

Assessing the Need for and Availability of Mental Health Services for Juvenile Offenders

Executive Summary

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Report Highlights

In September 2000, the Nebraska Coalition of Juvenile Justice commissioned the University of Nebraska-Omaha, Department of Criminal Justice to examine the following questions:

- What is the prevalence of mental health problems among juvenile offenders in Nebraska?
- How do offenders currently access mental health services in Nebraska?
- How can access to appropriate mental health services be improved?

This report presents the findings from this effort in five chapters. A brief summary of findings for each chapter is presented below.

Chapter 1: Introduction and Study Overview

- This study focuses on the juvenile justice process and juveniles processed as delinquents and status offenders as defined by Section 43-247 of the Nebraska Juvenile Code (1998).
- For the purposes of this report, mental health problems refer to the signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder (USDHHS, 1999: 5), and mental health disorders represent the array of diagnoses contained in the Diagnostic Statistical Manual of Mental Disorders, Version IV (DSM-IV; APA, 1994).
- This report also distinguishes substance abuse from other mental health problems and disorders.

Chapter 2: Documenting the Need for Mental Health and Substance Abuse Treatment within the Juvenile Justice System

- Overall Prevalence: 14% of study participants scored above cut-off points for Alcohol/Drug Use; 40% scored in this area for Angry/Irritable, 23% for Depressed/Anxious; 35% for Somatic Complaints, 14% for Suicide Ideation, and 26% for Thought Disturbances (Boys Only).
- Gender and Race Differences: Female offenders scored higher than male offenders on all scales, except Alcohol/Drug Use where there were no discernable differences. Results did not differ across race/ethnicity except in the case of Alcohol/Drug Use for which White offenders scored higher than their Black and Latino counterparts

- Co-Morbidity: 33% of male offenders and 41% of female offenders scored in the problem range for at least two MAYSI-2 scales.
- Female offenders with mental health problems were more likely to experience problems at school (68%) than female offenders without mental health problems (56%), but this finding did not apply to male offenders.
- Family conflict was more likely when mental health problems were present regardless of gender.

Chapter 3: Barriers to Building Effective Juvenile Justice Systems of Care

- The relationship between offending and substance abuse and/or mental health problems forces policy-makers to recognize behavioral health as a public safety issue and build juvenile justice systems of care that address these problems and criminal behavior simultaneously.
- Fragmentation threatens overall system effectiveness and the implementation of treatment “best practices” because it impedes interagency collaboration, consistent screening and evaluation, systematic access to treatment, appropriate treatment programming, and program evaluation.
- A state survey was conducted, requesting information from Juvenile Justice Specialists in each state on the structure of juvenile justice, the role that treatment in juvenile justice, and progress toward implementing treatment “best practices.” In total, 26 states and 2 commonwealths returned surveys yielding a 46% response rate.
- Compared to other states, Nebraska implemented 3% of the best practices “a lot of the time” and 26% of best practices “a lot of the time” or “some of the time,” ranking it 21st out of 26 states/commonwealths.

Chapter 4: Accessing Mental Health Services through the Nebraska Juvenile Justice System

- In Nebraska processing offenders, holding them accountable, identifying their risk and treatment needs, and providing them with correctional, mental health, or substance abuse treatment services currently involves at least four separate bureaucracies with different and often conflicting philosophies, policies, and goals.

- There is a close relationship between Medicaid and the juvenile justice system because counties and juvenile courts rarely have funds to pay for evaluations or services; Probation currently receives no state funds to access evaluations or services; and the Office of Juvenile Services does not have an adequate state budget to handle these costs.
- Using conservative estimates, between 8 and 13 decision-makers are involved in accessing substance abuse and/or mental health problems treatment for offenders on probation; between 10 and 13 are involved in OJS custody cases; and between 11 and 14 are involved if the offender is placed in a YRTC or some other type of placement (e.g., foster home, group home, residential treatment facility).
- A preliminary assessment of collaboration indicated that interagency collaboration throughout the state is more informal than formal. The extent to which collaboration is dependent upon geographical location and the relationships developed between local offices of state-based agencies.

Chapter 5: Evaluating Nebraska’s Ability to Access Mental Health and Substance Abuse Treatment through the Juvenile Justice System

To assess the barriers that exist in Nebraska, seven focus groups were held involving juvenile detention facility and program personnel, probation officers, OJS personnel, mental health providers, and Region personnel. Surveys were also mailed to Separate Juvenile Court judges and county judges in remaining counties, county attorneys, and public defenders in Douglas, Sarpy, and Lancaster counties. Responses from these groups included:

- Currently, there is no standardized process across juvenile justice agencies to determine which offenders needed further evaluation or to determine what type of evaluation is necessary.
- The most significant barrier to accessing services is the availability of a continuum of services for offenders, including acute care; intensive outpatient; dual diagnosis treatment; services for young offenders under the age of 12; sex offenders; and offenders with conduct disorder.
- Resources currently drive the availability of services rather than offender need; furthermore, respondents believed that this relationship was unacceptable and ineffective in addressing mental health and substance abuse problems adequately.
- Respondents believed that conflicts in philosophies and policies and procedures across juvenile justice agencies created system fragmentation and the absence of communication and collaboration between juvenile justice agencies and providers.
- There was general consensus that the availability of services for mental health and substance abuse services was bleaker in rural areas than in urban areas.

Chapter 6: Creating a Coordinated Approach to System Change

Several juvenile justice “signs of progress” demonstrate the strong desire and willingness of various agencies and groups to improve the juvenile justice system. Such improvements, however, will fall short of long-term change if Nebraska is unable to build an infrastructure to coordinate and support these initiatives. Creating an effective juvenile justice system of care in Nebraska requires a statewide commitment to juvenile justice and the specific work in the following areas (see executive summary and full report for detailed recommendations):

- Develop a juvenile justice policy and strategic plan to create a coordinated and comprehensive response to juvenile offenders.
- Implement a consistent and standardized process across juvenile justice agencies to identify offender treatment needs.
- Work to improve access to a continuum of treatment services that integrate accountability and behavioral health treatment.
- Focus on “out of the box” initiatives, designing interventions that “fit” juvenile offender needs (e.g., multi-systemic therapy, team management approaches) throughout the state and across juvenile justice agencies.
- Allow funding to follow the child (i.e., need for service) rather than the services (i.e., service availability).
- Fund a research arm for juvenile justice to measure system’s ability to obtain goals and objectives on a regular basis.
- Integrate training on substance abuse and mental health problems into current detention facility, Probation and OJS training programs (i.e., all juvenile justice agencies), and provide regular training to providers on the juvenile justice system and “best practices” for treating juvenile offenders.

Author's Note

The executive summary provides an overview of the full *Assessing the Need for and Availability of Mental Health Services for Juvenile Offenders* report. The full report contains a more thorough discussion of the juvenile justice system, research literature related to this study, and the background, methods, and results of this study.

Additionally, the full report contains appendices with additional information on certain topics, such as wraparound programming and the various instruments used to collect various types of data for this study.

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Chapter 1: Introduction and Study Overview

Over the past decade, mental health problems among juvenile offenders have gained significant attention from state and federal agencies (Annie E. Casey Foundation, 1997; Bilchik, 1998, Coalition for Juvenile Justice, 2000; Coccozza & Skowyra, 2000; McKinney, 2001; Rotenberg, 1997, Teplin, 2001; USDHHS, 1999). Consistent with these developments, the Nebraska Coalition of Juvenile Justice formally recognized mental health problems as a juvenile justice issue in its 2000 state plan. Specifically, the Coalition was interested in the following questions:

- What is the prevalence of mental health problems among juvenile offenders in Nebraska?
- How do offenders currently access mental health services in Nebraska?
- How can access to appropriate mental health services be improved?

In September 2000, the Coalition commissioned the University of Nebraska-Omaha, Department of Criminal Justice to examine these questions. This report presents the findings from this effort. To begin, this chapter outlines the Nebraska juvenile justice system and defines the concepts and assumptions used throughout this report.

Description of Nebraska Juvenile Justice

According to section 43-247 of the Nebraska Juvenile Code (1998), the juvenile justice system has jurisdiction over any juvenile who commits a traffic, misdemeanor, or felony offense (delinquent), lacks proper parental care and/or supervision (abused/neglected), or is deemed uncontrollable by his parents/guardians (status offender). This study focuses on delinquents and status offenders, excluding abused/neglected youths and juvenile offenders processed as adults because court processing and access to treatment differs for these populations. Excluding these

