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Bridging the Gap: The Collaboration of Mental Health Services and the
Juvenile Justice System

Gregory L. Medley

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JAMES MADISON UNIVERSITY

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FACULTY COMMITTEE

Committee Chair: Renee Staton

Committee Members/Reader

Lennis Echterling

Eric Cowan

This project is dedicated to my wife and family who have stood by me patiently over the years as I move forward in the helping profession.

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Abstract

This paper explore the mental health needs of juveniles in the juvenile justice system. The need for mental health services in detention centers has been identified consistently throughout the United States. It is clearly noted in research that meeting the needs of youth in local community detentions centers are inadequate. With 65% to 70% of youth in contact with juvenile justice system having a diagnosable mental health disorder; over 60% of youth with a mental health disorder also having a substance abuse disorder (Mental Health and Juvenile Justice Collaborative for Change, 2015). As a result, I have created a manual that would assist front line staff, local mental health professionals, administrators, and families in addressing the needs of this population.

Introduction

I have worked as a counselor for several years in an adult medium security prison in the State of Virginia. My job duties entail conducting individual counseling, program counseling, annual reviews, and sex offender work to name a few. One of my most rewarding and productive groups that has received the most attention is a peer support process group. The focus of this group is exploring individual attitudes/beliefs and self-responsibility. These points of interest have always resonated with me as I call attention to individual choice and problem solving skills. Most members have received long sentences, serving single or multiple life due to horrendous acts in their community. Currently, this group has paroled 10 members over the past three years. These opportunities to build rapport and to discuss possible reasons for their incarceration as well as examining their worldview has been constant. Most have stated that mental health issues, trauma, and/or substance abuse was the main reason for them being incarcerated and these issues started in their childhood or teenage years. Exploring these past issues have merited understanding, but intervention was warranted decades earlier during their juvenile years.

Prior to my work with adult prisoners, I also spent several years in the juvenile justice system and community services as a clinician. The work was personally rewarding, but there was never enough resources to meet the needs of the youth; especially those with mental health issues. Furthermore, staff seemed limited in their understanding of mental health issues and how to deal with it. For example, a kid that presented with bizarre behavior would be alienated from his peers in order to maintain a safe milieu for the rest of the population. Most of the youth incarcerated had experienced

some form of trauma and required mental health needs to be addressed. It is these interactions with individuals from adult prisons and juvenile detention settings that clearly demonstrated to me the need to develop a training manual that would assist the youth's family, juvenile detention staff, mental health professionals, probation officers, and administrators. The manual would provide an overview of various topics that are fundamental in increasing the quality of life for juveniles with mental health issues as well as assist in training staff that are tasked with maintaining public safety and rehabilitative services within detention centers.

The overlapping of the juvenile justice and mental health systems have received increasingly more attention in recent years. The reason for this increased observation has been the growing number of young people currently involved with the juvenile justice system. In 2010, the National Center for Juvenile Justice estimated that there were 1.6 million juveniles arrested. Of that 1.6 million juveniles, the arrest rate for drug abuse violations were above the rates in the 1980 for both male and female (Sickmund & Puzzanchera, 2014)

With so many juveniles entering the justice system, it is vital that we deal with the specific behavior or circumstances that bring them into the system, as well as the underlying mental health and substance abuse problems. Although the prevalence of mental health and substance abuse disorders among youth in the juvenile justice system varies, research suggests that these problems are significantly higher for juvenile delinquents than for the general population (Boesky, 2002). Of the juveniles that come in contact with the juvenile justice system, 150,000 meet the criteria for at least one mental

disorder, 225,000 suffer alcohol abuse or dependence, and 95,000 may suffer from a diagnosable substance abuse or dependence disorder (Cocozza J. J., 1992).

Estimates of incarcerated juvenile offenders with a diagnosable mental health disorder run between fifty and seventy – five percent (Cocozza & Skowyra, 2000). A study by the Urban Institute found that over ninety two percent of youth who entered the Virginia youth prison system presented with issues related to Attention Deficit Hyperactivity Disorder, Conduct Disorder, Oppositional Defiant Disorder, substance abuse, and Substance Dependence. With that in mind, over 90% of youth incarcerated in Virginia require mental health service (Durnan & Harvell, 2017). The government, (Adminstration, 2014) noted that more than four in ten of the youth receiving services in the United States have a co-occurring substance abuse disorder.

The overlap between the juvenile justice and the mental health systems raise difficult questions surrounding meeting the needs of youth involved in various systems. Currently, within some states, the primary method for addressing issues involves the collaboration and coordination between the mental health system and juvenile justice. This system level of collaboration is the focus of the approach coined the “system of care”. Under this system, responsibility for meeting the mental health needs of juveniles can be maintained within the community. Collaboration involving strategic planning, multi-agency budget submissions, implementation of comprehensive screening and assessment, case management and cross training of staff (Cocozza & Skowyra, 2000) However, these collaborative approaches are met with resistance due to different philosophical views, responsibility of funding, and fragmentation of service delivery (Shufelt, Cocozza, & Kathleen Skowyra, 2010).

Juvenile Delinquency and Criminal Behavior

What is juvenile delinquency? Webster dictionary defines the term as “a status in a juvenile characterized by antisocial that is beyond parental control and therefore subject to legal action” (G. & C. Merriam, 1977). According to current research, Juvenile delinquency refers to antisocial and criminal behavior committed by individuals under the age of 18. Once a person reaches adulthood, antisocial and criminal behavior is known as crime. In this way, juvenile delinquency is the child and adolescent version of breaking the law or crime. There are two primary types of delinquent behavior; status and delinquent offenses (Roberts, 2004). Status offenses are behaviors that are considered inappropriate or harmful because of the age the youth involved. For example, underage smoking, using tobacco, drinking alcohol, running away from home, skipping school, and violating an imposed curfew by the juvenile courts.

Delinquent offenses are violations of legal statutes that also apply to adults in the criminal justice system. Delinquent offenses include acts of violence against other individuals, such as murder, rape, robbery, assault, and child abuse. Delinquent offenses also include acts of property crime, such as vandalism, automobile theft, burglary, and grand larceny. There are other miscellaneous crimes sometimes known as public order offenses that are also delinquent offenses. These include driving while intoxicated, cruelty to animals, possession and use of a controlled substance, forgery, fraud, disorderly conduct, gun violations, prostitution, traffic violations, and loitering (Roberts, 2004).

Criminal behaviors among youth have decreased on the past decade, but serious incidents such as teens committing murder and other violent crimes continue to be a significant problem among this group (Hein, et al.). In 2017, teenagers aged 13 to 19 accounted for 10 percent of the population, but 25.8 percent of all arrests, 23.8 percent of all arrested for violent crimes, and 40 percent of arrests for property crime (Puzzanchera, 2019). There is a large body of literature examining juvenile delinquency and crime, which stated that factors such as gender, education, socio-economic status, and family environment are all strong correlates to criminal behavior. Two factors, mental illness and substance abuse, have received less attention in the literature, but are also important to examine (Development Services Group, 2017).

Studies have shown that youth with mental health issues or substance abuse problems consistently have higher offending and prevalent rates than those without mental health problems (Hyde, 2016). In addition, there is a significant amount of research indicating a large number of youth in the Juvenile Justice system have a problem with a substance use disorder. These studies indicate prevalent rates near 70-90 percent (Teplin, et al., *Psychiatric Disorders of Youth in Detention*, 2006). According to government statistics, research also reveals higher rates of violence and aggression among youth with mental health problems. Some evidence suggest that mental illness may have contributed in part to some of the youth's illegal behavior and may be a factor interfering with rehabilitation (Skowrya & Coccozza, 2001). The overrepresentation of mental disorders among youth in the legal system reflects an urgent need for mental health services in detention settings.

Barriers to Service Delivery

One of the largest barriers to service delivery stem from lack of family support. Often, the family resists treatment due to not wanting individuals outside the family in their affairs and will undermine treatment or simply cease to participate in services. Studies were done to understand the gaps in mental health services offered to youth in the juvenile justice system. One of the key findings that was highlighted focused on family involvement and support:

“When parents are not involved, the juvenile commitment to being successful, taken medication, seeing a therapist, and developing coping skills decreases. With no family support, a juvenile’s attitude is why make changes when there no motivation from family to do so.”

There were several other issues that were cited which created barriers in obtaining mental health services for families in the juvenile justice system. Those barriers included chemical addiction, mental health issues, lack of support or being overwhelmed, and poverty as family involvement issues. Parental fatigue or burnout was found to be a major cause of lack of family involvement (Fretty, 2017). Research has also shown that accessing mental health services can be a difficult task for the delinquent youth and family due to the number of agencies that may be potentially involved as well as family members having basic information about the juvenile justice system and their rights and responsibilities as parents (Mankey, Baca, Rondenell, Webb, & McHugh, Guidelines for Juvenile Information Sharing, 2006) A statewide needs analysis was conducted to determine the systemic, legal, and service delivery barriers to meeting the mental health and rehabilitative needs of juvenile offenders in the Commonwealth of

Virginia. Although the study was Virginia specific, many of the barriers identified are common problems encountered in other states. Since the focus was mental health delivery to juvenile offenders, many of those interviewed were probation officers, detention center superintendents, and community service board directors and staff. A summary of key findings and recommendations were given to decrease the barrier to offenders receiving help. One of the most striking is the need to have treatment services available in detention centers as well as community based treatment services (Virginia Commission on Youth, 2014). Since the majority of juveniles in detention centers come from poverty stricken environments, resources to attain mental health service, dental service, or simply to have a yearly physical can be difficult task. In my experience with working with juveniles in detention centers, these settings can be very intimidating and stressful. Therefore, the need to provide mental health treatment for those individuals suffering with mental illness becomes very essential. During the initial first couple of days, youth can be assessed for substance abuse, mental health, or health issues. For example, incarcerated youth have an increased risk of sexually transmitted diseases. Plus, parents or parental figures involvement seem to increase with my experience in working with youth. In addition, it is vital that parental involvement is in every step of intervention for treatment to be successful. Furthermore, during the first couple days of an admission into a detention center, the youth that is incarcerated seem very reflective of the past decisions and open to discussion about how they can create change. (Redding, 2000) Stated “this was a time for both the resident and his family to most likely want to participate in treatment”. It was also suggested that professionals, community agencies, the juvenile’s family and juvenile detentions work together to better serve the resident.

A second finding that was essential to treatment for youth in detention centers focused upon training and mentoring. The report stated that many juvenile justice personnel felt conflicted regarding their role with the residents. Some youth workers felt that keeping the resident confined and away from the public was their main responsibility, while others felt responsible in playing a role in rehabilitation (Virginia Commission on Youth, 2014). Nonetheless, the uncertainty regarding whether the mission of the juvenile justice system is punitive or rehabilitative has created a significant barrier for mental health treatment in these centers.

A third barrier that seems to impact juvenile accessing mental health treatment is simply believing they didn't have a problem. I have been informed by numerous prisoners that family members or friends told them they would simply "grow out of it". For this reason, seeking help for Attention Deficit Hyperactivity Disorder (ADHD), a learning disorder, or depression was not a concern. Researchers surveyed youth for alcohol, drug, and mental health disorders in detention and found that the most frequently cited barrier to service was that youths believed their problems would go away without getting any help. Others reported that the youths were unsure where to go or whom to contact for help (Development Services Group, 2017).

