suicide (Timmons-Mitchell, et al., 1997).

Similarly, Teplin et al., (2002) assessed a randomly selected stratified sample of 1,829 African-American, non-Hispanic White, and Hispanic juvenile offenders confined to Cook County detention. They discovered that two-thirds of males and nearly three quarters of females met the criteria for one or more of the following mental health disorders: affective disorders, anxiety disorders, psychosis, attention-deficit/hyperactivity, disruptive behavior disorders, and substance use disorders. Even more astonishing is that excluding conduct disorder (which is highly prevalent in the juvenile justice system), 60 percent of males and more than two thirds of females met criteria and had a diagnosis specific impairment for one or more mental health disorders. The data suggests that adolescents of the juvenile justice and mental health systems are often the same individuals and that they shift back and forth between mental health and juvenile justice systems (Teplin et al., 2002 & Timmons-Mitchell et. al., 1997).

Furthermore, in a study by Atkins, Pumariega & Rogers (1999), estimates of juveniles confined in youth corrections facilities, with mental health problems, were comparable to rates of juveniles treated in community mental health centers and psychiatric hospitals. Seventy-two percent of these adolescents were classified as mentally ill.

Additional studies examining mental health rates of adolescents placed in youth corrections facilities have yielded similar results. Using a structured diagnostic interview for 350 detained males and females, the state of Maryland (Shelton, 1998) discovered that 57 percent of its juveniles placed in youth corrections facilities had a history of mental illness, 83 percent reported a history of alcohol and drug use, and 19 percent reported having suicidal thoughts. In assessing the mental health disorder of 693 youth in detention centers, the state of Georgia's juvenile justice system found that 61 percent of its juveniles had mental disorders, including substance use disorders (Marsteller, Brogran, & Smith, 1997). Similarly, the state of Virginia, while reviewing data from 17 residential corrections facilities, showed that eight to 10 percent of adolescents needed immediate mental health treatment (acute services) and that 77 percent of the adolescents met DSM-IV criteria for a mental disorder (Policy Design Team, 1994). By qualifying the definition of mental illness, the Policy Design Team came up with four categories based on the degree of functional impairment. The categories included none, minimal, moderate and severe/urgent. Of a total of 605 juveniles who participated in the study, 38 percent of the males and 43 percent of the females fell into the moderate range of mental illness and seven percent of the males and 15 percent of the females fell within the severe/urgent range. The most frequent diagnostic category was conduct disorder (52 percent) and 16 percent were believed to qualify for a diagnoses without accompanying conduct disorder or substance abuse disorder.

In assessing the mental health symptoms of adjudicated youth involved in the State of Washington Juvenile Rehabilitation Administration system, Stewart & Trupin (2003) discovered significant findings. Those who reported a high level of mental health symptoms (not DSM diagnoses) on the Massachusetts Youth Screening Inventory-Two (MAYSI-2), with or without co-occurring substance use problems, were likely to receive longer sentences and less likely to be eligible for community transition programs.

The differences in prevalence estimates may be partly related to the diagnostic testing instrument used. For example, some diagnostic instruments yield estimates of psychopathology while others yield estimates of clinical symptoms (Stewart, & Trupin 2003). Wasserman, McReynolds, Lucas, Fisher, and Santos (2002) suggest that prevalence studies in these areas may have been limited by use of inappropriate instruments, inadequate information about what point in the juvenile justice process assessments were conducted, and unspecified or possibly unknown sample characteristics. In addition, higher rates of mental illness appeared in studies that used direct youth assessment rather than record review. A common procedure for identifying youth with special needs relies on the documentation of prior mental health services. However, relying on this practice alone to determine service needs for youth entering the juvenile justice system deprives critical rehabilitation services to those youth who have not been treated for their mental illness in the past. In 1999, Novins, Duclos, Matin, Jewett, and Manson, conducted a study of incarcerated juveniles (as cited in Wasserman et al., 2002), only 34 percent of those with recorded diagnosis of affective, anxiety, or disruptive behavior disorders had received services.

Other explanations indicate that previous studies often failed to identify the time frame for the diagnosis because differentiating between lifetime and current diagnosis is critical for determining accurate prevalence rates and in planning for immediate service needs. To address these incongruent findings, Wasserman et al. (2004) conducted a study that examined the practicability of administering the Voice DISC-IV to accurately assess the rate of psychiatric disorders in male youths who were recently admitted to the juvenile correctional institutions in Illinois and New Jersey. Findings appear to be valid as the rates of disorders are comparable to those found on other formats. In the past month, 18.9 percent met the criteria for having any kind of anxiety disorder, 9.1 percent met the criteria for having any kind of mood disorder, and 49.3 percent met the criteria for having any kind of substance use disorder. Thirty one and one eighth percent met the criteria for having any kind of disruptive behavior disorder in the past month, including Attention Deficit Hyperactivity Disorder. Even more alarming is that within the past six months 31.8 percent met the criteria for Conduct Disorder.

While there are differences in numbers, most studies are comparable in their findings. However, nearly all studies may underestimate the prevalence rates of mental illness among youth incarcerated in corrections facilities. This is partly due to studies excluding youth who were not incarcerated at the time as their charges may have been less serious, they were released, or they were placed into the mental health system. Also underreporting of symptoms by youth is quite common particularly for those with disruptive behavior disorders (Teplin, et al., 2002).

Table 1 summarizes the Prevalence of DSM Diagnoses in Incarcerated Juvenile Justice Samples conducted between 1992 and 2002. These studies are a representative sample of the prevalence of mental health disorders among juvenile offenders in youth corrections facilities.

Table 1: Prevalence Rates of DSM Diagnoses in Incarcerated Juvenile Justice Samples

While juvenile corrections provide mental health services for youth, the problem lies in the fact that there is a lack a research base to support its effectiveness. The following section provides a review of terms and definitions related to mental health disorders. An overview of classification and categorical systems will be presented.

	Davis et al 1991	Otto et al 1992	Marsteller et al 1997	Timmons- Mitchell et al 1997	Atkins et al 1999	Teplin et al 2002
Type of Disorder or Diagnostic Category						
Conduct Disorder/ Disruptive	81%	50-90%	35%	100% 96% M F	42.7%	40.9% 44.6% M F
Substance Abuse & Dependence	79%	25-50%	30%	88% 56% M F	20%	49.4% 45.9% M F
Mood/ Affective Disorders	32.3%	32-78%	13%	72% 82% M F	24%	18.7% 27.1% M F
Anxiety Disorders	6.4%	6-41%	30%	52% 72% M F	33%	21.2% 29.4% M F
ADHD	18.5%	0-46%	7%	76% 68% M F	1.3%	16.5% 21.1% M F
Psychotic	.6%	1-6%	N/A	16% 12% M F	45.3%	1% 1% M F
PTSD	N/A	N/A	N/A	N/A	N/A	N/A
Mental Retardation	4.1%	7-15%	N/A	N/A	N/A	N/A
Learning Disabilities	N/A	36%	N/A	N/A	N/A	N/A
Sleep Disorders	2.9%	N/A	N/A	68% 76% M F	N/A	N/A
Eating Disorders	N/A	N/A	N/A	0% 16% M F	N/A	N/A
Personality Disorders	16.8%	2-17%	N/A	N/A	N/A	N/A

How Are Mental Health Disorders Classified?

Mental Health Disorders in Juveniles Defined

Juveniles with mental health disorders comprise a heterogeneous population with varying degrees and manifestations of mental illness. This has added to the difficulty in addressing mental health issues. Part of this intricacy is the multiple uses and definitions of the term mental health disorders. However, a distinction may be drawn between youth with serious mental illness and youth with serious emotional disturbances. The juvenile with serious mental illness poses the greatest challenge to juvenile correctional administrators and staff. Youth with serious mental health issues require multiple services and supports. Necessary services include medications, intensive services for acuity, substance abuse treatment, and educational services (Underwood, Barretti, Storms, Safonte-Strumbolo, 2004).