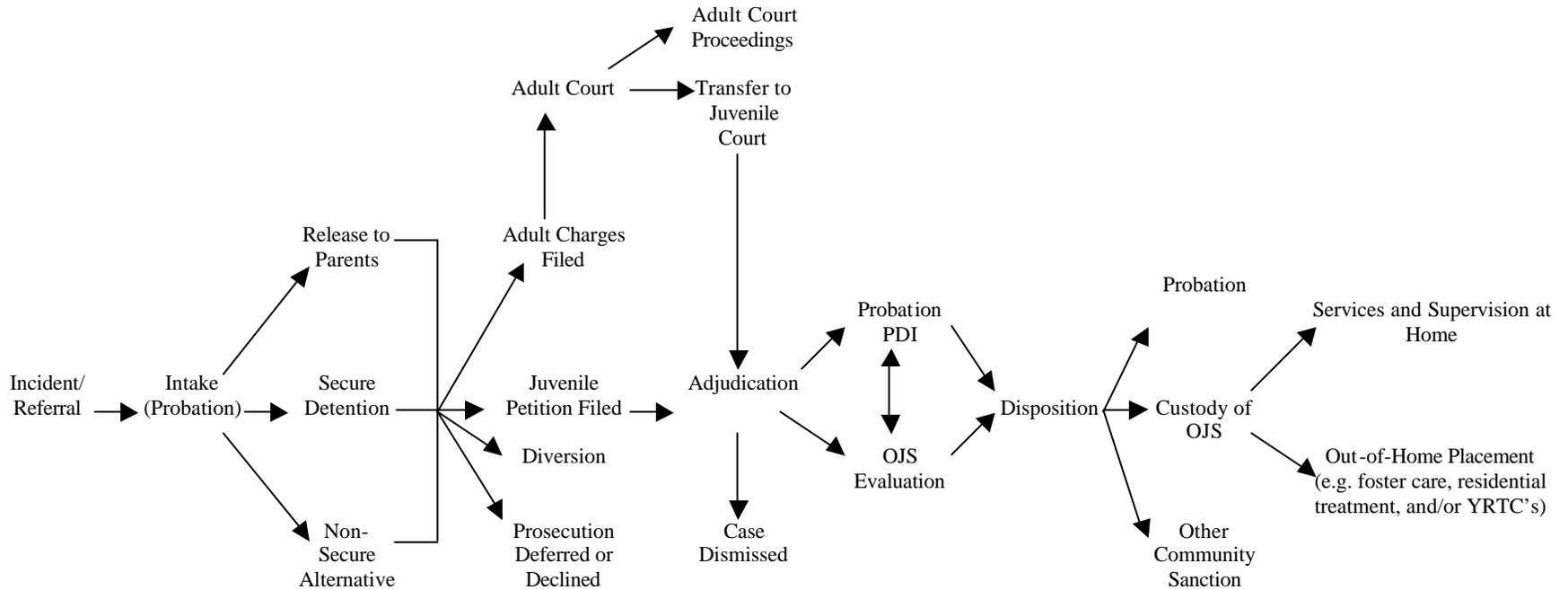
groups, however, is not meant to trivialize the treatment issues that permeate these populations. Rather, their absence signifies their complexity and need for special attention.

Figure 1.1 illustrates the basic steps in the Nebraska juvenile justice process, but it is important to note that specific experiences may differ slightly throughout the state because the responsibility for juvenile justice is shared across county and state levels of government. Separate Juvenile Courts and juvenile probation offices, for example, only exist in Douglas, Sarpy, and Lancaster Counties. Juvenile cases in other areas of the state are processed in county courts and probation districts supervise mixed caseloads (i.e., juvenile and adult cases). Similarly, the availability of detention facilities/programs and diversion programs varies because individual counties are financially responsible for them. Probation and OJS are state-based agencies, but application of their services occurs in locally-based offices which often implement agency policies and procedures differently from one another. Probation is organized within 16 probation districts across the state and the Office of Juvenile Services is organized into 6 regional areas. Thus, while state law governs juvenile justice, application of the Juvenile Code is largely dependent on a county's ability to fund various services implicated in this process and the consistency across locally-based state agencies.

Definition of Mental Health Problems and Disorders

For the purposes of this report, mental health problems refer to the signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder (USDHHS, 1999: 5), and mental health disorders represent the array of diagnoses contained in the Diagnostic Statistical Manual of Mental Disorders, Version IV (DSM-IV; APA, 1994). Distinguishing mental health problems from mental health disorders is necessary to clearly understand the role that each one plays in juvenile justice (Barnum & Keilitz, 1992; Woolard et. al., 1992).

Figure 1.1: Nebraska Juvenile Offender Case Flow Chart



For instance, research indicates that a smaller percentage of offenders (approximately 11-20%) suffer from a serious, emotional disorder (e.g., early signs of schizophrenia, major depression, and bi-polar disorder), than less intense disorders that may be more temporary in nature (e.g., conduct disorder or adjustment disorder; Cocozza & Skowrya, 2000; USDHHS, 1999). Both require intervention, but the type of intervention differs substantially (e.g., placement in a psychiatric hospital versus counseling integrated with correctional supervision). Consequently, mental health problems and disorders represent two points on a continuum of individual mental health that call for different types of intervention to restore an individual to optimal mental health functioning.

Role of Substance Abuse

Although the DSM-IV includes substance abuse and chemical dependency as mental health disorders, this report distinguishes substance abuse from other mental health disorders for three reasons. First, collapsing the two potentially skews prevalence estimates because substance abuse is typically higher among juvenile offenders than other mental health disorders. Secondly, separating the two provides the opportunity to recognize and measure co-occurring disorders (i.e., substance abuse and other mental health disorders), and finally, this distinction recognizes debates related to professional scopes of practice for treating substance abuse versus other mental health disorders.

Structure of the Report

This report uses several chapters to detail the role of mental health and substance abuse problems and treatment in juvenile justice systems nationwide and in Nebraska. Chapter 2 presents the results from a statewide prevalence study conducted in Nebraska. Chapter 3 highlights barriers to building systems of care using information collected from research and a

state survey. Chapter 4 details how juvenile offenders currently access mental health treatment services in Nebraska, and Chapter 5 summarizes the weaknesses of this system from the viewpoints of juvenile justice professionals and service providers. Finally, in Chapter 6, statewide “signs of progress” are presented and a coordinated approach to improve Nebraska’s juvenile justice system of care is discussed.

Chapter 2: Documenting the Need for Mental Health and Substance Abuse Treatment within the Juvenile Justice System

Overview

Balancing rehabilitation and public safety is a fundamental premise of the juvenile justice system, but balanced approaches rarely occur because juvenile justice policy and resources are often prioritized in uneven ways. This point seems particularly salient when substance abuse and mental health problems are considered. Supervision alone will seldom reduce the influence of these problems on offending (MacKenzie, Gover, Armstrong, & Mitchell, 2001; Peters, Thomas, & Zamberlan, 1997; Petersilia and Turner, 1993), and isolated substance abuse and mental health treatment programming is limited in its ability to alter “criminal” thinking (Buckley & Bigelow, 1992; Melton & Pagliocca, 1992; West, 1980). Integrating treatment and supervision, however, produces an approach that addresses offender risk and treatment needs simultaneously and enhances the juvenile justice system’s ability to reduce or eliminate problem behaviors in the short-term as well as the long-term. Such an integrated approach requires policy-makers and juvenile justice professionals to understand the link between substance abuse, mental health disorders, and delinquency. Using this information, juvenile justice professionals can implement procedures to identify offender risks and treatment needs and then match these factors to appropriate levels of treatment and supervision. To provide a starting point for this discussion, this chapter examines the prevalence of substance abuse and mental health problems among offenders in Nebraska.

The Relationship between Substance Abuse, Mental Health Disorders and Delinquency

Based on current estimates, 21% of children in the general population experience minimal impairment from one or more mental health disorders; 11% experience significant impairment; and 5% experience extreme impairment. Although equivalent prevalence estimates

do not exist for juvenile offenders, Otto, Greenstein, Johnson, & Friedman (1992) and Weirson, Forehand and Frame (1992) summarized research in this area and concluded that juvenile offenders experience higher prevalence levels for overall mental health problems and specific disorders. This finding was reinforced more recently by Grisso (1999), who reported that offender estimates were four times higher for conduct disorder, 10 times higher for substance abuse, and 3-4 times higher for affective disorder (p. 147; see also Cellini, 2000; Cocozza & Skowrya, 2000; Kazdin, 2000).

Prevalence of Mental Health Problems among Juvenile Offenders in Nebraska

To date, only two studies have attempted to measure the prevalence of substance abuse or mental health problems among juvenile offenders in Nebraska's juvenile justice system. A study was conducted at the youth rehabilitation treatment centers in Geneva and Kearney in which a total of 143 offenders (93 girls and 50 males) were selected from facility populations on September 30, 1999 and evaluated by qualified staff using the DSM-IV (Chinn, 1999b). Results included:

- 32% of female offenders had psychiatric/medical symptoms; 63% had mild/moderate mental health symptoms; 80% were diagnosed with chemical abuse/dependency; and 84% of those with chemical dependency had a dual diagnosis.
- 14% of male offenders had psychiatric/medical symptoms; 90% had mild/moderate mental health symptoms; 84% were diagnosed with chemical abuse/dependency; and 76% of those with chemical dependency had a dual diagnosis.

A needs assessment study was also conducted on a sample of 157 pre-adjudicated detained offenders at the Lancaster County Detention Center using the Massachusetts Youth Screening Instrument—Version 2 (Nordness, Grummert, Schindler, Moss, & Epstein, 2001). The results of this study revealed the following:

- 15% of youths exceeded the Caution (11%) and Warning (4%) cut-off scores on the Alcohol/Drug Scale;

- 29% of youths exceeded the Caution (18%) and Warning (11%) cut-off scores on the Angry/Irritable scale;
- 23% of youths exceeded the Caution (17%) and Warning (6%) cut-off scores on the Depressed/Anxious scale;
- 34% of youths exceeded the Caution (28%) and Warning (6%) cut-off scores on the Somatic Complaints scale; and
- 13% of youths exceeded the Caution (3%) and Warning (10%) cut-off scores on the Depressed/Anxious Scale.

While these studies provide some insight into the prevalence of substance abuse and mental health problems, they are limited to processing decision points that do not include a cross-section of offenders in the system. To expand upon these two studies, the current study utilized the MAYSI-2 at the pre-disposition investigation stage.

Study Overview

Data were collected in 13 Probation Districts throughout the state between July 9, 2001 and September 30, 2001 at the pre-disposition investigation (PDI) stage of juvenile justice processing. The Massachusetts Youth Screening Instrument-Version 2 was used to collect information on offender symptoms related to mental health problems (MAYSI-2: Grisso & Barnum, 2000; see the full report for more methodology details and a copy of this instrument). Specifically, the MAYSI-2 contains 52 items with a “yes/no” response format, which create the following scales: Alcohol/Drug Use, Angry/Irritable, Depressed/Anxious, Somatic Complaints, Suicide Ideation, Thought Disturbances (boys only), and Traumatic Events (see Appendix A of the full report for a short description of each scale). All scales apply to both male and female offenders except Thought Disturbances. The Thought Disturbance scale is applicable only to boys because scale items did not provide accurate results for girls (Grisso & Barnum, 2000).