The Role of Substance Abuse in Delinquency

According to the latest statistics approximately 24.6 million Americans have used some form of illicit substance in the last 30 days (Buddy, 2019). Many individuals have used drugs in the past or are currently using drugs and do not believe they have a substance abuse problem. After reading the following statistics, some of you may have come to the realization that the United States has significant problems with individuals

abusing illicit drugs. There are 19.8 million individuals in America who use marijuana, 1.5 million individuals use cocaine, 6.5 million who use prescription drugs (nonmedical users), and 1.3 million individuals use some form of hallucinogens including ecstasy and others (Buddy, 2019). Many individuals who are substance abusers are trying to find a way to escape their current problems and do not know how to effectively cope with their daily life struggles. Sadly, depression, developmental issues, alienation, and other psychosocial disorders are frequently linked to substance abuse among adolescents (Bukstein, 2001). Users are at higher risk than nonusers for mental health problems, including suicidal thoughts, attempted suicide, completed suicide, depression, conduct problems, and personality disorders. Marijuana use, which is prevalent among youth, has been shown to interfere with short-term memory, learning, and psychomotor skills. (Bureau of Justice Statistics, 1992).

In the state of Virginia, a high school risk behavior survey was given regarding current tobacco use, the use of alcohol, use of marijuana, and a host of other risk factors. The teenagers throughout the state report that 16.3% currently smoke cigarettes, cigars, use smokeless tobacco, or an electronic vapor product at least one day during the 30 days before the survey. They also reported that 24.5% reported currently drinking alcohol at least one day during the 30 days before the survey and 12.6% took pain medicine without a doctor's prescription or differently than how a doctor told them to use it. Some of the pain medicine listed was Vicodin, Percocet, and Hydrocodone. Lastly, marijuana use was reported at 16.5% in Virginia High Schools (Centers for Disease Control and Prevention, 2019)

Among juvenile delinquents, substance abuse continues to be significant problem

in those teenagers who continually find themselves incarcerated. One study, found that over 80 percent of criminal justice-involved youth reported substance use (mainly marijuana) in the past 6 months, and nearly half of male and female juvenile detainees had a substance use disorder (National Institute for Drug Abuse, 2016). Juveniles entering the criminal justice system can bring a number of serious problems with them; substance abuse, academic failure, emotional disturbances, physical health issues, family problems, and a history of physical or sexual abuse. (Mignon, Falla, Myers, & Rubington, 2009). Researchers established years ago that substance abuse issues in teenagers is correlated with higher rates of suicide, homicide, violence, accidental deaths, unprotected sex, arrest, teen pregnancy, elevated infant mortality, poor physical and mental health, and unstable relationships (Cole & Weissberg, 1995). However, following ten years of decline between 1994 and 2004, juvenile arrest rates increased to its highest level in 2006. In 2016, the Department of Justice reported that the arrest rate for males and females have declined in the last ten years with females accounting for 29% of the juvenile arrests in 2016 (Hockenberry & Puzzanchera, 2018). Families play an important role in the recovery of substance abusing juveniles, but this influence can be either positive or negative. Parental substance abuse or criminal involvement, physical or sexual abuse by family members, and lack of parental involvement or supervision are all risk factors for adolescent substance abuse and delinquent behavior (Steiker, 2016).

Substance abuse treatment for juveniles that are incarcerated can be limited due to the available resources of that particular community. Research by the National Institutes of Health state that substance abuse treatment as well as most other services, were more prevalent among large state funded residential facilities (where 66% provided treatment),

than local detention centers (20%), and community corrections facilities (56%). The data also showed that the number of youth attending treatment in all types of facilities on any given day was very low (Young, Dembo, & Henderson, 2007). Since juvenile delinquents enter the juvenile justice system for various reasons and issues, the need to have an integrated approach is essential. Some of the most pressing needs of juveniles in detention is their physical and mental health. Along with substance abuse, these issues can have a lifelong impact on the teen; therefore, a treatment plan that is both integrated and comprehensive would be the most effective to address their needs. The authors summarized the evidence for the effectiveness of a number of different types of treatment programs (e.g., support groups, outpatient, day treatment, and inpatient programs; therapeutic communities for adolescents; family therapy). They recommend a comprehensive service model targeted to youths' drug abuse treatment needs as they move through different parts of the justice system, for youths placed in commitment programs, and community reentry. No information is presented on the prevalence of drug abuse treatment services at different points in the juvenile justice system (Young, Dembo, & Henderson, 2007).

The Role of Trauma in the Juvenile Justice Population

What is trauma? According to the American Heritage Dictionary, trauma is: 1. a wound; especially one produced by sudden physical injury. 2. An emotional shock that creates substantial and lasting damage to the psychological development of the individual, generally leading to neurosis. The American Psychological Association describes a traumatic event as directly experiencing, to witness, or indirectly learning about a close family member or friend being involved in an event that exposes them to

actual or threatened death, serious injury, or sexual violation (American Psychiatric Association, 2013). Research has shown that 70% of adults will encounter a traumatic event during the course of their life time. There are some individuals that will experience several traumatic events during their life span simply due to the environment in which they were reared. Individuals that have been exposed to repeated experiences related to the threat of life or severe harm are called poly-victimization. According to the American Bar Association, the emotional effects of exposure to poly-victimization and violence can be persistent and cause numerous mental health issues. Some examples of environments that may exacerbate poly-victimization are war stricken countries, abusive neglectful families, and low income urban cities. By no means is this an exhaustive list of examples regarding traumatizing events. In fact, losing a family member or friend through death can have an enormous impact on an individual's physical health and psychological development.

In recent years, one area that has been receiving increasing research attention involves the effects of abuse and neglect on the developing brain, especially during infancy and early childhood. This recent attention is because of new research stating that the brain can be altered due to traumatic experiences, early abuse, and neglect. There are a few theories regarding how maltreatment and trauma interferes with the physical development of the brain. The first theory notes an abnormal level of the hormone cortisol which is associated with the fight or flight responses, mood issues, attachment problems, and issues with cognition may be instrumental in the development of negative effects on the brain and body. "Higher cortisol levels could harm cognition processes, subdue immune and inflammatory reactions, or heighten the risk for affective disorder"

(Lipschitz, III, & Southwick, 2002). In addition, a long term study was conducted on adults who were sexually abused as children show these individuals were “biologically changed with resting levels of cortisol, asymmetrical stress responses, and abnormal physical development including increased rates of obesity and earlier onset of puberty” (Trickett, Noll, & Pullman, 2011). Lastly, when youth are involved or exposed to extreme traumatic events, the brain highlights the pathways for developing a fear response. As a result, the child may respond to fear without conscious thought. For example, an abusive parent may glare at their child causing fear or making them keenly aware of their presence (Child Welfare Information Gateway, 2015).

Many juveniles in the juvenile justice system have experienced or witnessed violence and suffered the fear of on-going exposure to injury. Numerous studies have shown that a large number of juveniles who have witness and experienced violence are linked to negative outcomes later in life (University of New Hampshire, 2014).

Case Study

Griselda is a 15-year old Hispanic female whose father was murdered when she was five years of age. Following his death, her mother remarried and moved in with her step-father. Griselda also reported that her two older sisters moved in with them.

Additionally, she lived in an economically disadvantaged neighborhood where violence was the norm. Her step-father who left when she turned 12, physically and verbally abused Griselda and her other family members. Griselda’s mother worked two jobs and was also verbally and physically abusive toward her. She also had several female family members and friends who were sexually assaulted during this time. One of the family members that was assaulted was her older sister. Griselda begin to hang out with gangs

when she was 13 years old and considered them her real family because they protected her from “bad shit”. She also started smoking marijuana daily after joining the gang and using various other drugs to get high. It was also during this time she assaulted another teen and received 12 month of house arrest. She reported that she blacked out during the incident and does not remember much of it. She later discovered that she had broken the nose of the other youth involved. Despite her lack of remembering what happened during the incident, Griselda does recall having a memory of someone being shot in the head and watching him die. At age 15, she was adjudicated of drugs and weapons related charges and sentenced to 18 months in detention center.

Griselda’s story describes the impact of experiencing traumatic events during a pivotal point in a teen’s physical and emotional development. Her story also demonstrate the traumatic experiences of many juvenile delinquents that are involved in the juvenile justice system. Research states that up to 90% of justice involved youth experience some type of exposure to trauma events. On average, 70% meet criteria for a mental health disorder with approximately 30% of youth meeting criteria for post-traumatic stress disorder (SAMHSA, 2019). Youth who report severe neglect or maltreatment in childhood are found to be at a higher risk compared to non-neglected children and are found to be more involved in adolescents and adulthood criminality (Dierkhising, et al., 2013). Youth in the juvenile justice system often have experienced twice as many trauma episodes including physical abuse, sexual abuse, life-threatening incidents, and community violence, especially those individuals from urban communities (Ford, Kerig, Desai, & Feirman, 2012). Many also come from families that are attempting to cope with

other issues within the family such as substance abuse, mental health problems, legal issues, unemployment, and intergenerational incarceration (Network, 2017)

Trauma Informed Care

Having worked in a juvenile detention setting, I can attest that traumatic experiences do not end when juveniles are placed in detention settings. For example, in a nationwide survey of residential facilities, 56% report being exposed to a violent situation while in custody of the facility. The survey also state that 29% had been physically assaulted and 12% were sexually assaulted by staff or resident of the facility. Additionally, in 13 states around the Country 20%-36% report being sexually assaulted while in custody (Sickmund & Puzzanchera, 2014). Add the first hand traumatic events that many of these juveniles have experienced before entering the Juvenile Justice system, it is important to explore ways to decrease the impact of trauma on this population.

One of the ways to assist in decreasing the impact of trauma and PTSD on the Juvenile Justice population is to have the system become more trauma informed. This can be accomplished through understanding how traumatic experiences impact a juvenile's behavior, substance abuse use, and mental health. The United States Attorney General task force on Children Exposed to Violence identified 9 practical steps that would assist in implementing steps to address trauma in children's lives. The steps were a collaboration between experts in law enforcement, child protective services, juvenile justice system, and traumatic stress research group. According (Cruise & Ford, 2011). The steps include:

1. Make trauma –informed screening, assessment and care the standard in juvenile justice services.
2. Abandon juvenile justice correctional practices that traumatize children and further reduce their opportunities to become productive members of society.
3. Provide juvenile justice services appropriate to children’s ethno-cultural background that are based on an assessment of each violence exposed child’s individual needs.
4. Provide care and services to address the special circumstances and needs of girls.
5. Provide care and service to address the special circumstances of lesbian, gay, bisexual, transsexual, and questioning youth.
6. Develop and implement policies in every school system across the United States that aim to keep children in school rather than relying on policy that lead to suspension and ultimately drive children into the juvenile justice system.
7. Guarantee that all violence-exposed children accused of a crime have legal representation.
8. Help, do not punish, child victims of sex trafficking.
9. Whenever possible, prosecute young offenders in the juvenile justice system instead of transferring their cases to adult courts.

(U.S. State Department of Justice, 2012)

The Benefits of Collaboration

Teenagers with mental health issues and behavioral problems may face many challenges in the home, at school, and in the community. Due to their issues, they may require multiple agencies to be involved in their family problems to assist them. Each of

the agencies involved may have their own intake requirements and laws that govern what services are provided for the client.

Willie's Case

Willie was a 15 year old African-American who had been recently released from the local Juvenile Detention Center. He lived with his mother, but often would stay with his grandmother because his mother worked two jobs. One year prior, his father had died in an automobile accident and his life changed according to Willie and family. Willie presented with problems of substance abuse use, truancy from school, running away from home, and had stolen his mother's car. While he has many strengths, such as he's intelligent, creative, and athletic. He continued to present with behavioral problems and has been removed from school. During one of his family sessions, Willie became irritated because his grandmother was preaching about his behavior. At one point, he started to unconsciously roll fake paper marijuana joints and was not aware of the behavior until his mother told him to stop.