Grisso and Barnum (2000) refer to the range of mental health disorders as lying within the *narrow band*, i.e. serious mental health disorders and formal DSM-IV diagnosis, and *broad band*, i.e., severe emotional and adjustment problems regarding family, school, or community. As the DSM-IV-TR (2000) struggles with appropriately integrating the mental health needs of juveniles, there can be confusion in identifying mental health disorders in this population. Mental health issues and behavioral issues are not always fully distinct. Thus, a flexible diagnostic classification approach is necessary in distinguishing between the mental health and juvenile justice issues and implementing treatment strategies to deal with both sets of issues. For example, antisocial and/or aggressive behavior is often mistaken as serious mental health disorders, when, in fact, there may be no manifestations of serious mental illness or it coexists with the antisocial and/or aggressive behavior.

Categories of Juveniles with Mental Health Disorders

To lessen the confusion between definitional and diagnostic concerns, Underwood and Berenson (2001) proposed a categorical approach to mental health.

They recognized that juveniles with mental health disorders who enter the juvenile justice system are different in terms of demographics, personal histories, personality functioning, and manifestations of mental disorders. When planning mental health services for these youth, it is important for juvenile justice administrators to have a framework based on the range of mental health disorders so that the appropriate treatment addresses the unique needs of each youth.

The following framework is presented to distinguish between six categories of mental health disorders that are common among the juveniles in the juvenile justice system. Each group of disorders has unique behavioral symptoms that pose as challenges to the treatment and management of juveniles in the justice system. These indicators must be addressed, by providing mental health interventions tailored to the individual, so that more comprehensive treatment can be implemented for the purpose of reducing the risk of future mental health crisis and criminal behavior.

Table 2: Categories of Juveniles with Mental Health Disorders

Typical DSM-IV Diagnoses	-Major Depression -Dysthymia -Bipolar Disorders	-Post Trauma Stress Disorder -Obsessive Compulsive Disorder -Phobias	-Schizophrenia -Schizoaffective - Schizophreniform -Delusional -Psychotic Disorders	-Conduct Disorder -Oppositional Defiant Disorder -Intermittent Explosive Disorder	-Alcohol and Substance - Abuse/Dependence diagnoses with other mental health diagnoses	-Manifest themselves by odd/eccentric behaviors, dramatic/emotional reactions and anxious/fearful responses to expectations.
Some Alterations in Mood and Behavior	-Shifting mood -Irritation -Episodes of Anger -High risk behaviors -Disinterest - Hopelessness	-Mimic mood of staff and peers -Bed time agitation - Ruminative Thinking	-Frequent talking to oneself -Brief outbursts of anger -Inappropriate laughter	-Adversarial relationships -Limited problem-solving -Manipulative -Anger often reflects fear	-Drug-seeking behavior -Symptom presentation may shift from depression and anxiety to withdrawal	-Behaviors may appear spontaneous and natural -Compulsive, manipulative, covert and acting out behavior common
Some Management Issues	-Open settings/& active participation encouraged -Behavior therapy -Supportive confrontation	-Extra reassurance needed -Verbal de-escalation strategies -Active Listening	-Careful observation of youth -Low stress and non-confrontational methods	-Consistency -Direct, confrontational methods -Ongoing testing to rule out organic factors.	-Staff should be cross-trained in mental health and substance use disorders -Modulated therapeutic confrontations	-Accountability needed -Clear expectations from staff -Positive role models from staff -Use of behavior contract

Affective-Based

Affective disorders refer to long-standing, chronic mood states that have the potential to affect all aspects of a juvenile's life. Affective disorders can involve a significant elevation of mood states and can occur as full or partial episodes. Judgment and reason can also be affected. Psychological and physiological symptoms affect energy levels and mood regulation. Juveniles with affective disorders may experience feelings of sadness, hopelessness, helplessness, worthlessness, and agitation. They may also experience sleep disturbance, lethargy, and decreased interest in pleasurable activities or lack motivation. Common diagnoses found in the DSM-IV-TR include major depression, dysthymia, and bipolar disorders (Underwood & Berenson. 2001).

Affective disorders are common among juvenile offenders, ranking closely behind conduct and alcohol dependence disorders. When working with juveniles with affective disorders, it is important to be aware of the following alterations in mood and behavior.

1. Depressive states, co-occurring with conduct disorders, increase suicidal ideations and behavior.

2. Shifting mood states, from elevation to depression within brief periods, often occur without obvious provocation and are unpredictable.
3. Experiences feelings of agitation and irritability.
4. Exhibits spontaneous episodes of anger.
5. Engages in high risk behaviors.
6. Disinterest in daily activities resulting in social isolation and withdrawal often increases apathy.
7. Hopelessness and helplessness accompanied with an “I don’t care” outlook on life are symptoms of depressed mood states.
8. Resist pharmacological management or seek inappropriate levels of medication in order to dull mood states.

Anxiety-Based

Anxiety disorders refer to the persistent experiences of nervousness, tension, apprehension, and fear. These feelings may be real or imagined and affect concentration, daily performance, and can impair physical ability. Juveniles with anxiety disorders can become apprehensive about the outcomes of routine. They may experience panic attacks and/or develop phobias that can interfere with daily activities. Anxiety disorders in juveniles may be characterized by extreme terror, worry and hypervigilance. Juveniles may experience intruding and invasive thoughts of past abuse and may actually relive certain emotions that were present during the episode(s) of the original abuse. Some may have witnessed high levels of violence, aggression, and chaos in their families, schools, and neighborhoods. Diagnoses found in the DSM-IV-TR include posttraumatic stress, obsessive-compulsive, panic disorders and phobias. When working with juveniles with anxiety disorders, it is important to be aware of the following alterations in their anxiety and their behavior (Underwood & Berenson, 2001).

1. Limit testing behavior with the goal of diminishing internal conflict which emanates from the anticipation of danger.
2. Increased agitation occurs during periods of unrest in their environment. These juveniles tend to mimic the mood and tension levels of their peers and staff.
3. Increased agitation around bed time which may stem from intruding thoughts of being abused in the past.
4. During heightened states of anxiety, these juveniles may be very difficult to manage as they may episodically exhibit panic or dissociation.
5. Anxiety can mimic physical symptoms. Availability of medical staff is necessary.
6. Anxiety and depression co-existing together is common which results in a greater risk for suicidal behavior.
7. Ruminative thinking that can generate more anxiety.

Psychotic-Based

Psychotic disorders refer to a disintegration of thinking processes, affecting cognitive function, perception, judgment, and mood. These disorders involve the inability to distinguish external reality from internal beliefs. Juveniles with psychotic disorders may experience poor reality testing, hallucinations, delusions, paranoia, social withdrawal, and ideas of reference. Disorganized speech and psychomotor disturbance are also common. These juveniles may have significant histories of bizarre experiences. Members of their families may or may not have struggled with similar or other mental health issues. DSM diagnoses include some organic mental disorders, schizophrenia, schizoaffective, schizophreniform, brief reactive, delusional, psychotic and substance-induced psychotic disorders. These juveniles may appear to be odd and different with profiles including language and communication deficits along with psychomotor retardation. They tend to withdraw from interpersonal activities and may become paranoid

of their surroundings. Staff members generally are aware that these juveniles are not fully in contact with reality and may describe these juveniles as “unusual”. However, based upon cultural differences and level of intelligence, these juveniles might overcompensate in certain areas, allowing them to appear better adjusted psychologically. When working with juveniles with psychotic disorders, it is important to be aware of the following alterations in their thought and their behavior (Underwood & Berenson, 2001).

1. Juveniles in an active psychotic episode should be probated to community psychiatric facilities as soon as possible.
2. Adjustment to the correctional facility will be extremely difficult and if possible, removal from the facility to a psychiatric center is optimal.
3. Poor pharmacological management due to denying the existence and intensity of their problems is part of the symptomatology.
4. Teasing and victimizing behaviors exhibited by peers and staff due to their ignorance of the illness is common.
5. Frequent talking with oneself and arguing with unseen individuals is characteristic of psychosis.
6. Brief outbursts of terror which may be closely followed by eruptions of inappropriate laughter should not be confused with acting-out behavior.
7. Unprovoked impulsive behaviors that can range from low level impulsivity to acts of violence may occur.