Sample

In sum, 357 offenders completed pre-disposition investigations during this time and 243 offenders agreed to complete the MAYSI-2 survey, yielding an initial response rate of 68%. After accounting for missing data, the final response rate was 65% (n=232). The sample characteristics are listed below:

- 64% were male;
- 67% were White and 19% were African-American;
- 76% were 15 years old and older;
- The top four adjudicated offenses were: theft (22%), alcohol or drug-related charges (22%), assault (15%), and status offenses (10%);
- 21% had prior contact with the juvenile justice system;
- 10% had previously attended some level of treatment; and
- 37% were eligible for Medicaid and this status was unknown in 31% of the cases.

Results

By using cut-off points, the data provided insight into (1) the overall prevalence of substance abuse and mental health problems; (2) the prevalence of co-occurring disorders; and (3) the relationship between substance use/mental health problems and offending, experience in the juvenile justice system, and social functioning.¹ Caution cut-off scores indicate “possible clinical significance” and the need for a more thorough evaluation to determine the presence of a problem or disorder, and warning cut-off scores signify the need for immediate attention and possible intervention (e.g., suicide ideation; Grisso & Barnum, 2000).

1. Overall Prevalence

¹ Despite the utility and strength of the MAYSI-2 as a screening tool for substance use and mental health problems, Grisso and Barnum (2000) note that the MAYSI-2 does not provide psychiatric diagnoses, and its content has not been selected to correspond specifically to criteria for DSM-IV diagnostic categories. Reliability and validity analyses are available upon request from the authors.

As shown in Table 2.1, 14% of study participants scored in the caution (11%) or warning (3%) areas for Alcohol/Drug Use; 30% scored in these areas for Angry/Irritable, 23% for Depressed/Anxious; 35% for Somatic Complaints, 14% for Suicide Ideation, and 26% for Thought Disturbances (Boys Only). Additionally, 71% of boys and 72% of girls reported experiencing at least one traumatic event in their life. Youths were more likely to fall into the “caution” category than the “warning” category except in the case of Suicide Ideation. The situation was reversed for this scale, with a greater portion of youths falling into the “warning” category than “caution” category.

Table 2.1: Proportion of Youths at or above the Caution & Warning Cut-Off Scores

	Caution		Warning	
	Cut-Off Score (# Items)*	Percent at or above Cut-Off	Cut-Off Score (# Items)	Percent at or above Cut-Off
Alcohol/Drug Use				
Entire Sample	4-6	11%	7+	3%
Boys Only	4-6	11%	7+	5%
Girls Only	4-6	11%	7+	1%
Angry/Irritable				
Entire Sample	5-7	17%	8+	13%
Boys Only	5-7	15%	8+	11%
Girls Only	5-7	20%	8+	18%
Depressed/Anxious				
Entire Sample	3-5	17%	6+	6%
Boys Only	3-5	14%	6+	5%
Girls Only	3-5	23%	6+	8%
Somatic Complaints				
Entire Sample	3-5	31%	6+	4%
Boys Only	3-5	27%	6+	4%
Girls Only	3-5	40%	6+	5%
Suicide Ideation				
Entire Sample	2	3%	3+	11%
Boys Only	2	3%	3+	5%
Girls Only	2	5%	3+	22%
Thought Disturbance				
Boys	1	18%	2+	8%
Traumatic Experiences				
Boys	1	71%	—	—
Girls	1	72%	—	—

*Cut-off score refers to the number of “yes” responses to items included in the scale.

Mean differences across gender and race were also examined (see full report for analysis details and table of results). These analyses indicated that all scales differed by gender except Alcohol/Drug Use. Female offenders scored higher than male offenders on the Angry/Irritable, Depressed/Anxious, and Suicide Ideation and Somatic Complaints scales. Conversely, results did not differ across race/ethnicity except in the case of Alcohol/Drug Use for which White offenders scored higher than their African-American and Latino counterparts. A marginal significant difference was also found for the Depressed/Anxious scale, indicating that Latino offenders had a slightly higher scale mean than any other group.

2. Prevalence of Co-Occurring Problems

Currently, there is growing recognition that offenders have multiple problems/disorders (i.e., co-occurrence or co-morbidity; Coccozza & Skowrya, 2000; Davis, et al. 1991; Ferguson et al., 1994; Milin, Halikas, Miller & Morse, 1991; Peters & Bartoi, 1997; SAMHSA, 1999; Ulzen & Hamilton, 1998). To assess the prevalence of co-morbidity in the current sample, the presence of one or more MAYSI-2 problem scores was examined. This process revealed that 33% of male offenders and 41% of female offenders scored in the problem range for at least two MAYSI-2 scales. Consistent with earlier prevalence findings, the distribution of problem cases was larger in the “caution” category than the “warning” category.

The extent to which mental health problems co-occurred with substance use was also measured using the Adolescent Chemical Dependency Inventory (ACDI; Risk & Needs Assessment, Inc., 1993) and the Simple Screening Instrument (SSI; Winters & Zenilman, 2000). The ACDI and SSI were included in these analyses for two reasons. First, both currently play a role in justice processing. Probation administers the ACDI to screen offenders for substance abuse problems, and the Nebraska Substance Abuse Task Force is advocating the use of the SSI

as part of the Justice Assessment for Substance Abuse process. Secondly, these tools resulted in different identification rates than the MAYSI-2. As illustrated in Table 2.2, separate analysis found that the MAYSI-2 was a more conservative predictor of substance abuse: Whereas 15% of offenders fell into the cut-off categories using the MAYSI-2, 41% and 47% of offenders were identified using the ACDI and SSI.

Table 2.2: Comparison of Problem Alcohol/Drug Use across Screening Tools

Instrument	N*	No Problem	Caution	Warning
MAYSI-2	232	85%	11%	3%
ACDI	209	59%	32%	9%
SSI	154	53%	27%	20%

*Different “n’s” resulted from missing data. Percentages in table were replicated when all survey instruments were limited to the same number of offenders.

Table 2.3 contains the prevalence of co-occurring problems using all three tools. Based on the MAYSI-2, 79% of the offenders with problem use were identified as having co-occurring mental health problems using the MAYSI-2 Alcohol/Drug Use scale compared to 52% using the ACDI and 53% using the SSI. Differences across instruments were less noticeable when the specific nature of co-occurrence was examined (see Table 2.3). The rank ordering for co-occurring combinations, for instance, was identical regardless of the tool examined. Overall, problem use was most likely to co-occur with Somatic Complaints and Angry/Irritable symptoms and less likely to co-occur with Depressed/Anxious and Suicide Ideation symptoms.

Table 2.3: Co-occurrence Rates by Substance Abuse Instrument

	MAYSI-2 n=34	Adolescent Chemical Dependency Inventory n=86	Simple Screening Instrument n=73
Co-Occurring Problems	79%	52%	53%
SA Co-Occurs with...			
Somatic Complaints	58%	37%	40%
Angry/Irritable	56%	27%	31%
Depressed/Anxious	35%	17%	26%
Suicide Ideation	26%	12%	18%

3. Relationship between Substance Abuse/Mental Health Problems & Social Functioning

The current study is limited in its ability to conclude that substance abuse and/or mental health problems cause delinquency, but it does provide the opportunity to examine the relationship between these risk factors and other characteristics such as charge type, problems at school, and family conflict. Problem use and/or mental health problems permeated all offense categories but were concentrated in the categories of theft, alcohol/drug offenses, and assault. For the entire sample, these three offenses contained 61% of all offenders with one or more problem scores; 54% of male offenders with one or more problem scores; and 73% of female offenders with one or more problem scores. When status offenses are included, this figure rises to 87% for female offenders.

Gender differences are apparent when the relationship between mental health problems and school problems and family conflict were considered (see Table 2.4). Female offenders with mental health problems were more likely to experience problems at school (68%) than female offenders without mental health problems (56%), but this finding did not apply to male offenders. Family conflict, however, was more likely when mental health problems were present regardless of gender. Sixty-five percent of female offenders with one or more mental health problem reported family conflict compared to only 38% of female offenders without mental health problems. Similarly, 61% of male offenders with one or more mental health problems reported family conflict compared to only 42% without mental health problems.

Table 2.4: School and Family Problems among Male and Female Offenders

Type of Problem	Entire Sample N=230		Male Offenders n=148		Female Offenders n=82	
	No MH Problem	1+ MH Problem	No MH Problem	1+ MH Problem	No MH Problem	1+ MH Problem
School Problems						
No	46%	40%	42%	46%	56%	32%*
Yes	54%	60%	58%	54%	44%	68%

Table 2.4: School and Family Problems among Male and Female Offenders (Continued)

Type of Problem	Entire Sample N=230		Male Offenders n=148		Female Offenders n=82	
	No MH Problem	1+ MH Problem	No MH Problem	1+ MH Problem	No MH Problem	1+ MH Problem
Family Problems						
No	59%	37%*	58%	39%*	62%	35%*
Yes	41%	63%	42%	61%	38%	65%

*Indicates that differences are statistically significant (p<.05)

Summary

Overall, these findings reinforce the need for an integrated, comprehensive approach in the juvenile justice system. Without this approach, it is unlikely that juvenile justice will effectively prevent further involvement in the juvenile and/or criminal justice system especially among offenders with high risk to community and high treatment needs. The next chapter provides insight into this issue by identifying the system characteristics necessary to offer comprehensive services to juvenile offenders, including a review of “best practices” and the barriers to creating a juvenile justice system of care.