What agencies are responsible for addressing the need of Willie and his family?

As we examine Willie case, three or more different agencies could have a stake in addressing Willie and his family's complex issues. Rather, addressing the needs requires a more balanced solution- "one that involves both the juvenile justice and mental health system as partners in all efforts to identify and respond to the mental health needs of these youth" (Shufelt, Coccozza, & Kathleen Skowyra, 2010). My mother often stated "two heads are better than one". This statement is especially true in terms of providing mental health services to juvenile delinquents and their families. How does collaboration among agencies increase the quality of life for incarcerated youth?

Several years ago, I was participated in a collaborative initiative that assisted in developing and utilizing mental health services within the local juvenile detention center. A mandate from this community based initiative stated that local community services would require a trained mental health clinician to provide mental health services from the detention center location. From this new initiative, there were immediate benefits observed by all shareholders that were involved. For instance, administrators and staff from the detention center were less stressed when a detainee acted out with suicidal ideations or acts of self-harm. Prior to mental health services being located in the center, the use of mechanical restraints was significantly higher. Plus, there was a reduction in injury to staff and detainee due to a decreased use of physical holds designed to keep the youth safe. This initiative represented a shrift from a system that had been overly restrictive, and at time unresponsive to the developmental needs of this population.

Currently, within some states, the primary method for addressing issues involves the integration and coordination between the mental health system and juvenile justice. Such system level collaboration is the focus of the approach coined the “system of care”. Under such a system, responsibility for meeting the mental health needs of juveniles can be easily maintained at a community level. Collaboration involving strategic planning, multi-agency budget submissions, implementation of comprehensive screening, assessment, case management, and cross training of staff are essential in increasing the quality of life for the youth and family (Cocozza & Skowyra, 2000).

Collaboration also benefits the youth and the family through exploring the needs of the youth in juvenile justice system. Research has consistently shown that when agencies make the commitment to work together with one another to provide comprehensive,

effective services using a positive approach it benefitted the youth and their family throughout the collaborative process (Leone, Quinn, & Osher, 2002). In my opinion, one of the best ways to collaborate with any service is to personally visit that agency if possible. As a juvenile in the juvenile justice system, here are some of the agencies that the youth and family may collaborate with while incarcerated. According to (Lane & Turner, 1999). These agencies, family members, community stakeholder can have a profound impact in decreasing recidivism and improving the quality of life for the juvenile:

- Community mental health programs
- Court personnel including lawyers and the judge
- In-Home services
- Law enforcement personnel
- Family of the juvenile
- Schools
- Social Services agency
- Child Protective Services
- Medical doctors/ Clinics
- Landlords of the family
- Employers or coworkers of family members

Overview of the Training Procedure

With the growing problem of youth entering the juvenile justice system with a mental health disorder and substance abuse issues, there is a significant need for adequate mental health services in detention centers. Moreover, detention centers could benefit

from training that encompasses mental health, trauma informed personnel, and substance abuse issues. (Harowski, 2003) contend that anyone who has spent any time in a juvenile correctional facility would immediately identify that adequate training is needed to effectively work with this population, as well as observe that the mental health job role push the traditional boundaries of health care career expectations. With the growth in juveniles being incarcerated with mental health needs, more resources are needed to address this problem.

As a result, a manual was developed to assist administrators, counselors, youth workers, and the detainee/juvenile in obtaining pertinent information about the mental health system and juvenile justice system. In addition, substance abuse, juvenile delinquency, the impact of trauma, and treatment of juvenile offenders will be explored. Each section of the manual provides a broad overview of the topic, but can be used to expand the knowledge base of a parent, youth worker, mental health professional, or an administrator, depending upon the expertise of the individual providing training.

With the growing problem of youth entering the juvenile justice system with mental health disorder and substance abuse issues, there is a significant need for adequate mental health services in detention centers. Moreover, detention center could benefit from training that encompasses mental health and substance abuse issues. With the growth in juveniles been incarcerated with mental health needs, more resources are needed to address this problem.

As a result, a manual will be created to assist administrators, counselors, youth worker, and the detainee in obtaining pertinent information about both the mental health system and juvenile justice system. In addition, substance abuse, juvenile delinquency,

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Prior to introducing the first section of the manual, it is recommended that those individuals participating in the training receive a tour of the juvenile correctional facility. The tour will allow all the stakeholders to observe the daily operation of the facility as well as see the living quarters of the teenagers being housed. The tour will also allow family members the opportunity to observe firsthand the living space of their teen and formulate any questions regarding the incarceration. Furthermore, the tour would allow the opportunity for stakeholder to speak with front line staff and the administrator regarding the facility. Following the tour, the trainee will have the opportunity to introduce themselves and express what they hope to receive from the training.

Section I of the manual will give an overview of the Juvenile Justice system. During this time, the facilitator will discuss the legal process once a teen find themselves involved in the juvenile court system. Most importantly, the youth and family will get a basic understanding of their rights while their child is incarcerated. Lastly, this section will provide a list of glossary terms commonly used in the juvenile justice system that will assist them in increasing their knowledge on the juvenile justice system.

Section II of the manual will give an overview of the mental health system. Secondly, the facilitator will provide a basic understanding regarding how mental health disorders are classified according to the Diagnostic Statistic Manual. This section will also review types of mental health services within the mental health system and

commonly seen psychiatric disorders within the juvenile justice system. Additionally, commonly used psychiatric medication being used to treat mental disorders among children and adolescents will be examined.

For those teenagers in the juvenile justice system, substance abuse issues are very problematic and has become vitally important due to the current opioid crisis in the United States. Section III of the manual gives an overview of substance use among the corrections population and provides a working definition for substance abuse. The facilitator will also guide a discussion on how substances are categorized. Concluding this section, the facilitator will examine the side effects of illegal drugs possibly used by the juvenile justice population.

Section IV of the manual will examine the impact of trauma on the youth in the juvenile justice system. During this section, the facilitator will provide a working definition of trauma as it pertains to the juvenile justice system. The facilitator will also explore how exposure to trauma can impact the behavior of the youth within the corrections setting. The group will discuss the prevalence of trauma among youth in the juvenile justice system. Lastly, how an organization such as the juvenile justice system can become a more trauma informed system.

The legal term juvenile delinquent was created around the same time as the juvenile courts in the late 1890s. It was established so that young people who committed crimes could avoid the shame of being a criminal. Under this new institution, laws were created to provide treatment, rather than punishment for juvenile offenders. Young offenders are usually sent to court, where the main focus is to rehabilitate them, rather than to disgrace or punish (Heilbrun, 2005). However, in today's society the juvenile

justice system has bounced from reforming to incarcerating several times with no clear direction. Section V will examine how trauma impact the juvenile offender in detention centers. For example, in a nationwide survey of residential facilities, 56% report being exposed to a violent situation while in custody of the facility. The survey also state that 29% had been physically assaulted and 12% were sexually assaulted by staff or resident of the facility. Additionally, in 13 states around the Country 20%-36% report being sexually assaulted while in custody (Sickmund & Puzzanchera, 2014).

During any given day, more than 100,000 juvenile are held in juvenile justice facilities across the United States. Research has shown that one in five juveniles meet the criteria for a mental disorder. Often these disorders are coupled with a diagnosable substance use disorder (Teplin, et al., *Psychiatric Disorders of Youth in Detention*, 2006). With the increasing number of youth entering the juvenile justice system with mental health and substance abuse issues it is important to identify those youth needing these services. Section VI main objective is to understand the screening, assessment, and treatment modalities within the juvenile justice system. The facilitator will also examine screening and assessment instruments commonly used with the juvenile justice system. Finally, evidence based treatment modalities will be covered.

In order to deliver effective services for juvenile offenders, it is important to identify current barriers to services and explore ways of overcoming them. This section will identify the barriers and explore the options to effective delivery of service. Section VII main objective is to develop strategies and services in the most effective way for all the stakeholders involved. The facilitator will examine common links between the

stakeholders, identify barriers to systems coordination, and to initiate discussion for planning regarding systems collaboration.

Conclusion

In conclusion, there were several key points that were most noted from the information reviewed regarding youth being incarcerated in the juvenile justice system. First, as many as 70% of the two million arrested each year in the United States have a mental health disorder (Hammond, 2007). With so many juvenile entering the Juvenile Justice system with mental health issues, addressing this problem is extremely important in increasing these young people's quality of life. A second point taken from the data confirms that illegal drug use plays a significant part in juvenile delinquency. A study found that 80 percent of criminal justice-involved youth reported substance use (mainly marijuana) in the past 6 months, and nearly half of male and female juvenile detainees had a substance use disorder (National Institute for Drug Abuse, 2016). Juveniles that are incarcerated can bring a number of serious problems with them, such as substance dependency, academic failure, emotional disturbances, physical health issues, family problems, and a history of physical or sexual abuse. Stakeholders must be ready to address these problems with sound economics and evidence based practices. A third point that seems to be significant is the impact of trauma on teen in the juvenile justice system. There is clear evidence that abused and neglected youth in the child welfare system are at higher risk for involvement with the juvenile justice system. Research indicates that maltreatment of an adolescent is causally related to later delinquency, including serious and violent offending. The costs to the youth, their families, and communities are high, including significantly poorer life prospects than for most other

youth, expensive out of home placement, high rates of recidivism, and the victimization of community members (DeHart & Iachini, 2019). Finally, the need for collaboration was the last the point that was taken from the research that would be instrumental in improve a teen's life. Collaboration is necessary to improve communication, coordination, and cost across agencies. Collaborative approaches have demonstrated how family can be impacted by reducing the red tape involved in excessing services. Prior to my work with adult prisoners, I also spent several years in the juvenile justice system and community services as a clinician. I was able to witness firsthand the barriers and limitations that hindered services. My hope is that the training manual will increase opportunities to collaborate, reduce cost by cross training stakeholders, and hopefully increase the knowledge base of all individuals who participated in the training.