Co-Occurring Mental Health

Co-occurring disorders refer to the simultaneous experience of a substance use (abuse or dependence) and a mental disorder. A diagnosis of co-occurring disorders occurs when at least one disorder of each type can be determined independent of the other and is not a cluster of symptoms resulting from the other disorder (Miller, Zweben, Diclemente, & Grychtarik, 1995). These disorders have pronounced affects on the thoughts, mood and behaviors of juveniles. Juveniles with co-occurring disorders often have histories of deeply rooted mental health issues for which the substance use allows temporary relief of emotional pain. Juveniles with co-occurring disorders may also be more impulsive and potentially more violent than youth with an isolated mental health or substance use disorder. Often both the mental health and substance use issue are unrecognized and described by others as “acting out” behavior. These youth often fall “between the cracks” due to mislabeling and failing to recognize their unique and specific needs. Disorders seen in the DSM include the alcohol and substance abuse/dependence diagnoses along with another mental health diagnoses. Substance use in juveniles exhibiting co-occurring conduct disorders and depression becomes a major a risk factor for ongoing delinquency (Underwood & Berenson, 2001). When working with juveniles with co-occurring disorders, it is important for staff members to receive the following prerequisite training:

1. Cross-training in mental health and substance use disorders to fully understand each disorder, along with the co-occurring nature of the disorders is essential.
2. Dynamics of drug-seeking behavior as well as medical complications.
3. Symptom presentation may shift from signs of depression and anxiety to withdrawal.
4. Modulated therapeutic confrontations according to the fragility of the mental status of the juvenile.

Personality-Based

Personality disorders and traits refer to ingrained pervasive patterns of functioning that affect cognition, perception, mood, and behavior. The impact of these disorders affects the behavior of juveniles as they experience difficulties that are deeply rooted in their personality. These disorders

involve underlying features of personality and may not necessarily be pathological, although certain styles may cause interpersonal problems. These disorders are rigid, inflexible, and maladaptive and can often cause functional impairment and subjective distress. Juveniles with personality disorders and traits are difficult to manage and treat because the very existence of the disorder is often tied into the long-standing patterns of adversarial interpersonal relationships. Personality disorders seen in the DSM-IV-TR are divided into three categories because they share common features. They include odd and eccentric behaviors, dramatic and emotional reactions to daily events, and anxious and fearful responses to expectations (Underwood & Berenson, 2001). When working with juveniles with personality disorders, it is important to be aware of the following personality alterations as well as management issues:

1. Behaviors may appear totally unrelated to the primary mental health diagnoses.
2. Behaviors may appear spontaneous and natural.
3. Juveniles do not consider the impact of their behaviors on others due to the pervasive nature of the disorders and traits.
4. Behaviors, which are integral to the juvenile's way of life, pose serious obstacles to treatment. Staff must understand that these behaviors change slowly.
5. Symptom substitution including other compulsive, manipulative, covert and acting out behaviors is common.

It is important to note that juvenile offenders with mental health disorders will rarely display sole features of the aforementioned categories (Ries, 1994). Combinations of behaviors, based upon their experiences of life are manifested differently in each juvenile.

Disruptive Behavior-Based

Disruptive behavior disorders refer to a cluster of law-breaking and intrusive and invasive behaviors, often evidenced by disorderly conduct and aggression. Juveniles with disruptive behavior disorders are impulsive and often maintain underlying affective or anxiety-based disorders. They often may have histories of mood and anxiety disorders and criminal behaviors, with persistent disruptions that violate the rights of others and societal norms. Destruction of property, deceitfulness, and aggressive acts are often experienced in the course of these disorders. Genetic and biological factors may significantly contribute to the onset of symptoms. DSM diagnoses include oppositional defiant, conduct, and intermittent explosive disorders. The most common diagnosis for boys is conduct or oppositional defiant disorders often with an additional diagnosis of attention deficit hyperactivity, major depression, and/or alcohol dependence disorders (Underwood & Berenson, 2001). When working with juveniles with disruptive behavior disorders, it is important to be aware of the following alterations in mood and behavior.

1. Certain behaviors are exhibited in the attempt to dull or mask underlying emotional issues.
2. Adversarial relationships and negative attention seeking behavior is often preferred by juveniles with these disorders.
3. They often have limited problem solving skills.
4. Radically different ways of perceiving relationships is common.
5. Self-serving views of the world with the inability to understand the concept of injury to others is characteristic.
6. Use of power tactics and manipulative behaviors with peers and staff members are often common and perpetuate adversarial relationships.
7. The expression of anger is usually an attempt to re-channel underlying fears and anxieties.

Neurologically-based

Many disorders can be considered neurologically-based, but for the purpose of the article, refer to those neurological disorders found in the DSM. Disorders that limit intellectual functioning include mental retardation, learning disorders, motor skills disorder, communication disorders, pervasive development disorders, attention-deficit/hyperactivity disorders (ADHD/ADD), feeding and eating disorders, tic disorders, and elimination disorders. Many behaviors displayed by juvenile offenders with neurological disorders can be misinterpreted especially those with ADHD/ADD (Underwood & Berenson, 2001).

ADHD/ADD transpires as a result of neurological dysfunction in the prefrontal cortex. The prefrontal cortex controls the part of the brain that guides, directs, and focuses behavior (Amen, 1998). It allows individuals to formulate goals, to make plans, to follow through with those plans, to alter their direction and to improvise in the face of problems or failure, and to do so successfully, without external direction or structure (Ratey, 1995). Juveniles with poor prefrontal cortex functioning experiences difficulty thinking about what to say before they say it and often come into conflict with parents, teachers, police officers, and friends. Inattentive symptoms such as appearing not to listen, frequent forgetting, and failing to follow through on instructions are also quite common (McInnes, A., Humphries, T., Hogg-Johnson, S., Tannock, R., 2003). The inability to concentrate on certain tasks is another characteristic of ADHD/ADD. Situations that require concentration, impulse control, and quick reactions are hindered by the dysfunctional prefrontal cortex. Due to the lack of activity, the prefrontal cortex creates its own stimulation. This can lead to problems such as lying, stealing, and fighting. Many juveniles with ADHD/ADD unconsciously seek conflict as a way to stimulate their brain. Often times ADHD/ADD causes juveniles to repetitively make mistakes because they have trouble learning from their past experiences (Amen, 1998).

When working with juveniles with ADHD/ADD, it is important to consider the following:

1. Disruptive behaviors of juveniles with ADHD/ADD may not be willful and may be the result of their disorder.
2. The longer ADHD/ADD symptoms go untreated, the more likely the individual will progress into criminal behavior.
3. Even if juveniles with ADHD/ADD want to control their actions, their behaviors can still be inconsistent and unpredictable.
4. Juveniles with ADHD/ADD do not respond well to repetitive, effortful, tedious activities that others choose for them.
5. Many juveniles with ADHD/ADD have a low threshold for arousal and are easily provoked.
6. Juveniles with ADHD/ADD need immediate, frequent, predictable, and meaningful rewards.
7. Juveniles with ADHD/ADD are at a higher risk for depression and other mood disorders.

The following section provides information on the relationship between risk factors and youth characteristics.

The Relationship Between Risk Factors and Challenges of Youth

Over the past 10 years, researchers have emphasized prevention measures and protocols that focus on changeable treatment targets. These targets focus on observable and measurable behaviors. Additionally, these targets refer to behaviors that are desirable only when a juvenile is a member of a group whose risk of becoming ill is above average (Marczyk, Heilbrun, Lander, & DeMatteo, 2003).

Without proper interventions, these individuals run a high risk for future development of problems that may lead to further emotional deterioration and delinquency. Proper interventions must be administered to juveniles that focus on risk factors that can be changed (i.e., behaviors, attitudes). Research suggests that explanations of delinquency and other emotional and behavioral outcomes may be similar among juveniles with emotional and behavior problems than with juveniles who do not have emotional and behavior needs (Henggeler, 1998).