Chapter 3: Barriers to Building Effective Juvenile Justice Systems of Care

Overview

As juvenile justice evolved throughout the 20th century, its philosophical commitment to rehabilitation remained, but the practical role of rehabilitation was tempered with calls for more punitive policies, diverting attention and resources away from the juvenile justice system's capacity to "treat" offenders (Cocozza & Skowyra, 2000; Knitzer, 1982, 1984; Melton and Pagliocca, 1992). Consequently, state systems currently confront growing numbers of offenders with mental health and substance abuse problems without the resources to treat them. In fact, the extent to which juvenile offenders receive effective mental health and substance abuse treatment often depends on an individual state's commitment to identifying treatment needs among juvenile offenders, its ability to access and pay for treatment to meet those needs, and its willingness to implement a juvenile justice "system of care." The purpose of this chapter is to highlight literature related to systems of care and present results from a state survey to answer the following questions:

- What are the characteristics of an effective system of care?
- What are the major obstacles that prevent "systems of care" from developing or working effectively?
- To what extent do state juvenile justice systems incorporate solutions or "best practices" to overcome these obstacles?

Methodology

In addition to a review of research and other literature related to juvenile justice systems of care, a survey was sent to all Juvenile Justice Specialists who act as state and U.S. commonwealth representatives to the National Coalition for Juvenile Justice (N=57). This survey requested information on the structure of juvenile justice, the role that treatment in

juvenile justice, and progress toward implementing treatment “best practices.” In total, 26 states and 2 commonwealths returned surveys yielding a 46% response rate.

System of Care Characteristics

The relationship between offending and substance abuse and/or mental health problems forces policy-makers to recognize behavioral health as a public safety issue and build systems of care that address these problems and criminal behavior simultaneously. By definition, a system of care is a “comprehensive spectrum of mental health and other necessary services (i.e., substance abuse services, family services) that are organized into a coordinated network to meet the multiple and changing needs of youths and their families” (Stroul & Friedman, 1996, p. 16).

Important characteristics of an effective system of care include (Pumariega & Vance, 1999; SAMHSA, 1998; Stroul & Friedman, 1996):

- Interagency coordination and communication to ensure swift access to treatment services that meet individual needs;
- Early and consistent assessment to identify treatment needs;
- Treatment provided in the least restrictive environment possible;
- Treatment driven by families as partners in services planning and delivery;
- Comprehensive and strength-based treatment;
- No ejection or rejection from services due to lack of “treat-ability” or cooperation with interventions
- Integration of gender and culturally appropriate services when appropriate.

Effective juvenile justice systems of care occur when juvenile justice systems integrate these characteristics into offender processing through collaborative partnerships across juvenile justice agencies and with behavioral health systems (Whitbeck, 1992). Unfortunately, the development of such systems faces many obstacles stemming from fragmented juvenile justice systems (Cellini, 2000). For example, juvenile justice systems are often disjointed across county and state levels of government, and state-based juvenile justice agencies are often located in different areas of government (i.e., judicial branch v. executive branch; Kamradt, 2000).

Findings from the state survey reinforce the notion of fragmented systems. Thirty percent of the responding states did not have any agencies/services housed under one juvenile justice administration, 27% reported that only 2-3 agencies/services were housed under the same administration, 35% had 4-5 agencies/services housed under the same administration, and only 8% reported all agencies/services were located under one administration.

Fragmentation threatens overall system effectiveness because it impedes interagency collaboration, consistent screening and evaluation, systematic access to treatment, appropriate treatment programming, and program evaluation (Barnum & Keilitz, 1992; Bazelon Center for Mental Health Law, 2000; Friedman, 1994; Henggeler, 1997; Kamradt, 2000; Saxe et al., 1988). The absence of these factors, in turn, produces barriers difficult to overcome. Such barriers permeate juvenile justice systems throughout the nation but the extent to which they affect individual states varies. To more clearly understand the impact of these barriers, this chapter examines the role of “best practices” in states and U.S. commonwealths that participated in the current state survey (see full report for a discussion of and state survey results related to specific barriers).

The Role of Treatment “Best Practices” across Juvenile Justice Systems

Using state survey data, the percentage of best practices implemented in each state was derived by summing the responses to all best practice items and dividing this number by 30, the total number of “best practices” listed in the survey. States were then ranked according to the percentage of best practices implemented “a lot of the time.” When two or more states had equal percentages, the ranking was based on the percent located in “a lot of the time” and “some of the time,” and when equal percentages remained, the comparison was expanded to include “a little.”

As shown in Table 3.1, South Dakota implemented the highest percentage of best practices (57%) “a lot of the time” and Idaho implemented the least (0%). Following South Dakota, seven states implemented 40-49% of the best practices “a lot of the time” while six states implemented 20-39% and ten states implemented less than 15% best practices at this level. When “some of the time” and “a lot of the time” were combined, the figures changed slightly. Overall, Florida implemented the highest percentage of best practices (98%). Eight states implemented 70% or more of the best practices, 12 states implemented between 50 and 69%, five states implemented 20-39%, and only one state implemented less than 15% of the best practice approaches. Compared to other states, Nebraska implemented 3% of the best practices “a lot of the time” and 26% of best practices “a lot” and “some of the time,” ranking it 21st out of 26 states/commonwealths.

Table 3.1: Comparisons and Rankings for Best Practice Approaches Currently Implemented across States

Rank	State	Extent to Which “Best Practices” Currently Implemented:			
		A Lot	Some	Little	Not at All
1	South Dakota	57%	27%	7%	13%
2	North Carolina	43%	53%	3%	0%
3	Florida	40%	57%	3%	0%
4	Kansas	40%	43%	10%	7%
4	North Dakota	40%	43%	10%	7%
5	Virginia	40%	30%	27%	3%
6	Connecticut	40%	30%	20%	10%
7	Delaware	40%	30%	7%	23%
8	South Carolina	33%	53%	7%	7%
9	Alabama	33%	37%	17%	13%
10	Puerto Rico	27%	53%	3%	17%
11	Washington	23%	47%	17%	13%
12	Republic of Palau	23%	47%	13%	17%
13	Nevada	23%	40%	23%	13%
14	Wyoming	13%	50%	7%	30%

Table 3.1: Comparisons and Rankings for Best Practice Approaches Currently Implemented across States (Continued)

Rank	State	Extent to Which “Best Practices” Currently Implemented:			
		A Lot	Some	Little	Not at All
15	Missouri	10%	73%	17%	0%
16	Wisconsin	10%	53%	17%	20%
17	Illinois	7%	70%	10%	13%
18	Hawaii	7%	57%	33%	3%
19	Arizona	7%	27%	27%	40%
20	Vermont	7%	20%	33%	40%
21	Indiana	3%	53%	17%	27%
22	Tennessee	3%	33%	17%	47%
23	<i>Nebraska</i>	3%	23%	40%	33%
24	Oklahoma	0%	20%	17%	63%
25	Idaho	0%	13%	70%	17%

Implementing best practices is only the first step to improving system responses to mental health and substance abuse treatment needs. A second critical piece to implementation is evaluating how well the best practice approaches are working after implementation. Since most states implemented best practices within the past five years, many were difficult or impossible to evaluate. For changes that could be evaluated, respondents were asked to rank their effectiveness using a scale of 1 (poor) to 5 (excellent). These ratings were then averaged to obtain an overall success measure of the best practices in each state. Average ratings ranged from 2.00 (Vermont) to 3.90 in South Dakota, with the majority of states (70%) falling between 3.0 and 3.9 and only 30% of these states/commonwealths between 2.0 and 2.9. Nebraska ranked 18th out of 24 (due to ties) with a rating of 3.0, but this rating means little because only one best practice could be evaluated.

Taken together, it appears that best practice approaches related to effective juvenile justice systems of care characterize state juvenile justice systems, but not consistently within

states or across states. Perhaps the most concerning finding throughout this chapter is the wide range of implementation and effectiveness reported by states/commonwealths. Nebraska's juvenile justice system, in particular, does not reflect many system of care characteristics. The remaining chapters of this report provide an in-depth look at the current operation of the Nebraska juvenile justice system, highlighting the strengths and weaknesses that explain the rankings found in the state survey.

Chapter 4: Accessing Mental Health Services through the Nebraska Juvenile Justice System

Overview

Mental health and substance abuse treatment services play a significant role in the operation of juvenile justice systems nationwide, but multiple and confusing pathways to services often pose barriers to the development of an effective juvenile justice system of care. In Nebraska, for instance, processing offenders, holding them accountable, identifying their risk and treatment needs, and providing them with correctional, mental health, or substance abuse treatment services involves at least four separate bureaucracies with different and often conflicting philosophies, policies, and goals. The extent to which different agencies and systems can implement a system of care, however, relies less on their differences and more on their ability to coordinate policies, procedures, and services in order to build on system strengths and address system weaknesses.

The purpose of this chapter is to document the extent to which Nebraska's current system represents a juvenile justice "system of care" by addressing the following questions:

- Which Nebraska systems and agencies play a role in identifying the need for mental health and substance abuse services among juvenile offenders and what role do they play?
- Which Nebraska systems and agencies play a role in accessing treatment services for offenders and what role do they play?
- To what extent do these systems and agencies coordinate policies, procedures, and services?