Resources and Organizations

National Center for juvenile Justice (NCJJ)

<http://www.ncjj.org>

National Center for Mental Health and Juvenile Justice (NCMHJJ)

<https://www.ncmhjj.com>

National Child Traumatic Stress Network

<http://www.nctsnet.org>

National Council of Juvenile and Family Court Judges

<http://www.ncjfcj.org>

Office of Juvenile Justice and Delinquency Prevention (OJJDP)

<http://www.ojjdp.gov>

Virginia Department of Juvenile Justice (VDJJ)

<http://www.djj.virginia.gov>

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Training Manual for The Juvenile Justice System

Bridging the Gap Between Mental
Health and the Juvenile Justice System

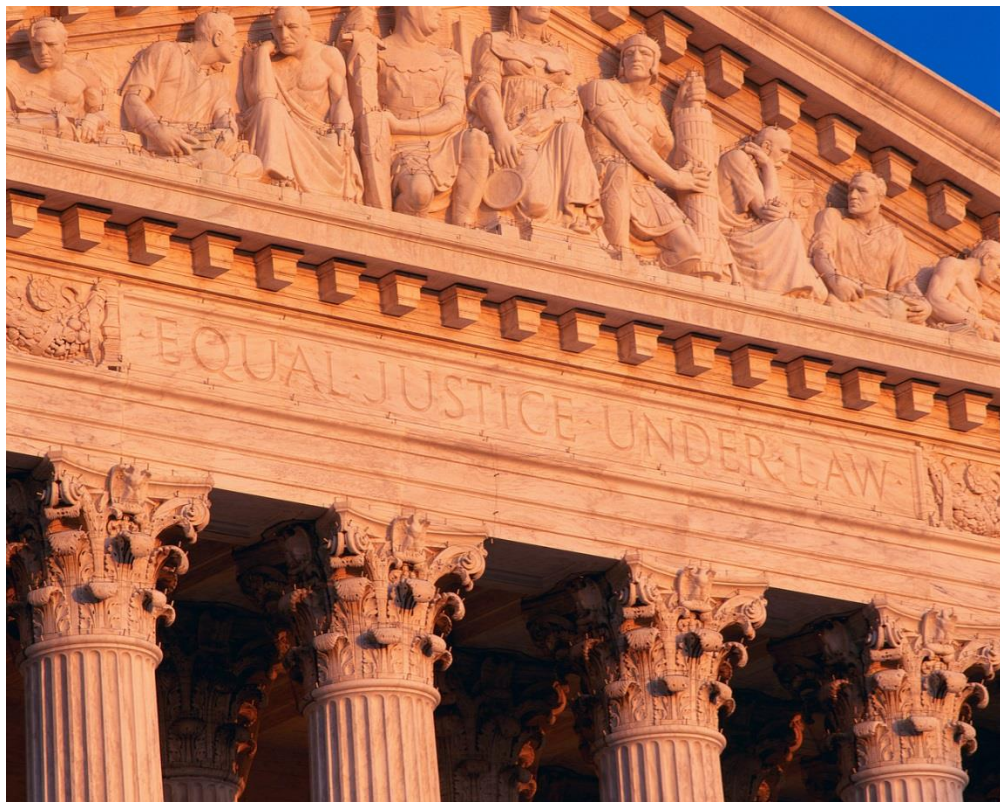


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Training Manual for Professionals and Staff Working with Juvenile Justice Offenders

Training Outline

The following outline covers the training information that will be presented to staff who work with offenders either in community based treatment programs or juvenile detention centers. It is developed to assist those who work with offenders involved in the juvenile justice system such as probation officers, social workers, mental health professionals, court service units, and other community based providers. It is a twelve hour training which focuses on understanding the juvenile justice system, mental health, and substance abuse systems. The training allow individuals from the various disciplines to provide their own expertise. Additionally, the information presented within this manual can be seen as a guide to expand the knowledge base of the individuals attending.

- I. Introduction
 - a. Learning about the presenter, audience, and current setting.
 - b. Rationale for the training
- II. Understanding the Juvenile Justice System
 - a. Scope of the System
 - b. Steps in the System regarding Legal Process
 - c. Rights of Parents and Residents in Detention
 - d. Commonly used terms in the Juvenile Justice System
- III. Understanding the Mental Health System
 - a. Scope of the System
 - b. To briefly define the term “mentally illness”
 - c. Mental Disorder classifications
 - d. Outline Treatment Settings within the Mental Health System
 - e. Commonly seen psychiatric disorders within the juvenile justice system
 - f. commonly used psychiatric medications in children and adolescents to treat mental disorders
- IV. Understanding the Substance Abuse Treatment System
 - a. The scope of Substance Abuse among Juvenile Offenders
 - b. Definition of Substance Abuse
 - c. Categorizing Substances of Abuse
 - d. Identifying side effects of abused drugs
- V. Understanding the Impact of Trauma on Juvenile Offenders
 - a. Definition of Trauma and Issues related to Trauma events
 - b. Prevalence of Trauma among Youth in the Juvenile Justice System
 - c. Becoming a trauma informed system

- VI. Understanding Screening, Assessment, and Treatment
 - a. To introduce screening, assessment, and Treatment
 - b. Screening and Assessment Instruments
 - c. Treatment Modalities for Juvenile Offenders

- VII. Developing Strategies for Collaboration Among the Systems
 - a. Barriers to System Collaboration and Coordination
 - b. Linkage between, Juvenile Justice, Mental Health, and Substance Abuse
 - c. To initiate discussion of strategic planning for systems coordination

Understanding the Juvenile Justice System

Overview of presentation: Lecture and Discussion

Materials and Equipment: Course Outline

Recommended Length of Presentation: Two hours

Objectives: Understanding the Juvenile Justice system

1. To introduce the trainee to the scope of the juvenile justice system
2. To provide an overview of the juvenile justice system and the legal process
3. Discuss your rights as parents and a resident in a detention facility
4. Provide a list of glossary terms commonly use in the juvenile justice system

The Juvenile Justice System

In 1899, the juvenile court was developed in Chicago by passage of the Juvenile Court Act. This date and place is generally regarded as the birth of juvenile justice and the birth of juvenile delinquency. A group of reformers known as the “child savers” were the advocates of this new institution, and they represented a variety of civic organizations. They held idealistic beliefs that the criminal justice system could manage unruly undisciplined children. A guiding doctrine of this belief was called *parens patriae*. This belief of children viewed children as impressionable and easily influenced by others and that they required a strong parental figure to change their behaviors. Thus, the state provided supervision to these difficult children. Vito & Wilson stated that “the objective of the parental role is to care for and treat the child, rather than to punish, to achieve change in the child’s behavior”. The establishment of juvenile courts, similar to the one in Chicago during 1899, caught on across America as a solution to the problem of children and adolescences with legal problems (G & D, 1985).

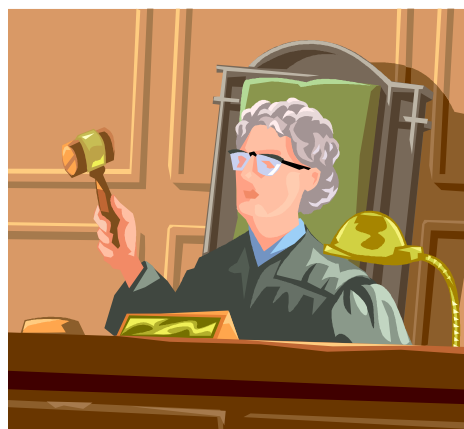
Today, the juvenile justice system in America is based on approximately 4,000 juvenile courts. These courts specialize in the problems of youth and operate with the philosophy of rehabilitation and that the worst delinquent is not to be considered a criminal or bad person, but instead a person who has made poor choices. The primary concern of the juvenile justice system is to maintain safety and security by detaining and providing for the care and custody of individuals who commit crimes.



What is going to happen to me now? Juvenile Justice Process

Steps in the Juvenile Justice System

1. The juvenile enters the system when an offense is committed and reported by a parent, citizen, agency complaint, or the police.
2. If the juvenile entered the system through police contact, a decision is made whether to counsel and release the youth back to the community or to arrest. If a parent, citizen, or agency made the complaint, then the complaint goes to intake.
3. An intake officer at the court service unit makes the decision whether to take informal action such as crisis-shelter care, detention outreach, or counseling; to take no action; or to file a petition. In some cases, a police officer or the original complainant will appeal to the magistrate if they disagree with the intake officer's decision. The magistrate must certify the charge and the matter is returned to intake to file a petition.
4. Once a petition has been filed, an intake officer decides if the juvenile should be detained or released to his or her parents/guardians. The decision is based on the juvenile's risk to self, community, or flight.
5. If the decision is made to detain the juvenile, a detention hearing is held within 72 hours in the Juvenile and Domestic Relations District Court to determine the need for further detention and examine the merits of the charges.
6. A preliminary hearing is held to ensure that the case has enough merit to carry it to trial. Issues of competency, insanity, subpoenas, and witnesses are also addressed. If no probable cause exists, the case is dismissed. If cause is determined; then the case moves to the adjudicatory hearing. Also during this phase issues of transfers and waivers are addressed by the court. If certification is ordered or a direct indictment issued, the case goes to the circuit court.
7. Innocence or guilt is determined at the adjudicatory hearing. Witnesses and testimony are presented similar to an adult trial. If found not guilty; the case is dismissed. If found guilty; a dispositional hearing is held.
8. At the dispositional hearing, the pre-disposition report (social history) is used to assist in selecting appropriate sanctions and services. The court decides if the juvenile will be committed to Department of Juvenile Justice (DJJ) or face community sanctions such as warnings, restitutions, or fines. A conditional disposition may be imposed such as probation, which includes participation in court service unit programs, referral to local services or facilities, to other agencies, to private or boot camp placement, or to post-dispositional detention. Once the requirements have been met, the juvenile is released by the court.



9. If committed to DJJ, the juvenile must undergo psychological, educational, social, and medical evaluations conducted at RDC.
10. From RDC, the juvenile may go to a privately operated residential facility or a juvenile correctional center (JCC). At the JCC, a committed juvenile receives 24-hour supervision, education, treatment services, recreational services, and a variety of special programs.
11. After completion of the commitment period, a juvenile may be placed on parole or directly released. During parole, the juvenile transitions to the community through agency program efforts and is afforded local services. Some juveniles may need 24-hour residential care and treatment services provided by a halfway house. Upon completion of parole or entry into the adult criminal justice system, the youth is discharged from the system.
12. (Appeals Process and Circuit Court Cases) A case may be sent into the appeals process following the dispositional hearing. After presentation to the circuit court, the case is reconsidered and the issue of guilt is examined. If the juvenile is found not guilty, the case is dismissed. If found guilty; the circuit court judge administers an appropriate juvenile disposition.
13. If the circuit court received the case through a direct indictment, a trial will take place. If found not guilty; the case is dismissed. If found guilty; the judge will decide whether to render a juvenile disposition or an adult sentence.

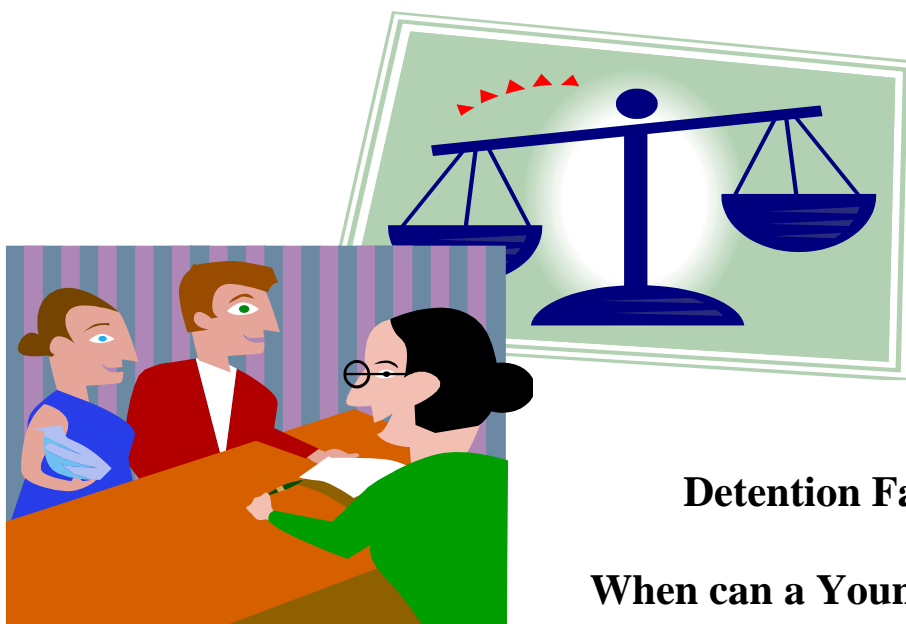


(Virginia Department Of Juvenile Justice, 2019)

Juvenile Detention Facilities

- It is hoped that all children stay out of trouble and never have to spend a single night in a detention facility. However, it is also understood that there may come a time when a teenager gets locked up. It is important to remember that even if a juvenile does get locked up, they still have certain rights while in detention.
- In this section we will cover:
 - What is a juvenile detention facility?
 - When can a juvenile be sent to detention?
 - When does the judge decide if a youth will be sent to detention?