The terms risk and protective factors have been used to explain mental illness and delinquency. These terms allow researchers to promote consistency in research and to compare other research findings. Risk and protective factors, drawn from epidemiological studies, correlate with the onset and pattern of mental illness and delinquency. The factors that contribute to mental illness and delinquency are referred to as “risk”. The factors that prevent or inhibit mental illness or delinquency are called “protective” factors (Farrington, 1998).

Relevant risk and protective factors for mental health and delinquency are not fully understood. The upbringing, lifestyle, and environments of juvenile offenders may include physical, verbal, and even sexual abuse and traumatic experiences (Garbarino, 1995). The risk and protective factor’s domain include individual, peers, families, schools and communities. These juveniles have poor employment histories, unstable interpersonal relationships, and ongoing substance abuse issues (Haapanen, 1990) Researchers have relied upon different risk and protective factors such as socioeconomic, situational and biological factors. (Cellini, 2000; Farrington, 1998; McCord, Widom, & Crowell, 2001). As such, the below review of the various challenges of youth serve as a framework to contribute to the emerging body of information on risk factors and mental health program services for juveniles in youth corrections facilities.

Individual & Peer Factors

Offending and antisocial behavior can be defined as recurring violations of socially prescribed patterns of behavior, often characterized by hostility, aggressive behavior, defiance of authority, and violations of social norms and mores (Simcha-Fagan, Langner, Gersten, & Eisenberg, 1975) Socially, these individuals may be described as egocentric, manipulative, grandiose, and forceful (Lyman, 1996), often evidencing shallow emotions, lack of empathy, and little remorse for wrongdoing (Gresham, 2000).

These behavior patterns can develop at an early age, which may correspond to etiological variations, and subsequent progressions of a serious criminal career, or most notably, mental illness. There are distinct pathways to the development of disruptive and serious delinquent behavior that can be prevented, but often is not. Early childhood factors include having a difficult temperament, hyperactivity/impulsivity/attention problems, and stubbornness. During the preschool years, if a child with aggressive and disruptive behavior begins to lie without any remorse, serious issues can emerge in early adolescence that may include stealing, engaging in sex, and abusing substances. Depression and exposure to violence along with a favorable attitude toward delinquent behaviors heighten the risk for becoming a serious juvenile offender. Many youth with disruptive disorders develop a spectrum of personality disorders in adulthood (Rey, Morris-Yates, Singh, Andrews, & Stewart, 1995).

Of noteworthy interest are correlations between juvenile delinquency and personality functioning, which have classically been associated with psychopathy and antisocial personality, including examples of recklessness, lack of a sense of responsibility, disinhibition, absence of shame, guilt, or remorse, impaired capacity for relationships, scarcity of affect, and lack of goal-directedness (Steiner, Cauffman & Duxbury, 1999).

In examining the characteristics of delinquents over the years, a variety of typologies have been proposed. Experts suggest (Loeber & Farrington, 1998) that there is a common theme of progression from fewer, less serious types of offending to further, more serious types of offending. Loeber, et al., (1991) summarize this progression into three different patterns and outcomes in the development of childhood disruptive behavior: (1) *authority-conflict*, including stubborn behavior, defiance, and authority avoidance; (2) *covert behavior*, including minor insidious damage and moderate forms of delinquency; and (3) *overt behavior*, including aggression, fighting, and violence.

Juveniles with serious antisocial and aggressive behavioral patterns who violate social norms and mores comprise between 35-50 percent of referrals to mental health clinics, making it the most commonly cited reason for bringing adolescents to the attention of mental health providers (Rogers, Johansen, Chang, & Salekin, 1997). Furthermore, institutional placement of juveniles with antisocial behaviors is becoming more common. These youth are three times more likely to report acts of vandalism, assault, shoplifting, gang involvement, and carrying a weapon on school property within the past 12 months than their public school counterparts (Fulkerson, Harrison & Beebe, 1997).

Many juvenile delinquents are invested in antisocial attitudes and beliefs that rationalize their violent solutions to their interpersonal problems. (Walker & Gresham, 1997). They commonly perceive another's behaviors and intentions toward them as hostile and threatening (Dodge, 1986). This may be due to a perceptual bias that distorts their ability to accurately decipher and interpret another's behavior, precipitating aggressive reactions to situations viewed as intimidating or threatening (Walker & Gresham, 1997).

Family and Neighborhood Factors

The profiles of juveniles in the juvenile justice system clearly indicate the extent of family and environmental risk factors. Family issues that have been consistently implicated in juvenile justice include poor parent-child relationships, lack of discipline, parental or family conflict, absence of a father, being born a teen mother, neglect, coercive child-rearing (Farrington, 1998; Patterson, Reid & Dishion, 1992), lack of warmth and affection, inconsistent parenting, sexual abuse, violence, disrupted attachments, and parental substance abuse (Henggeler, 1998).

Numerous studies link delinquent behavior and emotional distress with many different aspects of family functioning. Among these studies, family characteristics are suggested to be parental or familial antisocial behaviors or values, including criminal behavior as part of the family history, and stark parental discipline (Tolan & Lober, 1993). Several other studies across a range of populations related delinquent and poorly controlled emotional regulation to a lack of parental monitoring, neglect, poor discipline methods, and conflict about discipline (Farrington, 1989; Gorman-Smith, Tolan & Henry, 1998; Patterson et al., 1992). Similarly associated are low levels of parental warmth, acceptance and affection, low cohesion, high conflict and hostility, divorce, parental absence, and other losses (Farrington, 1994; Henggeler, Melton, & Smith, 1992; McCord, 1982).

Loeber and Stouthamer-Loeber (1991) completed a meta-analysis of concurrent and longitudinal studies and identified four heuristic paradigms that encompass much of the existing literature related to types of family problems associated with delinquent behavior. These family categories were identified as neglect, conflict, deviant behavior and attitudes, and disruption (Loeber & Stouthamer-Loeber, 1991).

Unstable or highly dysfunctional families can lead youth to look elsewhere for a family of their own. Experts believe that one of the many motivating factors for youth gang involvement is the unfulfilled need for a sense of family (Granello & Hanna, 2003). Juveniles who do not have a strong bond with their family and live in urban neighborhoods where crime is even higher are even more at risk

for engaging in deviant behaviors. Some communities have more opportunities for youth to engage in deviant behavior, others may encourage or tolerate criminal behavior. Some research suggests that in destitute communities, poor socialization has a significant effect on delinquency. Other risk factors include drug use in the community, poor academic achievement, truancy, lack of community or school involvement, long term unemployment in the areas, and high levels of community violence. Researchers further suggest that environments with collective efficacy, which involves an ability to look out for and support one's neighbors, may have lower crime rates even if otherwise disadvantaged.

Ethnic and Cultural Factors

In 1996, youth of color comprised about one-third of the juvenile population yet accounted for about two-thirds of the incarcerated population (Hamparian & Leiber, 1997). Other studies conducted on this disproportionate representation of minorities in the justice system have yielded similar results. African-American, Latina, and other youth of color not only continue to be, but are increasingly at risk for entry in juvenile justice systems rather than treatment centers (Bilchik, 1999; Elliot, 1994; Elliot, Huizinga & Menart, 1989; Tolan & Guerra, 1994).

Substantial evidence exists that youth of color are often treated differently than Caucasian youth within the mental health and juvenile justice system (Boyd, Franklin, 1991; Isaacs, 1992; Underwood and Rawles, 2002). Building Blocks for Youth, developed by the Youth Law Center, reports that youth of color experience a disadvantage as they move from arrest, to adjudication, to sentencing, and possibly to incarceration (Juszkiewicz, 1998).

Although the number of cases has increased for all racial groups in all offense and mental health categories over the last decade, rates for African-American youth remain well above rates for Caucasians and other minorities. Approximately two-thirds of the examined studies show that racial and/or ethnic status influences decision-making in at least one stage or another of the juvenile justice process. Even in controlling for offense, it is nearly twice as likely that cases involving African-American youth will enter detention and correctional facilities as cases involving Caucasian adolescents (Department of Justice, 1999).