Identifying the Need for Treatment

Pre-Adjudication

Figure 4.1 illustrates the process by which treatment needs are identified and addressed prior to adjudication (i.e., before an offender is processed through the juvenile court and found

responsible for the charges). In general, implementing and coordinating screening for mental health and substance abuse problems prior to adjudication is limited because of the due process protections inherent in the juvenile justice process. The juvenile justice system cannot require a youth to access or participate in treatment until he/she admits to the charges or the court finds him/her responsible for the charges. Since this determination is impossible prior to adjudication, treatment remains optional during this time. Due process protections, however, are not the most significant obstacle to identifying and addressing mental health and substance abuse needs at this stage. The more substantial issue is the lack of coordination and resources across county and state-based agencies to help families who are interested in identifying problems early and accessing appropriate services as soon in the juvenile justice process as possible.

Post-Adjudication/Pre-Disposition

Figure 4.2 shows the ways in which treatment needs are identified and addressed after adjudication (for a more thorough description of these pathways, see the full report).

Implementing and coordinating screening is arguably easier at this point but because of the system fragmentation and conflicting policies between Probation and the Office of Juvenile Services, access to appropriate treatment is often a long, complicated process.

Accessing Mental Health and Substance Abuse Services

If mental health and substance abuse treatment services are delivered through the juvenile justice system, they must be part of the offender's disposition order. Offenders on probation as well as offenders placed in custody of OJS access treatment services, but the types of treatment available vary substantially across these agencies (see Figure 4.2). In most cases, offenders will receive probation or be placed in the custody of OJS, but in Douglas and Sarpy counties, judges sometimes place offenders on probation and order them into OJS custody. Services are provided

Figure 4.1: Identifying Need & Accessing Mental Health & Substance Abuse Services: Pre-Adjudication Pathways

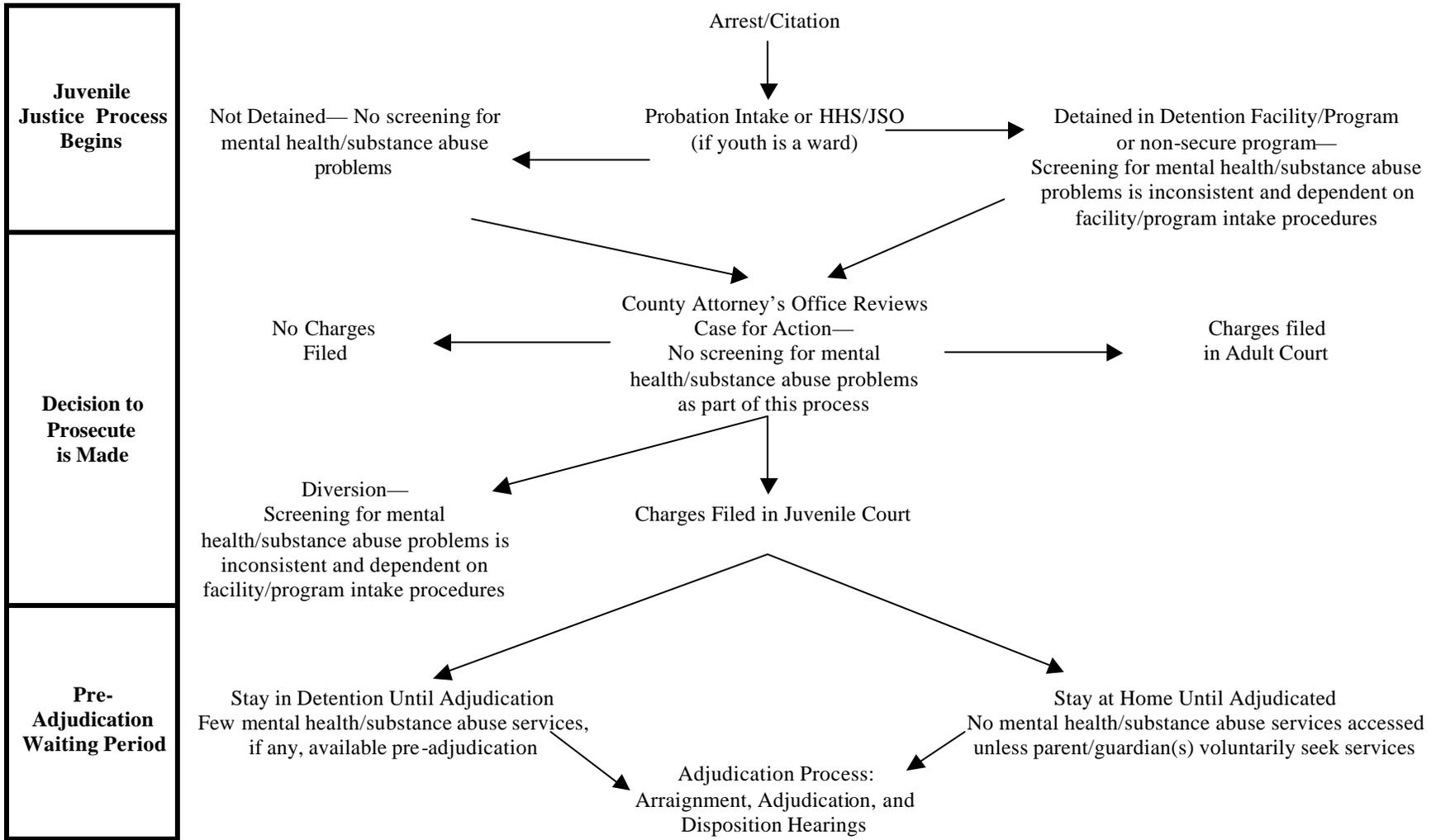
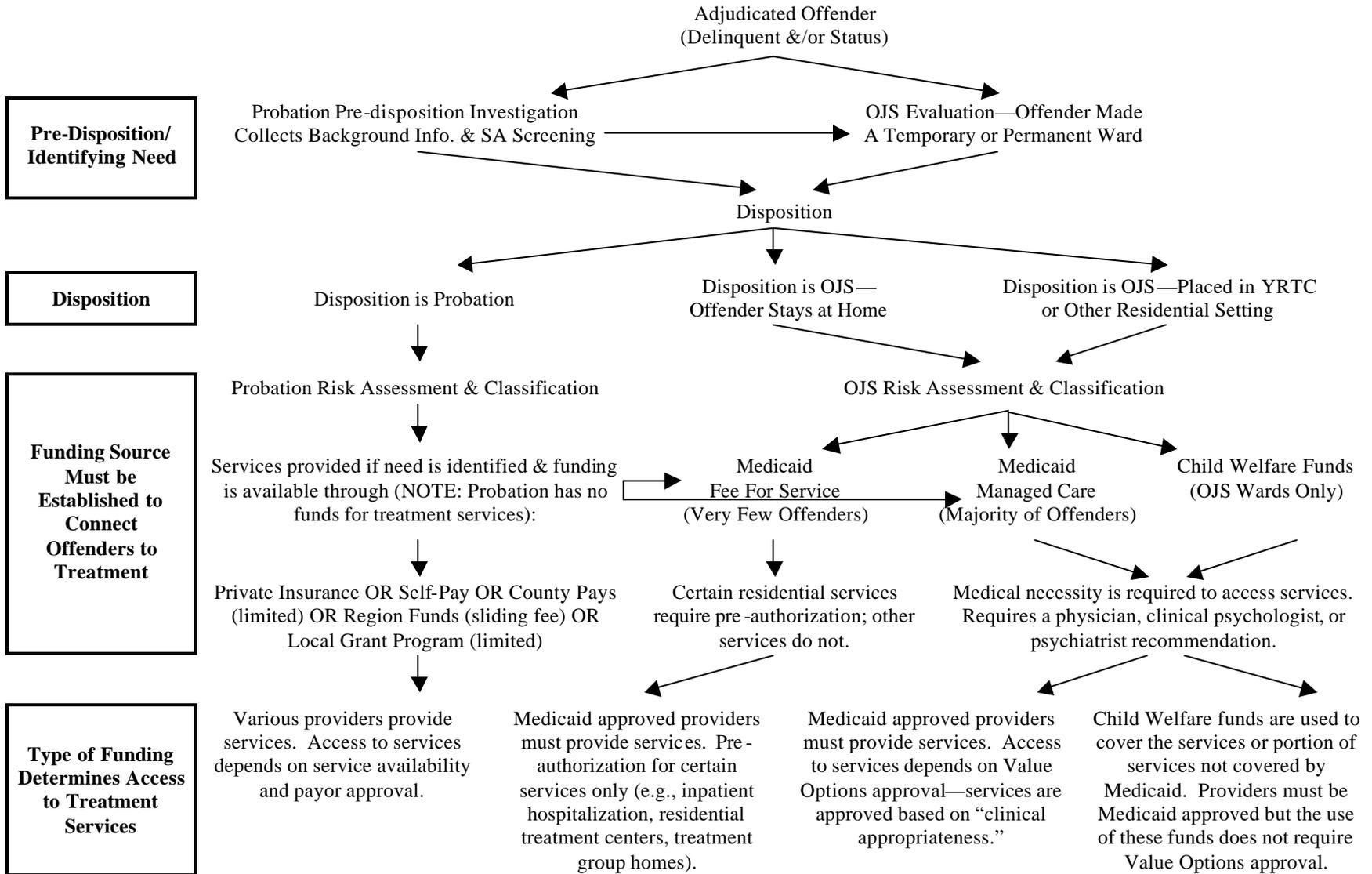


Figure 4.2: Post-Adjudication Pathways to Identifying Need & Accessing Mental Health & Substance Abuse Treatment



through a variety of avenues depending on the responsible agency (i.e.. Probation or OJS), where the offender lives, and the family's financial position. Agencies and programs that provide services to offenders include:

1. Providers: Most mental health and substance abuse providers are private businesses (profit and non-profit) that contract with Value Options, OJS, or individual Regions that provide treatment programming.