- What will the Judge consider when deciding whether or not to send a juvenile to detention?
- How can you keep a juvenile from going to detention?
- Do juveniles have the right to an education while in detention?
- Can juveniles take medication, receive counseling, or receive mental health services while in detention?
- Can juveniles be detained with adults?
- Can you visit juveniles in detention?
- What are the rights of juveniles in detention?



**What Is a
Juvenile**

Detention Facility?

When can a Young person be

Sent to Detention?

- Juvenile Detention Facilities are secure facilities where juveniles can be locked up for committing crimes or, if they have been accused of committing a crime, while they wait for their trial or sentence.

- Unlike adult jails, detention facilities must provide services, most importantly school, for the residents that are locked up.
- An adolescent can be sent to detention if she is accused of, or convicted of, committing a crime and is ordered to go by a judge.
- If ordered to detention by the judge, an adolescent may remain there until he/she has their trial and, if found guilty, receives sentence.
- If a juvenile is found guilty, he/she may be sent to detention as part of their sentence.
- If your juvenile violates the conditions of probation, she can also be sent to detention.

When Does the Judge Decide If a Juvenile Will Be Sent to Detention?



- In most cases, the judge will decide at a Detention Review Hearing.
- This will take place after the juvenile has been accused of committing a crime.
- The juvenile has the right to be represented by a lawyer at this hearing.
- Juveniles should be represented by a lawyer at this hearing.

What Will the Judge Consider?

Deciding Whether or Not to Send a Juvenile to Detention?

- The judge will consider:

- The seriousness of the current charge
- The juvenile's criminal history or lack of history
- The juvenile's situation in the community and at home
- Whether he/she has missed previous court dates
- The risk the juvenile poses to the community or to himself
- Whether the juvenile has ever escaped from a locked facility.



Remaining Free of detention; what can be done?

- **Show up at the detention hearing.**
 - Judges want to make sure that each juvenile has a structured, safe place to live. If the parent does not even appear at the juvenile's court hearing, the judge will be concerned about how responsible the parents will be once he/she returns home.
- **Tell the judge about the youth.**
 - Often all that the judge will know about the youth is that he is accused of committing a crime. You need to let the judge know about the individual. If you are the parents talk about your child, church, and after-school activities.
Remember: do not lie to help your child. If you have nothing good to say, think harder.
- **Tell the judge that you will make sure that your child makes the next court date.**
 - Judges want to know that children will make all of their court dates. Tell the judge that you will make sure that this happens.
- **Bring people from the community who can speak for your child.**
 - Judges want to know that the youth is part of a community. Bring people, friends, teachers, coaches, ministers — who



know the youth, who can speak for your individual, who can help look after



him if he is permitted to return home. If these people cannot make it, ask them to write a letter that you can bring to court.

- Even if the judge does decide to hold your child in detention until the case is resolved, all of the information you provide the judge at the Detention Hearing will have an effect on how your child is treated later on. It is worth the effort!

Does My Child Have the Right to an Education while in Detention?

Yes. Each facility must provide educational services for your child in detention comparable to what she would receive if she was in public school.

The facility should send reports of your child's academic performance to your child's school so that she can get the necessary credits.

If your child is a special education student, she has the right to take special education classes in detention.

The Detention Center must comply with your child's Individual Education Plan.

If they do not follow the IEP, please contact the local school system to determine the reason the plan is not being followed.





Can My Child Take Medication, Receive Counseling, or Receive Mental Health Services While in Detention?

- **If your child regularly takes medication the Detention Facility must continue providing that medication.**
 - It is up to you to make sure that the Detention Center gets your child's medicine, and that your child's Doctor lets the Detention Center know that they must dispense the medicine.
- **The Detention Center must evaluate every youth for mental illness within twenty-four hours of entering the Detention facility.**
 - If your child is in need of mental health services these must be provided.



- If your child has been receiving counseling services before being sent to detention, you should ask the Judge to order that arrangements be made for this counseling to continue.



Can My Child be detained with Adults?

- **No! Generally speaking, children can never be locked up with adults.**
- There are four exceptions to this rule:
 1. If the judge determines that your child is a threat to the safety of the other juveniles or staff in the detention facility and your child is fourteen years or older, your child may be placed in a jail or other facility for the detention of adults provided that:
 - Your child is kept entirely separate from the adults,

- Your child is supervised, and
- The facility has been approved by the state as a place where children can be detained.



2. If the head of the detention facility where your child is held, determines that your child is threatening the safety of others in the facility, would your child is fourteen or older, he may place your child in an adult facility, **for no more than six hours.**
3. If your child has just been charged with a crime, and the judge or intake officer determines that detention is necessary for the safety of the community, and your child is fourteen or older, your child can be held in an adult jail for no more than six hours.
4. The only time that a child can be held in an adult detention facility and not separated from the adults, is if your child's case has been transferred to Circuit Court and he is being tried as an adult.

Can I Visit My Child in Detention?

- **Yes.** Each facility will have different times when parents are permitted to visit their children. These times are very specific and you will need to call the facility where your child is held to learn when you can visit.
- **It is very important that you visit your child while he /she is detained.** Even if your child has done something wrong, she still needs to know that you love and

support her. You also need to remind your child that it is very important to be on her best behavior while in detention.

- The addresses and phone numbers for the closest facilities are:

- Shenandoah Valley Juvenile Detention Center

300 Technology Drive

Staunton, VA 24401-3968

(540) 886-0720

- Blue Ridge Juvenile Detention

195 Peregrine Lane

Charlottesville, VA 22902

(434) 951-9340



What Are My Child's Rights?

While in Detention?

- **Your child can call his lawyer, and his lawyer can call him when he is in detention.**
 - If your lawyer has not provided her number to your child when he first gets locked up, you should make sure that she does once your child is in detention.
- **If your child is not receiving an education, or medications, or counseling:**

- You should report this to the head of the detention facility (make sure you do this in writing!), and
- You should tell your child's lawyer what is happening;
- Your child's lawyer can set a hearing before a judge, and ask the judge to order the detention facility to provide these services to your child.
- **If your child is the victim of assaults and aggressive behavior, you should report this immediately to the head of the detention facility.**
 - **You should report this in writing!!**
 - You should tell your child's lawyer and probation officer.



Commonly used term in the state of Virginia regarding the Juvenile Justice System

1. **Adjudication**- the finding by the court that the accused is guilty of the offense charged, based on testimony and evidence presented.
2. **Adjudication hearing**- the court hearing where innocence or guilt is determined. Witnesses and testimony are present, similar to a trial.
3. **Alternative placement**- assignment of a ward to a residential facility other than a juvenile correctional center while in direct care.
4. **Child in need of Services**- a child whose behavior, conduct or condition presents or results in serious threat to the well-being and physical safety of the child.
5. **Child in need of Supervision**- a child who is habitually and without justification is absent from school despite opportunity and reasonable efforts to keep him in

school or who habitually runs away from home or a residential care court placement.

6. **Classification of wards-** a system to determine the treatment and security needs of committed juveniles and to assign them to an appropriate program and custody level.
7. **Commitment-** an order by a judge at the dispositional hearing which transfers a delinquent juvenile's legal custody to the State Department of Juvenile Justice. Depending on the circumstances, the commitment may be for a determinate or an indeterminate period of time.
8. **Court order-** an order issued by a state or federal court signed by a judge.
9. **Detention-** in its broadest sense, it means to temporarily place an individual in a secure setting resulting in the individual's loss of freedom.
10. **Detention order-** the official paper signed by a person authorized to detain youth which contain such information as the youth's name and address, birth date, offense, and the detaining jurisdiction ; sometimes referred to as an attachment.
11. **Dispositional Hearing-** a hearing in a juvenile's case similar to a sentencing hearing in a criminal court at which the court imposes treatment services and sanctions on a juvenile who has not been found innocent.
12. **Diversion-** removing a youth from the juvenile justice system as a result of an intake officer's decision to proceed informally on a complaint rather than to initiate court action. Diversion may include the provision of programs and services to youth through alternatives to the juvenile justice system or simply discontinuing the case.
13. **Due process-** those procedures and safeguards that protect the rights facing criminal or disciplinary charges.
14. **Petition-** a document filed with the court alleging that a juvenile is delinquent, a child in need of services, or an abused or neglected child, and asking that the court assume jurisdiction over the juvenile. A petition initiates formal court action.
15. **Recidivism-** a return to criminal behavior after conviction and treatment. Department of Juvenile Justice define a recidivist as a person who is found by a court to have committed a delinquent or criminal act after being placed on probation or released from confinement
16. **Restitution-** repayment for having committed a crime. Restitution can be made to a specific victim in a dollar amount to repay for damages or can be made to society by working without pay for a nonprofit or government agency.

(Virginia Department Of Juvenile Justice, 2019)

Understanding the Mental Health System: An Overview

Recommended Length of Presentation: Two Hours

Presentation: Lecture and Discussion

Materials and Equipment: Course Outline

Objectives Understanding the Mental Health System: An Overview
:

1. To introduce the trainee to the scope of the Mental Health System
2. To briefly define the term “mentally illness”
3. Disorder classifications
4. To outline treatment settings within the mental health system
5. Review commonly seen psychiatric disorders within the juvenile justice system
6. Review commonly used psychiatric medications in children and adolescents to treat mental disorders

Understanding the Mental Health System: An Overview

Scope of the System

The purpose of the mental health system is to provide a range of services to people suffering from one or more mental disorders in order to treat, minimize, and assist them in coping with their mental illness. Such disorders may be time limited, such as an adjustment reaction to a recent traumatic experience, or of long –term duration, such as a chronic mental illness. Most individuals who are mentally ill do not require long-term hospitalization and can live and work in the community with a variety of support from mental health and social service providers.

The change in the past two decades from institutionalization of the mental ill to community based treatment is due to a combination of factors including, increased concern regarding patients' rights and involuntary hospitalization, the development of better psychotropic medication, and the recognition of the importance of the patients family and psychosocial environment in symptom reduction and recovery.



Mental Health Services

Treatment and care for mental health-related issues is provided in a variety of settings. The environment, and level or type of care, will depend on multiple factors: the nature and severity of the person's mental condition, their physical health, and the type of treatment prescribed or indicated. The three primary types of treatment settings for receiving mental health care or services are 1) hospital inpatient, 2) residential and 3) outpatient. In addition, some mental health care services are delivered via online and telecommunications technologies.

Hospital inpatient settings involve an overnight or longer stay in a psychiatric hospital or psychiatric unit of a general hospital. The facility can be privately owned or public (government-operated). Inpatient hospitals provide treatment to more severely ill mental health patients, usually for less than 30 days. A person admitted to an inpatient setting might be in the acute phase of a mental illness and need help around the clock. Typically, a person who requires long-term care would be transferred to another facility or a different setting within a psychiatric hospital after 30 days of inpatient treatment.

Psychiatric hospitals treat mental illnesses exclusively, although physicians are available to address medical conditions. A few psychiatric hospitals provide drug and alcohol detoxification as well as inpatient drug and alcohol rehabilitation services and provide longer stays. A psychiatric hospital might have specialty units for eating disorders, geriatric concerns, child and adolescent services, as well as substance abuse services.

General medical and surgical hospitals may have a psychiatric inpatient unit and/or a substance abuse unit, although these units are not very common. They provide medical services that would not be available in a free-standing psychiatric hospital.

Residential mental health treatment environments generally provide longer-term care for individuals. Most residential treatment settings provide medical care but are designed to be more comfortable and less like a hospital ward than inpatient hospitals. Examples:

Psychiatric residential centers are tailored to people with a chronic psychiatric disorder, such as schizophrenia or bipolar disorder, or who have a dual diagnosis (i.e., a mental disorder and substance abuse problems), which impairs their ability to function independently.