Some believe this over-representation of youth of color in the juvenile justice system is a result of this population committing more crimes than Caucasian juveniles. Some studies of delinquent behavior do show that African American youth reported more offenses than Caucasian youth. Social and economic factors pertaining to African American and youth of color may present a partial explanation.

Delinquent behavior along with emotional disorders for this population stem from complicated medical, social and psychological factors (Bilchick, 1999 & Canino & Spurlock, 1994). Of all the minority adolescents who live in poor, urban communities, approximately 35 % live in "underclass" neighborhoods (Wilson, 1991) where crime rates are reported to be high. Most of their clinical profiles are characteristic of a young, undereducated, single family household headed by a mother, likely to be unemployed and on welfare (Isaacs, 1992).

Correlations with delinquency among youth of color include lack of legitimate job opportunities, increasing social isolation, poor schools, and weak community organizations (Isaacs, 1992). A culture of urban poverty, homelessness, and social disorganization yields maternal and child risk factors. Each subsequently constitutes more risk factors for adolescent and young adulthood crime and violence-me (Group for the Advancement of Psychiatry, Committee on Preventative Psychiatry, 1999). Furthermore these variables and others predict that youth of color have limited access to treatment networks and opportunities that would lessen the need for mental health services (Boyd-Franklin, 1991; Isaacs, 1992).

Substance Use Factors

Family functioning, school functioning, and peer relationships are consistently linked to substance-abusing youth who engage in delinquent activity (Henggeler, 1998). Youth placed in residential facilities are much more likely than youth in public schools to report the use of alcohol, and drugs. When compared to their public school counterparts, youth in community programs were two times more likely to use amphetamines and inhalants, three times more likely to use sedatives, five and one-half times more likely to have injected drugs, two and one-half times more likely to use marijuana and prescription drugs, six times more likely to use cocaine, four times more likely to use LSD, hallucinogens, and opiates, three times more likely to use alcohol or drugs before or during school, and two times more likely to drink at least six drinks when they drink alcoholic beverages (Fulkerson et al., 1997).

In recent years, it has been concluded that youth who abuse substances present with higher rates of comorbid psychiatric problems, such as depression and conduct disorder (Greenbaum, Foster-Johnson, & Petrila, 1996; Waldron, Slesnick, Peterson, & Turner, 2001; & Weinberg, Rahdert, Collier, & Glantz, 1998), and that youth who abuse substances are especially at high risk for developing co-occurring disorders (Capaldi, 1992; Cocozza, 1997; Thompson, Riggs, Mikulich, & Crowley, 1996). A 1999 study regarding psychiatric comorbidity among youth who abused substances demonstrated that youth who have substance abuse issues along with distinctive degrees of comorbidity, such as internalizing (i.e., affective disorders) and externalizing (i.e., conduct disorder) disorders, may be linked with differential longer-term treatment outcomes (Drake, Muesser, Clark and Wallach, 1996; Randall, Henggeler, Pickrel & Brondino, 1999). For example, adolescent substance abuse combined with comorbid externalizing disorders predicted high school dropout (Kessler, Foster, Saunder, & Stang, 1995) and inpatient treatment failure, (Abram & Teplin, 1991) whereas comorbid internalizing disorders predicted completion of inpatient treatment for substance-abusing adolescents (Kaminer and Frances, 1991).

Additionally, youth with substance abuse disorders and comorbid external disorders engage in even more delinquent acts than their substance-abusing delinquent counterparts. They also engage in higher rates of illicit drug use, use more marijuana and alcohol, and exhibit less family cohesion, greater conformity to antisocial peer pressure, and decreased school competence (Randall, et al., 1999). Consistent with previous investigations (Kessler, et al., 1995), comorbidity predicts poor treatment outcomes than substance abuse alone, and comorbid externalizing disorders, such as conduct disorder, predicts worse treatment outcome (Randall, et al., 1999).

Biological and Neurological Factors

Lewis (1992) has identified some youth as “intrinsically vulnerable children” who have cognitive, psychiatric, and /or neurological impairments, suggesting that such neuropsychologically impaired youth, by virtue of their hyperactivity and impulsivity, are more likely to be abused by adults in their families (Lewis, 1992). Some delinquent youth manifest characteristics that are biologically-based components of executive cognitive dysfunction or disorders of behavioral self-regulation. Biological factors, such as impairments of the central nervous system, head injury, poor nutrition, exposure to environmental toxins or genetic predisposition, are factors relating to mental disorders (Cellini, 2000). Examples that appear to be related to aggression in adolescents include difficulties with planning, focusing their attention, abstract reasoning, foresight, problem solving, self-monitoring, and motor control (Giancola, Martin, Tarter, Pelham, & Moss, 1996). Temperamental features can also influence aggressive behavior, such as sensation seeking and difficulties regulating affect (Pandina, Johnson, & Labouvie, 1992).

Youth With Special Needs

Youth with special needs, including ethnic minorities, females, mentally retarded, developmentally delayed, medically fragile, and violent adolescents, require unique intervention and treatment services. Specialized and culturally competent interventions must be integrated into the treatment plan of these youth. Collaboration with external and internal care systems and providers is especially important with these adolescents for the purposes of management and aftercare services. Some community programs provide separate housing units for these youth, as they benefit from smaller units, less stimulation, and more individual interaction (Underwood, Mullan & Walter, 1997).

Treatment expectations and curricula should be consistent with empirical literature for these youth. The following adaptations might be considered:

- Specialized training for all staff working with the group.
- Additional time with treatment interventions.
- Repetition of clinically relevant information.
- Graphic illustrations of program expectations.
- Use of behavioral rating systems.
- Modified positive reinforcement schedules.
- Customized treatment interventions.

The following section reviews standard components of mental health care for youth in correctional facilities.

Standard Components of Mental Health Care for Youth in Correctional Facilities

Correctional treatment programs are designed to reduce the incidence of delinquent and criminal behavior. Mental health interventions are designed to manage, and where ever possible, alter serious disorders of thought and affect. In planning for the delivery of mental health services in institutional settings that provide correctional treatment regimens, the following factors must be understood:

- Juvenile with mental disorders are a heterogeneous population, with differing etiologies, symptomatology, family dynamics, and courses of the disorders.
- Juveniles with mental health disorders have very high rates of co-morbidity with differing manifestations of psychopathology and with substance abuse disorders. (Fergusson, Horwood & Lynskey, 1993; Kashani, Orvaschel, Rosenberg, & Reid, 1989; Verhulst & Van der Ende, 1993).
- Female juvenile offenders who display co-occurring mental health and substance abuse disorders have high rates of depression (Angold & Costello, 1993; Capaldi, 1992; Robins & Regier, 1991; Timmons-Mitchell et al., 1997; Zoccolillo, 1992).
- Some juveniles with mental health disorders manifest deviant sexual arousal patterns and behavior (Kraemer, Spielman, & Salisbury, 1995).
- Juveniles with mental disorders, oftentimes, fail to benefit from traditional psychotherapies (Bourdin, 1999; Underwood, Mullan, & Walter, 1997). Cognitive-behavioral approaches have shown promising results with this population.
- Juveniles with mental health disorders often manifest symptoms of mental confusion, delusional thought processes, social withdrawal, and unpredictable behavior (Timmons-Mitchell et al., 1997; Underwood et al., 1997).
- Juvenile offenders with mental health disorders, almost by definition, maintain a diagnosis of Conduct Disorder, along with other diagnoses (Melton & Pagliocca, 1992).

The next section provides information on core post-release treatment strategies. These strategies may be tailored, depending on the nature of the post-release rehabilitation program and the characteristics of youth.

Screenings and Assessments

Screening refers to a “triage” process and should be conducted on the first day of a youth's admittance to the program with follow-ups throughout the program (Grisso & Underwood, 2005). Most are straightforward, short, and require minimal training to administer. Initial screenings are designed to identify mental health issues that may need to be further explored using various assessments methods. Screenings are helpful in identifying youth who are at increased risk of having learning disorders, mental health, substance abuse, and delinquency needs that warrant immediate attention.