2. Youth Rehabilitation and Treatment Centers: Health and Human Services operates two Youth Rehabilitation and Treatment Centers (juvenile correctional facilities)—one in Kearney for adjudicated male juvenile offenders and another in Geneva for adjudicated female juvenile offenders. Services offered at Geneva include psychological testing, evaluation and counseling services, drug and alcohol evaluation and education, and intensive residential drug/alcohol treatment programming. Services offered at Kearney include clinical evaluations, psychological testing, counseling services, group treatment, chemical dependency assessments, and chemical dependency treatment (counseling and education).

3. Hastings Regional Center: The Hastings Regional Center (HRC) is a residential treatment facility operated by the Department of Health and Human Services and funded through private insurance, Medicaid, and child welfare and other state funds. The facility operates a long-term (4-6 month) substance abuse treatment program (Hastings Juvenile Chemical Dependency Program) for 30 male offenders referred from YRTC-Kearney.

4. Lincoln Regional Center: The Lincoln Regional Center is operated by Health and Human Services and funded through private insurance, Medicaid, and child welfare and other state funds. The LRC provides mental health services to youth aged 12 to 19 in the state of Nebraska.

Services offered include: acute care, residential treatment, sex offender treatment, and Office of Juvenile Services evaluations.

5. Behavioral Health System Regions: Some offenders access treatment through their Region office by either receiving services provided by the Region (e.g., Region II) or by a Region-contracted provider. Although the number of Region contracts for adolescent services is minimal across the state, all Regions support Professional Partner Programs (i.e., wrap-around programming) for youths and their families.

6. Lancaster County Families First and Foremost Project: This project is a six-year federal grant provided to establish a comprehensive system of care in Lancaster County to meet the needs of youth with serious emotional disturbances.

7. Nebraska Family Central Integrated Care Coordination Project: The Integrated Care Coordination Project serves children with high care needs and multiple functional impairments (school, home, community, etc.) in the Central Nebraska Service Area using Medicaid funds.

Paying for Treatment Services: The Role of Medicaid

What is Medicaid?

Medicaid is a federal health insurance plan funded by federal and state dollars for children and adults who meet specific financial eligibility criteria. Children eligible for Medicaid benefits in Nebraska include wards of the state, children in low-income families, and children who are part of dependent aid programs (see Chapter 32 of the Nebraska Health and Human Services Finance and Support Manual, 1997). Most of these children access services through the Medicaid Managed Care System, but a small percentage access services through the Medicaid fee-for-service system. All Medicaid payments were made through the fee-for-service system prior to 1995 (i.e., implementation of the Nebraska Medicaid Managed Care Act, 1993),

which only required prior authorization for limited services such as inpatient hospitalization, residential treatment centers, and treatment group homes. All other services did not require pre-authorization. After 1995, a limited number of children remained on the fee-for-service system while the majority of children were converted to Medicaid Managed Care. Since the majority of offenders who receive treatment through Medicaid are managed care clients, this report is primarily based on the managed care pathway to treatment.

Offenders placed in the custody of OJS are automatically Medicaid eligible and can access treatment services if they are approved through the managed care system. Approval for services is obtained through Value Options, a for-profit managed care company that is currently contracted to administer Nebraska's behavioral health Medicaid benefits. Value Options ensures that Medicaid funds are administered in accordance with federal and state regulations (i.e., exclusions, waivers, etc.) and implements additional state guidelines that further clarify what services are covered by Medicaid and the process by which services are approved. Nebraska initially signed a contract with Value Options in 1995, renewed the contract in 2000 and will open the contract again in 2002. These contracts are monitored through the Medicaid Office, which is housed in the HHS/Finance and Support Division.

Relationship between Medicaid and Other State-Based Funding Streams

In addition to Medicaid, funding streams through the Division of Mental Health, Substance Abuse, and Addiction Services and HHS/Protection & Safety Division (i.e., child welfare funds) cover a portion of behavioral health services for offenders. Division funds are matched by counties and distributed through local Regions to provide behavioral health services (i.e., mental health and substance abuse) to the general public through sliding fee payments. Child welfare funds are also used to cover a variety of services for HHS wards (including OJS

wards) that are not covered by Medicaid. It is, however, HHS's policy to access Medicaid funds when possible and only use child welfare funds when Medicaid funds are unavailable. The disbursement of child welfare funds does not require medical necessity nor is it managed through Value Options, but Medicaid approved providers must provide the services. Conversely, the disbursement of Region funds follows Division regulations, which are not based on any of the Nebraska Medicaid Managed Care Program guidelines and regulations.

What is Medicaid's Role in Juvenile Justice?

There is a close relationship between Medicaid and the juvenile justice system for the following reasons:

- Counties and juvenile courts rarely have funds to pay for evaluations or services, Probation currently receives no state funds to access evaluations or services, and the Office of Juvenile Services does not have an adequate state budget to handle these costs;
- A number of offenders that need some type of treatment service are eligible for Medicaid coverage because their families' income or ability to provide medical care (i.e., Kids Connection).
- Once offenders become OJS wards, they become eligible for Medicaid; consequently, Medicaid funds for OJS wards arguably represent the juvenile justice system's primary resource for mental health and substance abuse services.

The process to access services through Medicaid is illustrated in Figure 4.3 (for a more detailed description of this process, see the full report).

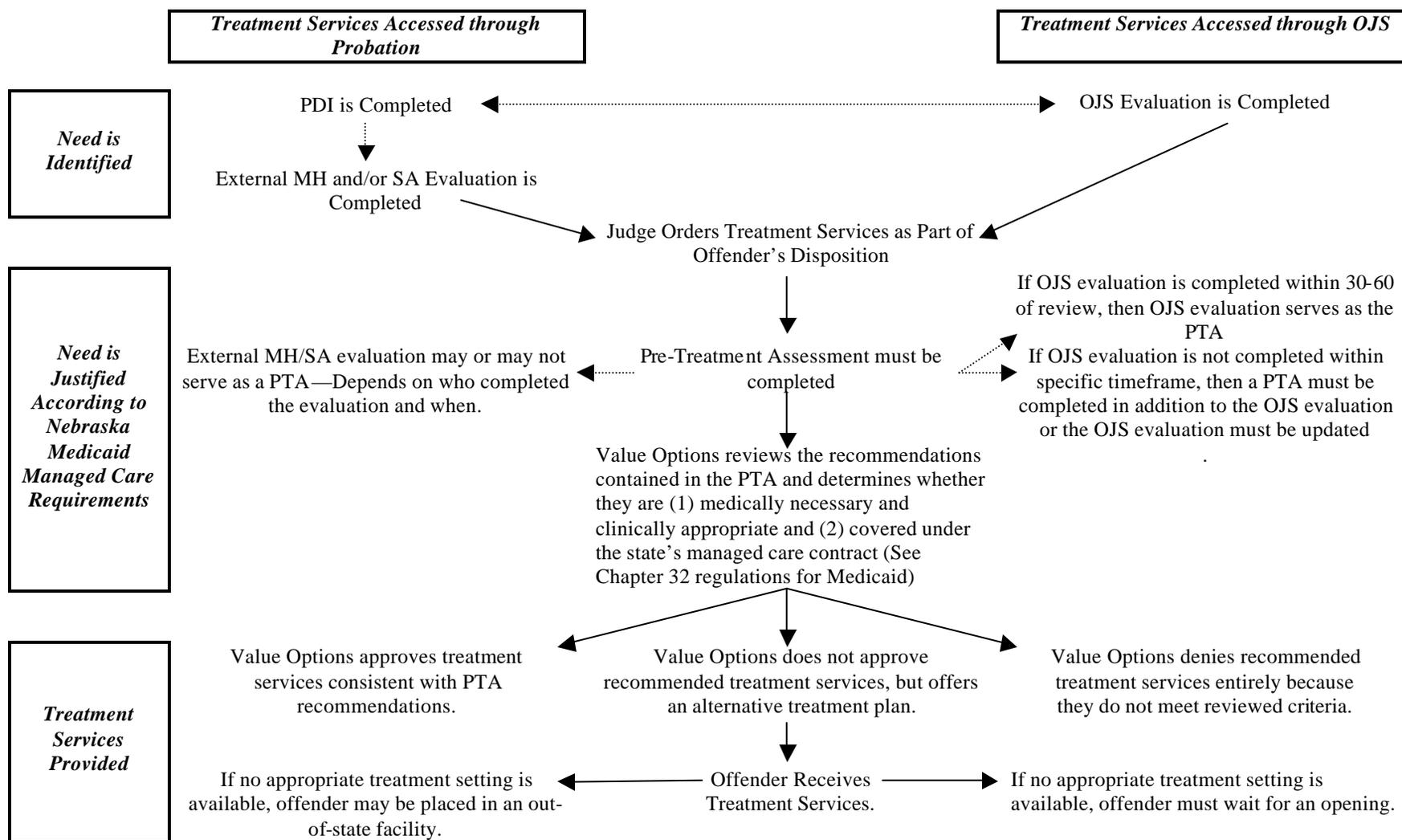
Overall Implications for Juvenile Justice

The juvenile justice system's reliance on Medicaid to access mental health and substance abuse treatment generates several concerns.

- Medicaid creates an additional set of tasks and responsibilities for juvenile justice agencies that already operate on strained staff and budget allocations.

Agencies that do not take a proactive role in accessing Medicaid funds substantially reduce their access to treatment services for offenders (e.g., Probation) while agencies more familiar with

Figure 4.3: Accessing Treatment Services through Medicaid—the Approval Process



Medicaid become overburdened with offenders who need to access services (e.g., OJS). In turn, offenders with treatment needs are potentially more likely to become OJS wards than probationers regardless of offense severity and criminal history.

- Nebraska's choice to base Medicaid coverage of behavioral health services on the medical model and medical necessity potentially decreases the collaboration between HHS/OJS and HHS/Division of Mental Health, Substance Abuse, and Addiction Services.