Alcohol and drug rehabilitation facilities are inpatient centers that treat addictions and may provide detoxification services. Patients typically reside in this type of facility for 30 days but stays may be individualized according to each facility's policy.

Nursing homes have psychiatric consultation available as needed.

Outpatient Settings – While there is wide variety in the types of outpatient settings, they all involve office visits with no overnight stay. Some are based in community mental

health centers; others are located in general hospitals where individuals visit an outpatient clinic for an appointment. In addition, many individuals in need of mental health counseling or treatment go to private offices to see a mental health clinician who is in solo or group private practice.

Partial hospitalization programs (PHPs), also called “day programs,” refer to outpatient programs that patients attend for six or more hours a day, every day or most days of the week. These programs, which are less intensive than inpatient hospitalization, may focus on psychiatric illnesses and/or substance abuse. They will commonly offer group therapy, educational sessions and individual counseling. A PHP may be part of a hospital's services or a freestanding facility.

Intensive outpatient programs (IOPs) are similar to PHPs, but are only attended for three to four hours and often meet during evening hours to accommodate persons who are working. Most IOPs focus on either substance abuse or mental health issues. IOPs may be part of a hospital's services or freestanding.

Outpatient Clinics are settings where patients obtain therapy services from a variety of mental health professionals. Depending on the particular clinic, individual therapy, group therapy and medication management may be available.

Community Mental Health Centers – Often referred to as Mental Health and Mental Retardation Centers (MHMR), these clinics treat persons whose incomes fall below a state-determined level. In seven North Texas counties (Dallas, Collin, Hunt, Navarro, Kaufman, Ellis and Rockwall) these public mental health services are delivered under the

Practitioners in private practice – Many individuals see a mental health professional in solo or group private practice at the practitioner's office for mental health treatment/counseling. Appointments may be for individual, group or family therapy. Many practitioners accept insurance payments, but practitioners vary in which insurance plans they will accept; some practitioners accept only personal payment for services.

Telepsychiatry, Telemental Health Services refer to the remote delivery of psychiatric assessment and care, or psychological support and services, via telephone or the Internet using email, online chat or videoconferencing. Most commonly, these services improve access to care for individuals with mental health issues living in remote locations or underserved areas, or who can't leave home due to illness, emergencies or mobility problems. They also allow clinicians to support their patients or clients between visits.

(Behavioral Health care, 2019)

Common Mental Disorders among Juvenile Offenders

- **Oppositional Defiant Disorder** is characterized by a pattern of negative, hostile, and defiant behaviors that lasts at least six months. These youth repeatedly refuse to comply with rules or authority figure request. Youth receive this diagnosis when they engage in these behaviors more often than peers their same age or developmental stage and only when these behaviors significantly interfere with their abilities function. (in relationships, at home/work)
- **Conduct disorder** is one of the most commonly diagnosed disorders among youth in the juvenile justice system. This disorder is characterized a recurring and enduring pattern of behaviors in which the basic rights of others or major age-appropriate societal norms /rules are violated. Youth with this diagnoses are usually aggressive toward others, are destructive toward property, engage in theft or deceitfulness, and violate important societal rules.
- **Attention Deficit/Hyperactivity Disorder** is characterized by continued pattern of difficulties related to inattention and/or hyperactivity/impulsivity that cause them significant problems. Their symptoms of inattention and/or hyperactivity/impulsivity are more frequent and severe than those of other youth who are the same age or at the same level of development.
- **Major Depressive disorder** in youth is characterized by sadness and irritability. Youth with this disorder find it hard to concentrate and often have appetite and sleep disturbances. Most people associate depression with a sad, withdrawn individual. However, among children and adolescents, depression often manifests itself as an irritable mood, aggression, and oppositional behavior.
- **Dysthymic Disorder** is one of the most common psychiatric disorders among youth in the juvenile justice system. Dysthymia differs from major depression in that it is a more mild and chronic form of depression. Youth with this disorder usually report feeling depressed all their life. Also, similar to major depression, an irritable, cranky mood rather than a sad mood is often more typical among youth involved with the juvenile justice system.
- **Bipolar Disorder** is characterized by severe mood swings experienced by the individual. Youth with this disorder typically alternate between symptoms of depression and mania, with periods of normal mood in between. Youth with this disorder during a manic phase may experience an excessive amount of energy and/or become extremely irritable. They may talk very fast, not need to sleep, and have difficulty concentrating.
- **Other Disorders-** Other disorders that occur among youth involved with the juvenile justice system are posttraumatic stress disorder, borderline personality disorder, psychotic disorders, mental retardation, anxiety disorders, and learning disorders.

Commonly Used Psychiatric Medications for Children and Adolescents

The following guide includes most of the medications used to treat child and adolescent mental disorders. It lists the problems each medication might treat and some of the common side effects. This guide is intended to be informative and useful, but it is not comprehensive. Children should take these medications only under the careful supervision of their doctors.

MEDICATION GUIDE

Medications are referred to by brand name, followed by generic name in parenthesis.



Medication		
Ritalin(methylphenidate)	Celexa (citalopram)	Prolixin (fluphenazine)
Dexedrine(dextroamphetamine)	Tofranil(imipramine)	Mellaril (thioridazine)
Cylert (pemoline)	Norpramin (desipramine)	Clozapine (clozaril)
Concerta (methylphenidate)	Elavil (amitriptyline)	Risperdal (Risperidone)
Catapres (clonidine)	Pamelor (nortriptyline)	Zyprexa (olanzapine)
Tenex (guanfacine)	Anafranil (clomipramine)	Serloquel (quetiapine)
Prozac (fluoxetine)	Wellbutrin (bupropion)	Ativan (lorazepam)
Zoloft (sertraline)	Effexor (venlafaxine)	Klonopin (clonazepam)
Paxil (paroxetine)	Serzone (nefazodone)	Xanax (alprazolam)
Luvox (fluvoxamine)	Rereon (mirtazapine)	Lithium
Tegretol (carbamazepine)	Haldol (haloperidol)	Depakote (valproic acid)
Neurontin (gabapentin)	Orap (pimozide)	

(The State of Connecticut Department of Children and Families, 2010)

(Comer, 2002)

Medication may be prescribed for psychiatric symptoms and disorders, including, but not limited to:

1. Bedwetting-if it persists regularly after age 5 and causes serious problems in low self-esteem and social interaction.
2. Anxiety (school refusal, phobias, separation or social fears, generalized anxiety, or posttraumatic stress disorders)-if it keeps the youngster from normal daily activities.
3. Attention deficit hyperactivity disorder (ADHD)-marked by a short attention span, trouble concentrating and restlessness. The child is easily upset and frustrated, often has problems getting along with family and friends, and usually has trouble in school.
4. Obsessive-compulsive disorder (OCD)-recurring obsessions (troublesome and intrusive thoughts) and/or compulsions (repetitive behaviors or rituals such as hand washing, counting, and checking to see if doors are locked) which are often seen as senseless but which interfere with a youngster's daily functioning.
5. Depression-lasting feelings of sadness, helplessness, hopelessness, unworthiness and



guilt, inability to feel pleasure, a decline in school work and changes in sleeping and eating habits.

6. Eating disorder-either self-starvation (anorexia nervosa) or binge eating and vomiting (bulimia), or a combination of the two.

7. Bipolar (manic-depressive) disorder-periods of depression alternating with manic periods, which may include irritability, "high" or happy mood, excessive energy, behavior problems, staying up late at night, and grand plans.

8. Psychosis-symptoms include irrational beliefs, paranoia, hallucinations (seeing things or hearing sounds that don't exist) social withdrawal, clinging, strange behavior, extreme stubbornness, persistent rituals, and deterioration of personal habits. May be seen in developmental disorders, severe depression, schizoaffective disorder, schizophrenia, and some forms of substance abuse.
9. Autism-(or other pervasive developmental disorder such as Asperger's Syndrome)-characterized by severe deficits in social interactions, language, and/or thinking or ability to learn, and usually diagnosed in early childhood.
10. Severe aggression-which may include assault, excessive property damage, or prolonged self-abuse, such as head-banging or cutting.
11. Sleep problems-symptoms can include insomnia, night terrors; sleep walking, fear of separation, anxiety.

(The State of Connecticut Department of Children and Families, 2010)



Understanding Substance Abuse in Juvenile Offender: An Overview

Recommended Length of Presentation: Two Hour

Presentation: Lecture and Discussion

Materials and Equipment: Course Outline, Overhead transparencies, and overhead projector

Objectives Understanding Substance Abuse in Juvenile Offender: An Overview

1. To introduce the trainee to the scope of Substance Abuse among Juvenile Offenders.
2. Definition of Substance Abuse
3. Categorizing Substances of Abuse
4. Identifying side effects of abused drugs

Scope of the Problem

The increase in criminal justice populations over the last decade is largely due to the enormous rise in the arrest and incarceration of drug law violators. Political pressure and public fear of drug related crimes has propelled legislators to enact stiffer penalties, including mandatory sentencing in prisons, for such drug offenses as possession of a controlled substance. In the past, such offenders were generally diverted to community based rehabilitation programs. Moreover, research has shown that a staggering number of criminal activity is related to, or committed by, individuals under the influence of drugs and alcohol. The resulting increase in detainees with substance abuse disorder within the criminal justice system has forced correctional settings and supervision programs to pay closer attention to the therapeutic and recovery needs of such offenders. Probation and parole supervision may require that the offender participate in a substance abuse program. Frequently, such services as provided under contract with a selected community provider.



Definition and Impact of Substance Abuse

Substance abuse is a maladaptive pattern of alcohol or other drug use resulting in recurrent and significant negative consequences such as family, vocational or legal problems. Ongoing substance abuse may progress to dependence, commonly known as addiction, which is frequently manifested by increasing need, or tolerance, for the substance.

Once a person becomes dependent on a substance, they will experience physical and/or psychological discomfort when cutting back or stopping the drug. This process is referred to as withdrawal.

Different substances will effect different parts of the brain and result in different behaviors while under their influence. Substances are often categorized as belonging to one of the following categories.

Categorizing Substances of Abuse



Depressants

These include alcohol, barbiturates, sedatives, tranquilizers, anesthetics and volatile solvents. These drugs slow down, or sedate, the brain centers that control speech, vision and coordination and alter the individual's ability to exercise judgment. Their use may lead to feelings of depression and increased risk of suicide. The use of alcohol is a frequent correlate of violent and criminal behaviors.

Stimulants

These include amphetamines ("speed"), cocaine including "crack", as well as caffeine and nicotine. These substances increase the heart rate and blood pressure and large doses can produce acute delirium and psychosis, including paranoia.



Opiates or Narcotics

These include opium, heroin, morphine, codeine, Demerol, Percodan, and methadone. These highly addicting substance decrease pain and may produce a sense of detachment from reality.

Hallucinogens

These include LSD, PCP and other synthetic drugs that cause hallucinations and other distortions of reality.

Cannabis (Marijuana)

This herb is generally inhaled in cigarette form which can temporarily cause euphoria and a heightened sense of awareness followed by depression and fatigue.

Combination and Designer Drugs

Many drug abusers use a combination of substances to either counteract the side effects, or to increase their impact. Using several drugs in combination and the use of designer or synthetic drugs, such as Ecstasy are common among juveniles and young adults.