A follow-up assessment should be conducted on youth's whose initial mental health screen is elevated. Mental health assessments are a more comprehensive and individualized examination of the psychosocial needs and problems identified during the initial screening and include the type and extent of mental health problems, substance abuse, delinquency needs, community adjustment and recommendations for treatment interventions. Using a range of assessment methods such as conducting a face-to face interview with the youth, observing their behavior, administering mental status exams, reviewing records, interviewing parents or other adults and taking family histories are ideal. (Center for the Promotion of Mental Health in the Juvenile Justice System [CPMHJJS], 2003). Generally, following an evaluation of these psychosocial needs include a diagnosis to guide the referral process or help with treatment planning. Furthermore diagnoses provide the juvenile justice and mental health providers with critical information that leads to the implementation of proven and evidence-based treatment principles.

Unlike screening, assessment serves a different purpose at different stages in the juvenile justice process. For example, at post-release intake, assessment results may be utilized to streamline services, resulting in a more appropriate and individualized post-release service plans. Before youth enter post-release programs, an initial mental health screen should be provided.

Treatment Planning

The purpose of the treatment plan is to integrate observations and findings from paraprofessional and professional staff members regarding the youth. Treatment plans address issues in education, community adjustment, life skills, medical health, mental health, community life activities, and other critical areas of care.

Treatment plans can serve as a “contract” between the youth, his/her family, juvenile justice staff, and the treatment provider. Treatment plans should be consistently updated on a monthly basis, with a formal meeting (professional staffing) with the youth, his/her parent, and members of the interdisciplinary treatment team. Treatment plans should be clear with measurable goals and objectives and whenever possible the youth should be involved in developing his/her individualized plan with the interdisciplinary treatment team. All youth should review and sign their treatment plans.

Treatment Strategies

Based on the needs of youth, specific treatment interventions should be implemented to address a wide variety of problems and solutions. Case management services should target behavioral symptoms and the provision of skills training for specific behavioral deficits. Treatment and case management interventions should rely on best practice and evidence-based procedures including positive reinforcement, behavioral monitoring, goal monitoring, behavioral shaping, coaching, modeling, role-play

practice, and constructive feedback. These techniques can be introduced and practiced in small groups and individual counseling sessions. Skill training should target a variety of symptoms by utilizing the following techniques: staying on topic, focusing attention, avoiding problem situations, identifying emotional triggers, accurate identification of their and others emotions, improving interpersonal behavior, and learning coping skills. Educational training for families should focus on improving their understanding of mental health and substance abuse disorders, recognizing and decreasing stresses that may lead to relapse, and teaching effective communication skills (Underwood, Barretti, Storms, Safonte-Strumbolo, 2004).

Structured Individual & Crisis Counseling

Structured individual and crisis counseling services should be used with youth based upon their level of risk (recidivism) and need (psychosocial). These services can be rendered by a paraprofessional or graduate prepared provider (Boesky, 2002). Individual counseling should focus on aspects of the youth's mental health, substance use, delinquency, community adjustment and family needs. Individual counseling also needs to focus on daily issues that arise and are pertinent to the youth's symptoms. Crisis intervention services should be provided to alleviate negative emotional symptoms (i.e., depression, anxiety, guilt, etc.) experienced by some youth. These services should be designed to encourage youth to utilize effective coping strategies and problem solving skills.

Group Counseling

Youth who show a readiness or a desire to improve their coping and relating skills should be allowed to join a group that will help them in this area. Structured group counseling is ideal to be used with youth to enhance their coping and problem solving skills. Short term psychoeducational and/or process group modules that are structured can help improve coping and problem solving skills. Sessions should be facilitated by a qualified mental health professional and a juvenile justice staff. During each session, each individual's interactions and behaviors should be observed so that they can be provided with constructive feedback of how they affect others around them. Immediate feedback not only allows youth to process the situation and to think of alternative ways to manage their behavior, but it also offsets the negative development of peer groups (Dishion, Thomas, McCord, & Poulin, 1999).

Family Interventions

Current studies support the need to shift away from the individual, intrapsychic view of services to one that encompasses the entire family (29). An examination of all key factors influencing the youth should be involved (i.e, school, peers, culture, and socioeconomic level). Family interventions should provide a variety of services consisting of face-to-face sessions, telephonic sessions, family sessions, or a combination of the aforementioned. According to Underwood et al., (2004), applying interventions with families should consider the following assumptions: First, every youth enters treatment with a "family", whether distant, functional, or dysfunctional, and the involvement of their family is a critical component in ensuring compliance and developing skills necessary to build and support productive lifestyle changes. Secondly, the family should be seen as the primary socializing unit, and in most cases, the most influential system to which the youth belongs. The focus of family interventions should be on the family strengths. Thirdly, the youth cannot be considered separately from the social context from which he/she resides. Lastly, the family remains a family, whether together or not, and family members will often continue to have relationships throughout their lives.

Pharmacological Management

Pharmacological management in this context refers to the administration of psychotropic medication to alleviate or minimize psychiatric symptoms. Medication helps youth to stabilize and control their symptoms, thus increasing their receptivity to other treatment services. Pharmacological management appointments with a psychiatrist should be consistent. Adequate time spent with each youth is needed in order to assess the ongoing issues. Communication with the team is essential in the proper management of medications. Reviewing the medical and clinical progress notes is critical as the treatment provider formulates recommendations for care. Feedback from all levels of providers regarding youth behavior is helpful. All providers should observe, monitor, and record data to assist in determining the effectiveness of medication. Each individual is unique and have mental illnesses that fluctuates in terms of severity, symptomatology; managing symptoms is a dynamic process. Generally influenced by genetic susceptibility and environmental issues, youth with special needs require a range of interventions, such as initial psychiatric evaluations, psychiatric consultations, psychiatric consultations in crisis, medication management, and individual therapy. Not understanding these susceptibilities, oftentimes leads youth to self-medicate with illegal substances to treat their psychiatric symptoms and to bolster their self-image by enacting criminal behavior. However, most are unaware that the use of alcohol and drugs counteracts any psychotropic medication, further aggravates symptom severity and complicates matters.

Prescribing psychoactive medication involves determining information on the type, history, duration, frequency, and severity of the mental health disorder in the attempt to further outline the type of medication that may be best utilized. Assessments conducted by the psychiatrist should include questions, such as past medication history and its effect, determining allergies, reviewing available medication records, and consulting with previous physicians regarding the course of medication and side effects.

Transition Planning

Transition planning implies bi-directional responsibilities and requires collaboration among community providers. Some youth will be fully released to their families, while others may be stepped down to less restrictive programs. Efforts in the past to help youth transition from higher to less restrictive programs have only been as effective as the involvement of the program's partnerships in the community. In order to move a transition planning system, the provider should be able to rely upon an integrated case management system to ensure that key individuals in all the relevant systems are involved. Coordinating the timing and delivery of services and assisting each youth and his/her family in extending services upon release are significant aspects of post-release programs.

Community reintegration and aftercare planning is ideally established at the outset of the stay within a juvenile correctional facility. This allows for well-planned community reintegration. In addition, responsibility and public safety is reiterated throughout the stay. Once it is determined that a youth is a candidate to be fully integrated back into the community, a juvenile risk assessment is administered. This refers to the likelihood of a youth's continued involvement in delinquent behavior, once fully released to the community. The risk assessment for delinquency should be minimally utilized at the beginning and end of a youth's stay in post-release programs.

In preparing juveniles with mental health disorders to re-enter the community, the following arrangements and linkages should take place:

1. Identify and contact community treatment agencies and providers who will be responsible for the implementation of services.
2. To the degree possible, have the juvenile and aftercare provider meet and discuss preliminary treatment goals.

3. Share critical information such as updated psychiatric and psychological evaluations to include risk to the community.
4. Prerelease planning with court personnel is critical as many of these juveniles have additional responsibilities to the court.
5. Transition of psychiatric services allows for continuity of medication.