This occurs because the current Medicaid structure does not incorporate Division treatment standards (e.g., levels of care and credential requirements) and does not recognize certified alcohol and chemical dependency counselor (CADAC) recommendations without a physician or mental health professional signature. Although all certified alcohol and substance abuse counselors adhere to Division standards and requirements, for example, they are not Medicaid-approved without mental health professional credentials. Similarly, Medicaid contracted providers must have a physician or mental health professional on staff, precluding many substance abuse providers from providing services to Medicaid-covered clients (i.e., wards). Such fragmentation in service delivery standards creates inconsistent substance abuse treatment services throughout the state as well as a lack of substance abuse services for offenders accessing services through Medicaid.

- The Nebraska Medicaid Managed Care Program (NMMCP) limits Nebraska's ability to implement a juvenile justice system of care balanced between treatment need and risk.

NMMCP does not recognize or incorporate offender risk into its approval process. For example, a recommendation for inpatient treatment is often denied if the offender has not failed outpatient treatment first or the residential portion relates to the offender's conduct more than his/her mental health or substance abuse treatment need. Conversely, correctional placements are often unable to treat the mental health/substance abuse issues adequately.

- The current Medicaid contract with Value Options does not cover family services, transitional services, or correctional services.

OJS must use family and other counseling services from various agencies and lower level placements such as group homes to facilitate an offender's return to home. These practices are particularly concerning because they contradict the well-documented "best practice" that calls for integrating mental health and substance abuse treatment with family, correctional, and transitional services.

Coordination of Policies, Procedures, and Services across Systems

A review of the agencies involved in identifying need and accessing services for offenders indicates that this process involves multiple agencies and decision-makers, but it does not provide estimates on how many decision-makers are involved in accessing treatment. Using conservative estimates of the number of decision-makers involved in processing an offender with substance abuse and/or mental health problems, between 8 and 13 decision-makers are involved in accessing treatment for offenders on probation; between 10 and 13 are involved in OJS custody cases; and between 11 and 14 are involved if the offender is placed in a YRTC or some other type of placement (e.g., foster home, group home, residential treatment facility).

The number of decision-makers may not matter if they interact efficiently to address offender accountability and treatment needs effectively. A preliminary assessment of collaboration, however, revealed that interagency collaboration throughout the state is more informal than formal. Secondly, the extent to which any collaboration occurs depends on geographical location and the relationships developed between local offices of state-based agencies. These findings in combination with the convoluted pathways to treatment services indicate that system barriers currently prevent the development of an effective juvenile justice system of care in Nebraska (Chinn Planning, 1999a; Chinn Planning, 1999b; Johnston, Bassie,

and Shaw, Inc., 1993). To more closely examine this issue, we turn next to viewpoints derived from juvenile justice professionals and service providers throughout the state.

Chapter 5: Evaluating Nebraska’s Ability to Access Mental Health and Substance Abuse Treatment through the Juvenile Justice System

Overview

Evaluating the juvenile justice system’s ability to identify need and access services for juvenile offenders rests on its mission and goals. In Nebraska, there are four different mission statements related to juvenile justice (see pages 76-77 of the full report). The first mission statement is found in the Nebraska Juvenile Code (1998). Although the Code focuses primarily on procedural issues and the rights afforded to juvenile offenders, the mission statement in section 43-246(1) indicates the general purpose of juvenile justice system. The Office of Probation Administration offers a second mission statement that relates to the role that Probation plays within juvenile justice. A third mission statement describes the purpose of the Office of Juvenile Services, which is housed in the Department of Health and Human Services Protection and Safety Division and a fourth, more comprehensive mission statement was produced by a 1992 juvenile justice work group, the Youth Services Planning Commission.

Although these mission statements differ to some extent, they incorporate common goals such as ensuring public safety, offender well-being, and offender accountability. Juvenile justice practice as well as research documents the need to incorporate mental health and substance abuse issues within correctional intervention in order to achieve these goals; thus, understanding barriers that prevent the juvenile justice system from efficiently and effectively identifying the need for services and accessing appropriate services provides some insight into its ability to achieve its broader goals (Hagan et. al., 1997; Lipsey & Wilson, 1998). To assess the barriers that exist in Nebraska, juvenile justice professionals and service providers were asked to participate in focus group discussions or complete surveys. This chapter summarizes the results

from those efforts and discusses themes related to (for a full presentation of these results, see full report):

- Agency roles;
- Identifying mental health and substance abuse problems;
- Accessing a continuum of mental health and substance abuse treatment;
- Paying for mental health and substance abuse treatment; and
- Providers' ability to treat juvenile offenders with mental health and substance abuse problems.

Assessing the Nebraska Juvenile Justice System

Method

1. Focus Groups

A total of seven focus groups were held: five at the University of Nebraska, Kearney and two at Mahoney State Park in March 2000. The purpose of the focus groups was to provide decision-makers the opportunity to characterize mental health and substance abuse service delivery within the juvenile justice system. Several groups were invited to participate including detention facility and program personnel, probation officers, OJS personnel, mental health providers, and Region personnel. Participation in these focus groups is reflected in Table 5.1. Focus group meetings lasted approximately two hours and were facilitated by a UNO researcher who used a list of open-ended questions to stimulate and guide discussion (see full report for a list of questions used to frame discussions). Upon the completion of the focus group meetings, notes were assimilated and themes were identified.

2. Surveys

Surveys were also mailed to (1) all Separate Juvenile Court judges and all county judges in the remaining counties (N=45); (2) all county attorneys (N=93); and (3) the public defenders

in Douglas, Sarpy, and Lancaster counties(N=3). Survey questions were based on the questions used for the focus groups (see Appendix 5 B for a copy of the surveys). Response rates for these groups are also contained in Table 5.1. When response rates were calculated for Separate Juvenile Courts, 44% of judges, none of the county attorney offices, and only 33% of public defender offices completed and returned a survey.

Table 5.1: Summary of Response Rates for Decision-Maker Focus Groups and Surveys

	No. Invited or Sent	Number Attended or Returned	Response Rate	Agencies/ Areas Identified	Agencies/ Areas Participating	Adjusted Response Rate
Focus Groups						
Detention Facilities	18	7	39%	13	11	85%
Probation	13	12	92%	13	11	85%
OJS/YRTC's	19	7	37%	9	7	78%
MH Providers	57	28	49%	48	24	50%
Region Personnel	17	11	65%	6	5	83%
Total	124	65	52%	89	58	65%
Mailed Surveys						
Judges	45	19	42%	6	5	83%
County Attorneys	93	16	17%	6	5	83%
Public Defenders	3	2 ¹	n/a	3	1	33%
Total	141	37	26%	15	11	73%

Results for Selected Issues (see full report for all results)

1. Agency Roles

- Mental health and substance abuse problems substantially impact the operation of detention facilities (secure and non-secure), but these facilities/programs have few resources and training to address these problems and have little influence in the court with regard to these issues.
- The impact of substance abuse and mental health problems on detention facilities and programs is further amplified because these facilities often house adjudicated wards waiting for a placement. Waiting periods can and do last several months.
- Probation (via the pre-disposition investigation) offers a starting point for consistently identifying substance abuse and mental health problems among offenders, but probation officers have little training or expertise in handling mental health problems/disorders.

- Probation officers, judges and county attorneys also indicated that Probation's role in treatment was limited because the Office of Probation Administration does not have funds to provide treatment services
- All groups identified OJS as the primary pathway to services. In fact, many respondents believed that offenders were increasingly placed in the custody of OJS to access services regardless of their previous criminal history or offense seriousness.
- OJS workers stressed the impact of this trend on caseload size and their frustration with the insufficient time they could devote to case management.
- Various factors created frustrations for OJS workers, such as large caseloads and mixed caseloads (abuse/neglect and delinquency), because they limited caseworkers' ability to manage offender cases and gain experience with the juvenile justice system and handling offenders.
- Providers and Region personnel felt removed from the juvenile justice process in many respects even though they play a critical role in the juvenile justice system of care.

2. Identifying Need

- All respondents acknowledged that there was no standardized process is currently used to determine which offenders needed further evaluation or to determine what type of evaluation is necessary.
- OJS workers, judges, county attorneys, and public defenders expressed their concern over the lack of any mechanism to measure the quality of the evaluations and the competency of the evaluators.

3. Access to Services

- According to all respondents, the most significant barrier to accessing services was the availability of a continuum of services, including acute care; intensive outpatient; dual diagnosis treatment; services for young offenders under the age of 12; sex offenders; and offenders with conduct disorder.
- When programs were available, several groups believed that providers were reluctant to take offenders because of their offending and quick to reject them from programs for behavioral problems.
- Various groups believed that the lack of full disclosure (i.e., full background information to identify safety concerns and risks) led to inappropriate placements (e.g., placing serious offenders in low security placements, mixing serious offenders with less serious offenders, placing predatory offenders in the same setting as victims of abuse, and placing multiple problem offenders in unprepared foster homes).

4. Payment for services

- All respondents reported that services are rarely affordable to non-wards who are not Medicaid eligible, and private insurance is often inadequate to pay for services. The lack of resources, in turn, places pressure on inadequate county and state (i.e., child welfare) funds to cover the costs related to treatment.
- Respondents in each group felt strongly that resources currently drive the availability of services rather than offender need; furthermore, they believed that this relationship was unacceptable and ineffective in addressing mental health and substance abuse problems adequately.
- The role of medical necessity was viewed as problematic because it created a significant barrier to accessing services. Medicaid managed care was considered incompatible with accessing appropriate treatment for offenders because it does not cover services critical to the needs of this population such as transitional, family, and wrap around services.
- The delays related to the Value Options approval process were considered unacceptable, prolonging treatment and contributing to inappropriate and ineffective treatment.