Identifying Side effects of illegal drugs

Short term effects of using marijuana:

- Sleepiness
- Difficulty keeping track of time , impaired or reduced short term memory
- Reduced ability to perform tasks requiring concentration and coordination
- Increased heart rate
- Potential cardiac dangers for those with preexisting heart disease
- Bloodshot eyes
- Dry mouth and throat
- Decreased social inhibitions
- Paranoia, hallucinations
- Increased appetite

Long term effects of marijuana

- Lowers sperm counts and difficulty with having children; decreased testosterone levels for men
- Diminished or extinguished sexual pleasure
- Enhanced cancer risk
- Increased usage requiring more of the same drug to get the same effect
- Increase in testosterone levels for women; also increased risk of infertility

Additionally, marijuana blocks the messages going to your brain and alters your perceptions and emotions, vision, hearing, and coordination.

Short term effects of using alcohol:

- Distorted vision, hearing, and coordination
- Altered perceptions and emotions
- Impaired judgment
- Bad breath ; hangovers

Long term effects of heavy alcohol use:

- Loss of appetite
- Vitamin deficiencies
- Stomach ailments
- Skin problems
- Sexual impotence
- Liver damage
- Heart and central nervous system damage
- Memory loss

How do you know if I, or someone close to you has a drinking problem?

Here are some quick clues:

- Uncontrollable alcohol use; regardless of what's decided about not drinking, one usually ends up drinking
- Using alcohol to escape problems
- A change in personality
- Drinking everybody under the table; an high tolerance for alcohol
- Blackouts- not remembering what happened the night before while drinking
- Problems in work or in school as a result of drinking.

The effects of methamphetamine use:

- Increased heart rate and blood pressure
- Increased wakefulness; insomnia
- Increased physical activity
- Respiratory problems
- Extreme anorexia
- Decreased appetite
- Hyperthermia, convulsion, and cardiovascular problems, which can lead to death
- Euphoria
- Irritability, confusion, tremors
- Anxiety, paranoia, or violent behavior
- Can cause irreversible damage to blood vessels in the brain, producing strokes

Methamphetamine is used in pill form, or in powdered form by snorting or injecting.

Crystallized methamphetamine known as “ice”, “crystal”, or “glass”. Other street names are “speed”, “crank”, and “meth”.

Cocaine and Crack Cocaine effects:

Physical risk:

- Increases in blood pressure, heart rate, breathing rate, and body temperature
- Heart attack, strokes, and respiratory failure
- Hepatitis or AIDS through shared needles
- Brain seizures
- Reduction of the body’s ability to resist and combat infection

Psychological risk:

- Violent, erratic, or paranoid behavior
- Hallucinations
- Confusion, anxiety and depression, loss of interest in food and sex
- Losing touch with reality; loss of interest in friends, family, sports, hobbies, and other activities

The side effects of Hallucinogens:

Physical risk:

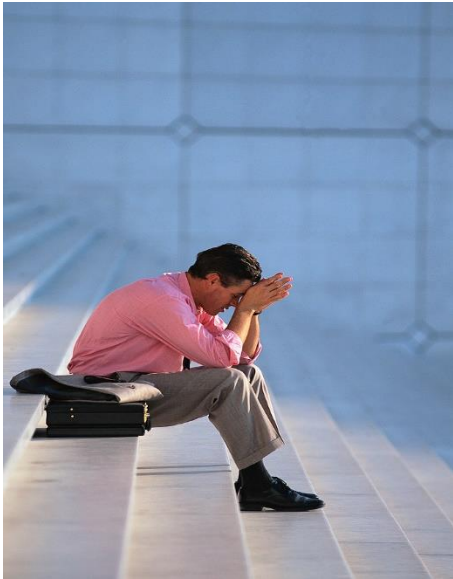
- Increased heart rate and blood pressure
- Sleeplessness and tremors
- Lack of muscular coordination
- Sparse, mangled, and incoherent speech
- Decreased awareness of touch and pain that can result in self-inflicted injuries
- Convulsions
- Coma; heart and lung failure



Psychological risk:

- A sense of distance and estrangement
- Depression, anxiety, and paranoia
- Violent behavior

Psychological risk cont.:



- Confusion , suspicion, and loss of control
- Flashbacks
- Behavior similar to schizophrenic psychosis
- Catatonic syndrome whereby the user becomes mute lethargic, disoriented, and make meaningless repetitive movements.

Side effects of using inhalants:



Inhalants risk: (even once)

- Sudden death
- Suffocation
- Visual hallucinations and severe mood swings
- Numbness and tingling of the hands and feet

- Heart palpitations, breathing difficulty
- Dizziness
- Headaches

Long term risk:

- Headache, muscle weakness, abdominal pain
- Decrease or loss of sense of smell
- Nausea and nosebleeds
- Hepatitis
- Violent behaviors
- Irregular heartbeat
- Liver, lung, and kidney impairment
- Irreversible brain damage
- Nervous system damage
- Dangerous chemical imbalances in the body
- Involuntary passing of urine and feces

(Estroff, Manual of Adolescent Substance Abuse Treatment, 2001)

(U.S. Department of Health and Human Services, 2006)

Understanding the Impact of Trauma: An Overview

Understanding the Impact of Trauma: An Overview

Recommended Length of Presentation: Two Hour

Method of Presentation: Role play, Lecture, and discussion

Materials and Equipment: Course Outline

Objectives: Understanding the Impact of Trauma on the Juvenile Offender

1. To introduce the trainee to the current definition of trauma and issues related to traumatic events
2. Prevalence of trauma among youth in the Juvenile Justice system
3. Becoming a trauma informed system

What is trauma? According to the American Heritage Dictionary, trauma is: 1. a wound; especially one produced by sudden physical injury. 2. An emotional shock that creates substantial and lasting damage to the psychological development of the individual, generally leading to neurosis. The American Psychological Association describe a traumatic event as directly experiencing, witness, or indirectly learning about a close family member or friend being involved in an event that exposing them to actual or threatened death, serious injury, or sexual violation (American Psychiatric Association, 2013).

Many juveniles in the juvenile justice system have experienced or witnessed violence and suffered the fear of on-going exposure to injury. Numerous studies have shown that a large number of juveniles who has witness and experience violence are linked to negative outcomes later in life (University of New Hampshire, 2014).



Trauma and Triggers

After experiencing trauma, the youth may

- **become irritable and angry for no apparent reason**
- **Be on constant alert**
- **Over-interpret signs of danger and may become fearful**
- **Over-react to seemingly normal situation**
- **May have flashback regarding the traumatic event**
- **Fight or flight regarding difficult situations**
- **Nightmares**
- **Dissociation**

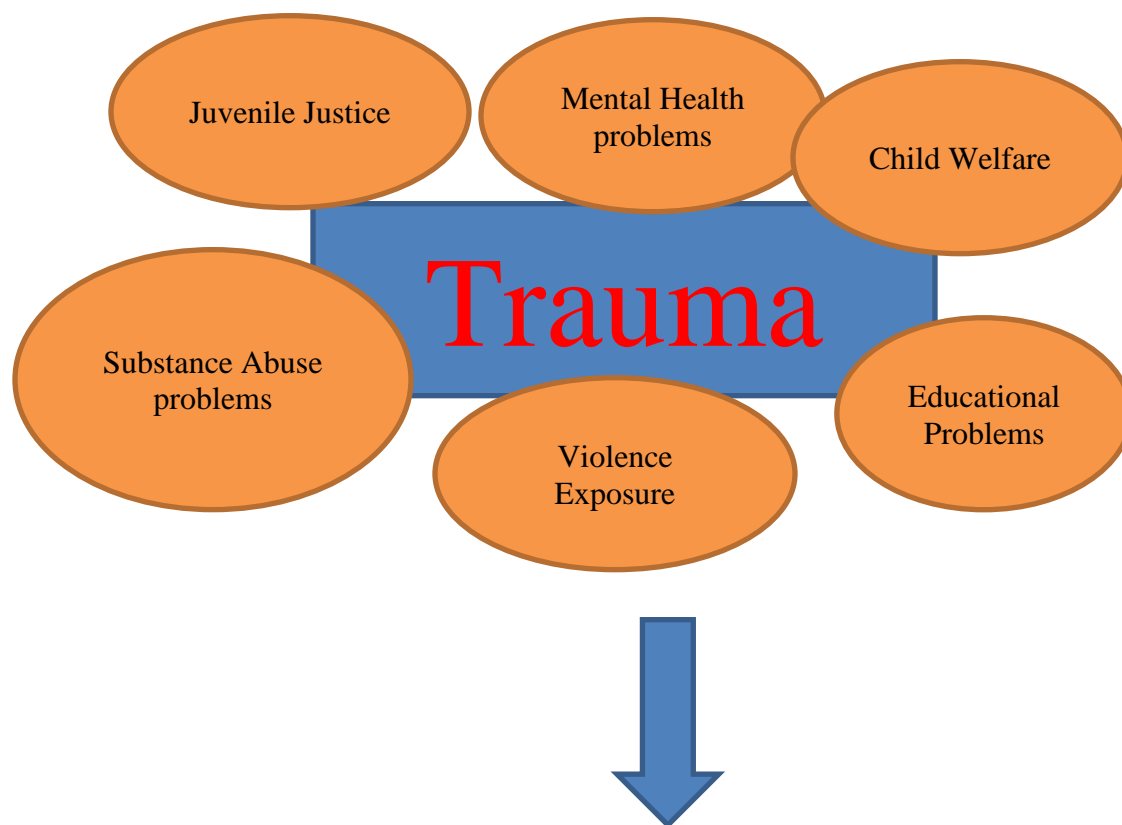
(U.S. State Department of Justice, 2012)

Role play Griselda's story

Griselda is a 15-year old Hispanic female whose father was murder when she was five years of age. Following his death, her mother remarried and moved in with her step-father. Griselda also reported that her two older sister moved in with them. Additionally, she lived in an economically disadvantage neighborhood where violence was the norm. Her step-father who left when she turned 12, physically and verbally abused Griselda and her other family members. Griselda's mother worked two jobs and was also verbally and physically abusive

toward her. She also had several female family members and friends who was sexually assaulted during this time. One of the family members that was assaulted was his older sister. Griselda begin to hang out with gangs when she was 13 years old and considered them her real family because they protected her from “bad shit”. She also started smoking marijuana daily after joining the gang and use various other drugs to get high. It was also during this time she assaulted another teen and received 12 month of house arrest. She reported that she blacked out during the incident and does not remember much of it. She later discovered that she had broken the nose of the other youth involved. Despite her lack of remembering what happened during the incident, she does recall having a memory of someone being shot in the head and watching him die. At age 15, she was adjudicated of drugs and weapons related charges and sentenced to 18 months in detention center.

Common Themes of Juvenile Justice Teenagers who have Experienced Trauma



Can lead to Posttraumatic Stress Disorder

- **As many as 50% of youth may have symptoms of trauma**
- **93% of children in detention report exposure to adverse events. These adverse and potentially traumatic events include accidents and serious illnesses, physical abuse, sexual abuse, neglect, traumatic loss, and domestic and community violence.**
- **The majority of youth were exposed to six or more events.**
- **Girls report greater exposure to all adverse events, except physical abuse and traumatic loss.**
- **At least 75% of children in the juvenile justice system have experienced traumatic victimization.**

- **As many as 50% of youth may have symptoms of trauma**
- **93% of children in detention report exposure to adverse events. These adverse and potentially traumatic events include accidents and serious illnesses, physical abuse, sexual abuse, neglect, traumatic loss, and domestic and community violence.**
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- **Girls report greater exposure to all adverse events, except physical abuse and traumatic loss.**
- **At least 75% of children in the juvenile justice system have experienced traumatic victimization.**



Trauma Teams Rock!