To the extent that well planned reintegration and aftercare services are designed, the likelihood of smooth transitions is enhanced.

Facility Programs and Interventions

The literature on programs for juveniles involved in corrections facilities is limited compared to the extensive literature that has been developed over the past decade on evidence-based "blueprint" intervention models for youth involved in community programs (Spencer & Jones Walker, 2004). Outcome studies of facility-based programs are rare (Josi & Sechrest, 1999).

Some programs have been utilized even though there is no evidence regarding their effectiveness. Others have not yet been utilized but have preliminary manuals because research to establish their value is underway. Nonetheless, there are now some innovative youth corrections programs available to practitioners in the field.

The programs described in this section were selected on the basis of a thorough search of the literature. Many programs are designed to address the multiple determinants of problem behavior. The authors of this article have selected facility programs with at least some known use in juvenile justice or adolescent clinical settings and some evidence of effectiveness. The selection of these programs does not define the best or most effective evidence-based practices in the field, only a representative sample. Therefore, practitioners should research programs to determine which evidence-based practices will be the best fit for them.

Family Integrative Transition (*FIT*)

In 2000, the Washington State Legislature directed the Department of Social and Health Services (DSHS) and the Juvenile Rehabilitation Administration (JRA) to develop a rehabilitation program for juvenile offenders who were sentenced to a state juvenile justice placement. Trupin & Stewart (2003) designed and implemented this program that focuses on juvenile offenders with co-occurring (substance abuse and mental health disorders) disorders. Family Integrative Transition (FIT) addresses the needs of this population who pose a high risk for committing more crimes when released into the community with promising results. Studies compared recidivism rates for those juveniles who were not involved with FIT and those juveniles who were involved with Family Integrative Transition program. Forty percent of juvenile offenders who were not involved with FIT committed a new felony within 18 months of being released. For those who did participate in FIT, the recidivism rate dropped to 27 percent (Aos, 2004).

The FIT program is based on a combination of evidenced-based approaches, Multi-Systemic Therapy (MST), Motivational Enhancement Therapy (MET), Relapse Prevention, and Dialectical Behavior Therapy (DBT). It is a rigorous treatment program that begins two months prior to a juvenile offender's release date and continues for four to six months while the juvenile re-adjusts back in to the community. For juveniles to be eligible they must be in a JRA institution, scheduled to be released into the care of a parole officer for at least four months, under 17 ½ years old, have a substance abuse or dependence disorder and any Axis I disorder, on medication, and residing in proximity of the institution. The program allows youth to engage in intense family and community-based treatment that addresses the many determinants of anti-social behavior. The FIT team is made up of four therapists including, a child

mental health specialist and a chemical dependency professional whose first and most important task is to engage the family in treatment. Once the family is engaged, the program attempts to facilitate and encourage behavioral changes in the juvenile's environment, highlighting the systemic strengths of family, friends, neighborhoods, and schools (Aos, 2004).

Mode Deactivation Therapy (MDT)

Mode Deactivation Therapy (MDT) was developed in response to the difficulty in treating youth with high levels of co-morbidity, which resulted in ongoing resistance to current treatments modalities as well as being considered treatment failures in both the outpatient and residential settings. Apsche et al (2004) have demonstrated that MDT is effective in reducing aggression and suicidal ideations within this population. Through the synthesizing of an applied CBT methodology as well as Linehan's work with Dialectical Behavior Therapy (DBT), MDT was developed for youth who displayed a reactive conduct disorder, personality disorders/ traits, and Post Traumatic Stress Disorder symptomology. Apsche and his colleagues have demonstrated the effectiveness of MDT in reducing aggression, specifically with youth who display the aforementioned diagnostic traits (Apsche, Bass, Murphy 2004; Apsche & Ward 2004). Apsche & Siv (2005) further emphasize the need for an efficacious methodology by positing the development of personality disorder traits/features as a coping mechanism by these youth. This methodology encapsulates the needs of these youth who present with a complicated neglect, multi-axial diagnoses, as well as often being the victims of sexual, physical, and/ or emotional abuse.

Mode Deactivation Therapy also includes a series of mindfulness exercises that are specifically designed for these adolescents. Exercises incorporated within the client workbook designed to allow the youth to practice the technique which helps ensure trust, reduce anxiety and increase commitment to treatment as it helps develop mindfulness skills for the youth. The mindfulness skills result in development of the youths heightened awareness of their fears, triggers and beliefs which helps, them to use this new coping strategies in place of the aggressive behaviors.

Several descriptive studies indicate that MDT has been more effective than standardized CBT in the treatment of this population of youth (Apsche & Ward, 2002). Mode Deactivation Therapy has also been demonstrated as effective in a series of case studies (Apsche, Ward, Evile, 2002 a & b; Apsche & Ward Bailey, 2003) and an empirical study which shows that it was more effective than standard CBT and social skills training (Apsche, Bass, Siv, 2005). Preliminary results of several recent case studies has shown MDT to be effective in reducing suicidal ideation and in reducing fire setting behaviors (Apsche & Siv, 2005, Apsche, Siv, Bass, 2005). The study of this methodology is important on several levels. The first level being the need to provide evidence based therapy for youth with deficits in multiple areas regarding their mental health issues. Kazdin and Weisz (2003) indicate how aggressive behaviors have an adverse effect not only on the adolescent but also in a variety of social settings such as academics, peer relations, and an increased contact with the juvenile justice system. Providing a methodology which allows increased progress with this difficult population as well as offering hope to both providers and clients is paramount for the benefit of both parties.

Dialectical Behavior Therapy (DBT)

Linehan (1991) developed Dialectical Behavior Therapy in an effort to effectively treat individuals with borderline personality disorder. Many providers have adapted DBT interventions for juveniles involved in corrections facilities. Dialectical Behavior Therapy posits that some individuals react to emotional stimulation abnormally due to their upbringing and certain, unknown biological factors. This program consists of two main components, weekly psychotherapy sessions and weekly group therapy sessions. Individual sessions address incidents that may have occurred during that week

and conflict resolution skills. Group therapy sessions address interpersonal skills, emotional regulation, and tolerance/acceptance of distress, which are core components to an adolescent's development. As mentioned above, DBT provides services to individuals who are diagnosed with borderline personality disorder. DBT focuses on decreasing a variety of behaviors. These behaviors range from being self-injurious, behaviors that interfere with therapy, response to quality of life, and responses to posttraumatic stress symptoms. However, DBT places emphasis on enhancing certain characteristics, such as self-esteem, acquiring additional goals, and learned behavioral skills from the group.

There have been some reports of positive outcomes from DBT treatment. Linehan (1991) has been actively replicating studies, utilizing DBT. In replicating her study, Linehan (1999) found that individuals, who received DBT treatment, displayed significant reductions in substance abuse, a significant increase in keeping individuals in therapy, and a significant increase in social and global conditions. Linehan (1991) discovered that adolescents, who received DBT, reported less crisis situations and a decrease in suicidal ideation.

Aggression Replacement Training (*ART*)

Perhaps, one of the most popularly used intervention strategies in youth corrections facilities is Aggression Replacement Training (ART). Aggression Replacement Training was designed for juvenile delinquents who perpetrated violent crimes against people or property. It is believed that many of these juveniles lack the interpersonal and social skills concerning the management of their anger and other mental health issues. This model assumes that much of the thinking processes of juveniles rely upon their concrete and egocentric ways of working through problems.

Aggression Replacement Training aims to correct negative attitudes, and therefore, equips youth to live more productive, healthy lifestyles. Three major components of ART training include: structured learning which targets the behavior; anger control training which targets the affective or emotional component; and moral education which targets the cognitive aspect of the individual (Glick & Goldstein, 1995). Each of these interventions aim at strengthening the juvenile's self-confidence and at learning new and more socially accepted behaviors.

Thinking Errors Approach (*TEA*)

Thinking Errors Approach (TEA) (Yochelson & Samenow, 1976; Yochelson & Samenow, 1977) is a widely used technique that challenges the core beliefs and thoughts of juveniles. TEA outlines specific thinking patterns, which in a given constellation, can lead to criminal behavior. These thinking patterns are referred to as criminal thinking errors. Commonly seen thinking errors exhibited by juveniles with mental disorders are as follows:

- Victim Stance
- "I Can't" Attitude
- Lack of a Concept of Injury to Others
- Failure to Put Self in Place of Others
- Ownership Thinking
- Exaggerated Pride
- Irresponsible Decision-Making
- Power Thrusting

This approach assumes that thinking is based on a private logic of dominating and controlling others and situations. The essence to this model of care is recognizing that juveniles' thought process

differs radically from other people who have not committed acts of aggression. Their thinking must be consistently challenged, and they must be held responsible for their distorted patterns of thought, that often act as excuses to violently act out or to mentally decompensate. Treatment providers encourage juveniles to identify their errors and record them in journal logs. Through group and individual counseling, juveniles begin to learn that their thinking patterns are the foundation to criminal behaviors and when challenged, these distorted thoughts can be eliminated.

Relapse Prevention Models

Relapse Prevention techniques have been used as baseline program elements for juveniles with mental illness. Relapse Prevention asserts that “there is no cure” and “maintenance is forever”. Models teach juveniles to learn to identify antecedents to their criminal behavior and their mental deterioration. These antecedents involve changes in affect, fantasies, thinking errors, cognitive distortions and offense planning.

When Relapse Prevention techniques are applied to juveniles with mental health disorders, it is based on the assumption that mental health emergencies are due to a cycle of behaviors, thoughts, and feelings that lead to further decompensation in the attempt to cope with the decompensation. Juveniles are taught to recognize their high-risk factors that place them at increased risk to decompensate. Juveniles are also taught about seemingly unimportant decisions that may place them in positions to lapse or negatively shift in their behaviors.

Specific skills and strategies are taught to juveniles regarding preventing relapse and how to handle it. Individual interventions and treatment plans are interlaced with external support systems to maximize early detection of problematic thoughts, feelings and behaviors.

The following are commonly used goals and objectives that may be part of a relapse prevention treatment protocol:

1. Juveniles will be able to define and explain the key components of relapse prevention.
2. Juveniles will discuss and list how relapse prevention components work together to prevent behavioral disruptive patterns.
3. Juveniles will be able to identify and list their high-risk factors.
4. Juveniles will be able to identify their mental health and behavior cycles.
5. Juveniles will be able to identify unhealthy behaviors that place them at increased risk to decompensate.
6. Juveniles will be able to identify avoidance and escape strategies for high-risk situations.
7. Juveniles will demonstrate their ongoing recognition and comprehension of relapse prevention concepts in group counseling.

Juvenile justice, mental health, substance abuse, and other human service systems must work collaboratively to address the multifaceted domains of each juvenile offender’s life. In doing so, it is critical that appropriate and effective screening procedures and assessments with accurate diagnoses be completed when the juvenile first enters the system.

Thinking For a Change (TFAC)

In the late 1990’s, Glick, Bush, and Taymans (2001) developed Thinking for a Change (TFAC), a cognitive behavioral intervention for the National Institute of Corrections. The program incorporates cognitive approaches for changing delinquent behavior by restructuring juvenile offenders’ thinking (e.g. antisocial attitudes, values, or principles) and teaching pro-social cognitive skills (e.g. ability to think

about the consequences and ability to work through problems) (Bush, Glick, & Taymans, 2001). Problem solving is the main focus of the curriculum and is enhanced by cognitive restructuring and social skills interventions. Cognitive restructuring guides offenders through a process of consciously examining their thoughts, and then making connections between their thoughts and the offenses they commit.

The curriculum is devised of 22 lessons with the idea of meeting weekly in a small group setting for one and a half to two hours, depending on the age group. In the first eleven sessions, cognitive restructuring concepts along with critical social skills are introduced and emphasized. Supported by cognitive self-change and social skill development, problem solving techniques are taught in lessons 16-21 (Bush, Glick, & Taymans, 2001).

Motivational Enhancement Therapy (MET)

Motivational Enhancement Therapy (MET) is based on principles of cognitive and social psychology. It seeks to evoke from clients their own motivation for change and to consolidate a personal decision and plan for change. This approach is mostly client centered and therefore the clients set their own goals. However, treatment providers may advise specific goals for juveniles.

The counselor's primary role is to elicit and consolidate the client's own intrinsic motivations for change. Treatment providers typically accomplish this through open-ended questions and reflection of juveniles' issues rather than through the use of confrontational strategies or advice giving.

Content of MET sessions depends upon juveniles' stage of motivation. Prochaska and colleagues (as cited in Carroll, 2000) described four stages of change:

1. Precontemplation, in which the youth is not considering change at all.
2. Contemplation, in which the youth is ambivalent, considering the pros and cons of changing the behavior.
3. Determination, where the balance leans in favor of changing behavior and the youth begins considering options.
4. Action, which involves the youth taking specific steps to change the behavior.

The counselor can determine the topics of each session, but the content should be provided by the youth in treatment. Examples of common topics include, weighing the positives and negatives of the behavior, giving reasons to stop or change behavior, and brainstorming ideas about how change can happen. MET is usually brief and limited to two to four hourly sessions, but is very effective (Carroll, 2000).

Summary

A significant number of juveniles with mental health disorders are involved in the juvenile justice system. Between 50 to 75 percent of all juveniles who enter the justice system has diagnosable mental health issues (Coalition for Juvenile Justice, 2000). Due to the result of this growing population, juvenile courts now expect that mental health treatment will be provided for youth while in juvenile correctional facilities. However, historically, the justice system does not have the capacity to provide effective mental health care. This creates a burden on the juvenile justice system as these administrators are hampered by inadequate approaches and practices for managing and treating this population. Nonetheless, the increase of juveniles with mental health disorders in the justice system has encouraged careful analyses of the development of newly emerging treatment strategies. In light of the concerns presented, this article reviewed the critical factors in mental health programming for juveniles in youth corrections facilities and provides recommendations for further development of treatment.

There is confusion between definitional and diagnostic concerns that further complicate matters.

Part of this intricacy may be due to the multiple uses and definitions of the term mental health disorders. To enhance the deliverance of consistent and universal treatment strategies, Underwood and Berenson (2001) proposed a categorical approach to mental health. They take into account what is scientifically known about the clinical profiles and the varying degrees and manifestations of mental illness that juveniles present when entering the juvenile justice system. Each class of disorders has unique characteristics that must be addressed to allow comprehensive treatment for the purpose of reducing the risk of future mental health crisis and criminal behavior.

Youth in the juvenile justice system run a high risk for future development of problems that may lead to further emotional deterioration and delinquency. Proper interventions must be administered to these youth that focus on risk factors that can be changed (i.e., behaviors, attitudes). The challenges we have reviewed serve as a framework to contribute to the emerging body of information on risk factors and mental health program services for juveniles in youth corrections facilities.

When providing treatment services to juveniles with mental health disorders standard guidelines and a code of ethics must be established as juvenile correctional systems meet the challenges posed by this population. Treatment protocols must be reliable, validated by research, and culturally sensitive in content while maintaining inherent therapeutic integrity.

After a thorough review of the literature, we selected community programs with at least some known use in juvenile justice or adolescent clinical settings and with some evidence of effectiveness. Since the literature on programs for juveniles involved in corrections facilities is limited, some interventions have been utilized in the juvenile justice system even though there is no evidence supporting their effectiveness. Other programs that have been developed have not been implemented because research to establish their value is underway.

Future studies are needed to determine the effectiveness of treatment models in the juvenile justice system. Studies should be conducted periodically throughout the first three years of a juvenile's release. Focus should comprise of the number, if any, and classification of violations. Peer association, school attendance, substance abuse, attitude towards delinquent behavior, employment history, and family functioning should be included as well. Characteristics of treatment programs should also be evaluated in order to identify the ones that will most likely produce ideal outcomes for each targeted behavior.

The juvenile justice system is not equipped to handle the demands that juveniles with serious mental illness entering the justice system require. To help juvenile justice administrators treat this population, more research is required.

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