One of the ways to assist in decreasing the impact of trauma and PTSD on the Juvenile Justice population is to have the system become more trauma informed. Meaning that Juvenile Justice System look to understand how traumatic experience impacts a juvenile's behavior, substance abuse use, and mental health. The United States Attorney General task force on Children Exposed to Violence identified 9 practical steps that would assist in implementing step to address trauma in children lives. The steps were a collaboration between experts in law enforcement, child protective services, juvenile justice system, and traumatic stress research group. According to source the steps include:

1. Make trauma –informed screening, assessment and care the standard in juvenile justice services.
2. Abandon juvenile justice correctional practices that traumatize children and further reduce their opportunities to become productive members of society.
3. Provide juvenile justice services appropriate to children's ethno-cultural background that are based on an assessment of each violence exposed child's individual needs.
4. Provide care and services to address the special circumstances and needs of girls.
5. Provide care and service to address the special circumstances of lesbian, gay, bisexual, transsexual, and questioning youth.
6. Develop and implement policies in every school system across the United States that aim to keep children in school rather than relying on policy that lead to suspension and ultimately drive children into the juvenile justice system.
7. Guarantee that all violence-exposed children accused of a crime have legal representation.
8. Help, do not punish, child victims of sex trafficking.
9. Whenever possible, prosecute young offenders in the juvenile justice system instead of transferring their cases to adult courts.

(Cruise & Ford, 2011)

Understanding Screening, Assessment, and Treatment

Presentation: Lecture and Discussion

Recommended Length of Presentation: one hour

Materials and Equipment: Course Outline

Objectives Understanding Screening, Assessment, and Treatment: An Overview
:

1. To introduce screening, assessment, and treatment
2. Screening and Assessment instruments.
3. Treatment Modalities for juvenile offenders

Screening, Assessment, and Treatment in the Juvenile Justice System

During any given day, more than 100,000 juveniles are held in juvenile justice facilities across the United States. Research has shown that one in five juveniles meet the criteria for a mental disorder. Often these disorders are coupled with a diagnosable substance use disorder. With the increasing number of youth entering the juvenile justice system with mental health and substance abuse issues it is important to identify those youth needing these services.

Three primary reasons to identify juveniles with a mental health disorder:

- The most simplistic reason resides in who has custody of the juvenile. As parents or legal guardians we are held responsible for the well-being and care of our children. Youth usually depend upon their parents or adults for assessing services for their well-being. For example, if there was a medical emergency involving a juvenile a parent, adult, caregiver, etc. would be obligated to ensure appropriate service would be found. Therefore, meeting the needs or custodial role of the juvenile while incarcerated is an obligation of the juvenile justice system.
- A second reason to identify juveniles with a mental disorder stems from a mandate from the juvenile justice system itself. The due process obligation states that juveniles have the right to be judged fairly for the crime they committed. Secondly, they have the right to avoid self-incrimination, to waive or obtain a lawyer, and various rights associated with the process in which the court hears evidence and gives sentencing. In addition, this process gives a determination whether a juvenile is competent enough to stand trial in delinquency cases.
- The juvenile justice system is responsible for making an effort in protecting the public from those youth deemed unsafe or dangerous to others. Youth in the juvenile justice system that have a mental disorder are not considered more violent than those without a disorder. However, their mental disorder does impact how and under what circumstances their aggression might be expressed.

List below are several screening instruments used among youth in the juvenile justice system. These instruments were chosen because of the level of training required, whether or not the instrument was researched with youth in the juvenile justice system, and the length of time used to administer the instrument. In addition, the instruments are practical and can be administered at any level of the due process.

(Grisso V. S., 2005)

Screening and Assessment Instruments

Massachusetts Youth Screening Instrument-Second Version (Maysi-2)

Description	A 52-item, self-report instrument that identifies potential mental health and substance use needs of youth at any entry or transitional placement point in the juvenile justice system. Usually administered 24 to 48 after entering a juvenile justice facility.
Constructs Measured	Alcohol/drug use Suicidal ideation Somatic complaints Traumatic experience Thought disturbance Angry-irritable Depression- anxious
Age Range	12-17 years
Administration/Scoring	Pencil and paper/computer automated administration
Administration time	10-15 minutes
Level of Training Required	In-service training with the instrument, no clinical experience.
Research in a General	Some Research
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English, Spanish, (under development)
Developer/Publisher	National Youth Screening Assistance Project (Maysi) Department of Psychiatry, WSH-8B University of Massachusetts Medical School Worcester, MA 01655 508-856-8564
Necessary Purchases	

(Grisso & Barnum, Massachusetts Youth Screening Instrument, 2000)

Adolescent Substance Abuse Subtle Screening Instrument (Adolescent SASSI)

Description	A self-report screening instrument that examines symptoms and other indicators of alcohol and drug dependence. The Adolescent SASSI, using a third grade reading level, examines both obvious and subtle symptoms related to alcohol and drug dependence
Constructs Measured	Substance use frequency, symptoms, and other indicators of alcohol and other drug dependence.
Age Range	12-18 years
Administration/Scoring	Paper-and-pencil and computer-automated administration. Scored by hand with a template or computer program.
Administration Time	15 minutes
Level of Training Required	Master's degree, clinical experience.
Research in General	Much Research.
Research With Juvenile Justice Youth	Yes.
Use with Ethnic Minorities	Languages: English and Spanish (under development) Research on ethnic differences.
Developer/Publisher	The SASSI Institute 201Camelot Lane Springville, IN 47462 800-726-0526
Necessary Purchases	Questionnaire (25 SASSIs profiles, 25 questionnaires); manual and test; scoring key; user guide. With computerized version, all of these, plus diskette.

(Grisso V. S., 2005)

Child and Adolescent Functional Assessment Scale (CAFAS)

Description	A clinician-rated instrument designed to assess the degree of impairment in children and adolescents with emotional, behavioral, or substance use symptoms or disorders. The CAFAS provides a quick visual profile of problem areas across settings and covers significant life domains, including substance use issues.
Constructs Measured	School/Work, home, community, behavior toward others, moods/emotions, self-harmful behavior, substance abuse, thinking problems.
Age Range	Two versions: 4-7 and 7-14
Administration/Scoring	Paper-and-paper and computer administration. Scored by hand with a template and with a computer program
Administration Time	10 minutes, longer if not familiar with youth. A structured option is available that takes 30 minutes.
Level of Training Required	In-service training with the instrument, no clinical experience.
Research in General	Some Research
Research with Juvenile Justice Youth	Yes
Use With Ethnic Minorities	Languages: English and Spanish. Research on ethnic differences: No known research
Developer/Publisher	CAFAS 2140 Old Earhart Road Ann Arbor, MI 48105 734-769-9725 www.cafas.com

(Bates, 2001)

Effective Treatment of Juvenile Delinquency within Juvenile Justice

1. **Multi-Systemic Therapy-** Intensive, multi-modal, family based treatment approach that fit with the known causes and correlates of delinquency and substance abuse.

Goals of Multi-Systemic Therapy:

- Empower families to cope with the challenges of raising children with behavioral and emotional problems.
- Empower youth to cope with family, peer, school, and neighborhood difficulties.
- Improve caregiver discipline practices, enhance family relations, decrease a youth's association with delinquent peers while increasing the association with pro-social peers, improve school or vocational performance, engage youth in positive recreational outlets and develop a natural support network of extended family, friends and neighbors.



Role of the therapist

- Collaborates with the family to determine the factors in the youth's social surroundings including peers, school, and community that are contributing to the identified problems and to design interventions. Secondly, the therapist assists in removing barriers to service access and for drawing upon the youth and the strength of the family to achieve change.
 - Evaluations have demonstrated reductions of up to 70 percent in long-term rates of re-arrest.
 - Reductions of up to 64 percent in out of home placements
 - Significant improvements in family functioning and a decrease in mental health problems of serious offenders
2. **Functional Family Therapy-** is a brief family centered approach for youth ages 11-18 at risk for and/or presenting with delinquency, violence, substance abuse, conduct disorder, oppositional defiant disorder or disruptive behavior disorder.

Goals of Functional Family Therapy

- To engage and motivate families to participate in therapy, reduce problem behaviors, increase the frequency of positive family interactions and generalize the change so that the youth and family can be self-reliant. The primary goal is to focus on reducing delinquent behavior by identifying



the issues and setting obtainable goals thereby creating change.

Role of the therapist

- The role of the therapist is to work with the family to develop individualized plans that fit the family needs, increase family communication, problem solving skills, and working with the family to enhance conflict management skills.
 - Identify risk and protective factors within the family.
 - The therapist also assists the family and youth to work with local resources in order to maintain positive changes and for additional support if needed.
3. Milwaukee Wraparound- a philosophy of care that includes a definable planning process involving the child and family that results in a unique set of community services and natural supports, individualized for that child and family to achieve a positive set of outcomes. The process encompasses various community agencies collaborating for the benefit of the family as well as providing a voice for the family while receiving services.

The goals of wraparound treatment

- The goal of wraparound is to ensure that a family formulates a single, cross system individualized treatment plan that links a child's strengths and needs with services and supports from the home, school, and community.
4. Cognitive behavioral therapy is an approach that explores distorted thought processes within the individual and working with them to modify their thinking patterns in a way that will lead to improved behavior when confronted with challenging situations. The cognitive behavioral approach is effective for youth in the juvenile justice system because it is highly structured and focuses on the triggers that may lead to disruptive or aggressive behavior.

The goal of cognitive behavioral treatment

- To teach the individual about the thinking and feeling link and to uncover possible triggers to behaviors.
- Assist the individual in appropriate problem solving skills

DEVELOPING STRATEGIES FOR EFFECTIVE DELIVERY OF SERVICES**RECOMMENDED LENGTH OF PRESENTATION: 1 HOUR**

METHOD OF PRESENTATION: Lecture and Discussion and Small groups

MATERIALS AND EQUIPMENT: Course Outline, blackboard or flip chart

OBJECTIVES:

1. To introduce the concept of collaboration between the juvenile justice, mental health and substance abuse treatment systems
2. To identify barriers to systems coordination
3. To initiate discussion of strategic planning for systems coordination

DEVELOPING STRATEGIES TO MET THE NEEDS OF JUVENILE OFFENDERS WITH MENTAL HEALTH ISSUES

In order to delivery effective services for juvenile offenders, it is important to identify current barriers to services and explore ways of overcoming them. This section will identify the barriers and explore the options to effective delivery of service.



GROUP EXERCISE - 45 minutes

At this point the trainer should ask the class to divide into groups of 4-5 individuals. Each group is to pick a recorder who will take notes of the discussion and report to the large group at the end.

All the groups will be asked to identify no fewer than 3 and no more than 6 barriers to effective service delivery for juvenile offenders both within the juvenile justice system and the mental health communities. For each barrier identified, the groups should explore a minimum of two **REALISTIC** strategies that can be used to overcome such barriers.

The groups should then be reassembled and the reports of each group written on blackboard or flip chart - 20 Minutes

As part of the conclusion, the trainees should then be asked that once they go back to work they are to think about and to try to overcome any of the identified barriers in their own settings.

Resources and Organizations

National Center for juvenile Justice (NCJJ)

<http://www.ncjj.org>

National Center for Mental Health and Juvenile Justice (NCMHJJ)

<https://www.ncmhjj.com>

National Child Traumatic Stress Network

<http://www.nctsnet.org>

National Council of Juvenile and Family Court Judges

<http://www.ncjfcj.org>

Office of Juvenile Justice and Delinquency Prevention (OJJDP)

<http://www.ojjdp.gov>

Virginia Department of Juvenile Justice (VDJJ)

<http://www.djj.virginia.gov>

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