5. Ability to Treat Offenders

- Judges, county attorneys, and public defenders reported that the quality of treatment was contingent on individual providers and geographical areas.
- Many respondents had faith in some programs but not others, and generally found that providers who specialized in treating juveniles were more effective because they had more contact with their clients and know them better.
- Respondents in various groups, including mental health providers, believed that providers could benefit from more training on how to treat and handle offenders effectively.
- Respondents were also concerned that families do not always play an integral part in the treatment process.

6. System Generally²

- All the groups believed that a fundamental problem was the system's reactive nature and a lack of prevention. For example, there are fewer resources and opportunities to connect offenders and families to appropriate treatment at the beginning of the system; rather, if services are needed, the offender must be adjudicated, assessed and given a disposition before services are available.

² Responses in this section are limited to focus group respondents because a similar question was not included on the judge, county attorney, or public defender surveys.

- Respondents believed that conflicts in philosophies and policies and procedures across juvenile justice agencies created system fragmentation and the absence of communication and collaboration between juvenile justice agencies and providers.
- Several respondents also viewed politics and a lack of resources as major barriers to improving the juvenile justice system. Specifically, mental health providers believed that politics and a competition between providers stymied collaboration among providers to address service provision issues adequately and effectively.
- Region personnel and providers discussed the need for juvenile justice personnel training on mental health and substance abuse problems as well as the language used by providers and Medicaid. Region respondents also felt that they, in addition to OJS workers, needed more training on the juvenile justice process generally and the language used within this process.

7. The Role of Geography and Offender Characteristics

- There was general consensus that the availability of services for mental health and substance abuse services was bleaker in rural areas than in urban areas.
- With regard to race, ethnicity and gender, many respondents believed that the lack of bi-lingual and culturally specific programming was problematic. The lack of culturally based services was particularly critical on Indian reservations, where quality services are scarce and youth experienced unusually high rates of social problems on a daily basis.
- Many judges and county attorneys stated that race, ethnicity, and gender did not influence the juvenile justice process, identifying need for services, or accessing appropriate services.

Discussion

A review of focus group and survey responses indicates that juvenile justice professionals and service providers recognized similar system weaknesses or barriers to treatment. These groups did not disagree on any issue but particular groups felt more strongly about some issues than other groups. Such consensus points to several areas that, if addressed, could potentially improve the Nebraska juvenile justice system's ability to identify need and provide appropriate treatment services to juvenile offenders.

These findings are not necessarily new; in fact, many of the problems presented in this chapter are listed in previous reports produced before this study (Herz & Mathias, 2000; Johnston, Bassie, and Shaw, Inc., 1993; Martin, 1993; Nebraska Commission for the Protection of Children, 1996; Nebraska Juvenile Justice Task Force, 1998; Sarata et. al., 1974). Within the last five years, for example, the *Nebraska Juvenile Services Master Plan Final Report* (Chinn Planning, Inc., 1999b) and the *Juvenile Detention Master Plan* (Chinn Planning Inc., 1999a) documented some of these issues and offered recommendations to address them. More recently, the Statewide Substance Abuse Task Force (Herz, 2001; Herz and Vincent, 2000) identified the lack of a standardized process for screening and evaluating substance abuse among juvenile offenders and advocated the implementation of the Standardized Model. Similarly, the Department of Health and Human Services produced two reports that addressed the delivery of services to HHS wards (i.e., OJS wards; *Children, Youth, and Families Services Integration Team Report*, 2000; *Nebraska Family Portrait*, 2001).

Given the documented attention to juvenile justice and the delivery of services shortcomings, why are the same issues surfacing in the focus groups and surveys conducted for the current study? Explanation for the “revolving door” of problems potentially rests in Nebraska’s lack of a coordinated juvenile justice policy. At least two factors support this contention. First, multiple and sometimes divergent mission statements reflect the state’s inability to develop clear juvenile justice goals to guide and implement a juvenile justice system of care (see Chapter 4 for examples of this point). A second contributing factor is the lack of advocacy for coordinated juvenile justice policy by Probation or the Office of Juvenile Services. Until recently, State Probation has not actively advocated for juvenile justice or developed ways to coordinate their services with the Office of Juvenile Services, and since 1997, OJS caseloads

and services have been blended into those related to all HHS wards, including abuse/neglected children, foster care children, and adopted children.

The Nebraska Family Portrait, for instance, does not refer to “offenders” despite the fact that 21% of the HHS wards are commitments for delinquency (State Ward Court Report, 2001). Furthermore, the Nebraska Family Portrait offers various recommendations for change in the areas of safety, permanency, well-being, policy and practice, training, quality assurance, and information systems; however, only a small percentage of the issues listed in each of these sections are directly related to OJS wards (9-20%). The highest number related to offenders specifically fell in the quality assurance section (67%), which had little to do with coordinated care and the provision of appropriate treatment. In fact, only one issue was related to coordinating activities with Probation. This is not to imply that OJS wards are neglected because the vast majority of issues and outcomes applied to all wards. Yet, applying reform generally without a juvenile justice-specific plan reinforces the notion that there is no leadership for juvenile justice policy or the development of a juvenile justice system of care.

Summary

Although this chapter has taken a critical look at Nebraska’s ability to identify treatment need and access appropriate services for juvenile offenders, there are many “signs of progress” throughout the state. Ironically, many developments represent the growth of an informal juvenile justice policy in response to the lack of formal policy. Chapter 6 summarizes these developments and provides a comprehensive strategy to improve upon and coordinate this progress.

Chapter 6: Creating a Coordinated Approach to System Change

The relationship between substance abuse and/or mental health and delinquency defines the role of treatment in the juvenile justice system. If substance abuse and mental health problems contribute to delinquency, treatment becomes not only a matter of public health but also one of public safety. Conversely, the absence of any relationship throws question on the need for such treatment within the juvenile justice system.

The purpose of this report was improve public health as well as public safety by (1) examining the prevalence of mental health problems and access to mental health services in Nebraska's juvenile justice system and (2) developing a coordinated approach to improve the system responses to treatment needs. In the end, this report produced a broader assessment of juvenile justice because mental health problems and treatment are impossible to separate from substance abuse or general juvenile justice processing. This chapter weaves system strengths and weaknesses discussed throughout this report to develop a comprehensive approach that will facilitate progress toward a juvenile justice "system of care."

Signs of Progress

- ❑ Kids Connection increased the number of youths eligible for Medicaid and can be used to access treatment for juvenile offenders.
- ❑ Drug treatment courts in Douglas, Sarpy, and Lancaster Counties integrate substance abuse treatment and supervision within a team-management setting.
- ❑ Juvenile Accountability Incentive Block Grants provided funds to many counties throughout the state to increase juvenile justice programming.
- ❑ The Substance Abuse Task Force documented the need for substance abuse treatment within the juvenile justice system and recommended the Standardized Model for improving the accuracy and consistency with which juvenile justice identifies the need for substance abuse treatment (see Herz, 2001a).
- ❑ The Juvenile Probation Services and Detention Implementation Team (LB 1167) produced recommendations to standardize pre-adjudication detention decision-making

process and improve consistency across diversion programs. This group is currently working on other issues related to the pre-adjudication of juvenile offenders.

- ❑ State administrators of Probation and the Office of Juvenile Services are collaborating to identify a common mission statement and process to identify the risks and needs of adjudicated offenders.
- ❑ Families First and Foremost promoted communication and collaboration between families, social services agencies, and juvenile justice personnel to identify the need for and provide mental health services as soon as possible in the juvenile justice process. The project also plans to open an assessment center in January 2002.
- ❑ Nebraska Family Central Integrated Care Coordination Project formalized collaboration between the HHS Central Service Area and Region III Behavioral Health Services and serves children with high care needs and multiple functional impairments.
- ❑ Legislative bills provided funding to OJS and local communities: Nebraska Health Care Funding Act (2001) and the State Budget Bill (2001) by the Nebraska Legislature provides funding (\$2,000,000 between fiscal year 2001-03) to the Office of Juvenile Services to enhance the YRTC's capacity to provide mental health and substance abuse services.

The progress in these areas demonstrates the strong desire and willingness of various agencies and groups to improve the juvenile justice system. It is important to build an infrastructure to coordinate and support these initiatives; otherwise, current improvements will fall short of long-term change in Nebraska. To help guide this process, we have listed several recommendations that are consistent with juvenile justice “best practices” and with many of the current developments underway in Nebraska. This list is intended to provide a guide to improving the provision of substance abuse and mental health services in Nebraska—it is not necessarily a list of what is missing in Nebraska. In other words, it is important to note that Nebraska is already implementing some changes that are consistent with these recommendations.

Overall Recommendations

1. Create a statewide juvenile justice policy that defines a “system of care” and emphasizes:
 - ❑ Interagency communication and collaboration
 - ❑ Treatment providers and Regions as a part of juvenile justice
 - ❑ The current and future role of juvenile justice “best practices” in Nebraska

2. Once a strategic plan is created, prioritize its recommendations at the state level and ensure that all legislative changes are consistent with mission and goals of the plan.
3. Eliminate fragmentation and duplication throughout the system in the following ways:
 - Form formal linkages between Probation and OJS to create a continuum of treatment and supervision care
 - Formally include treatment providers in juvenile justice
 - Formally include Regions in juvenile justice
 - Implement standards and consistent processes across all juvenile justice entities (i.e., get everyone on the same page and talking the same language).

Identifying Need

1. Consistently identify the need for mental health or substance abuse treatment through the use of a standardized process (i.e., screening, assessment, and evaluation) and instruments (e.g. the Nebraska Substance Abuse Task Force’s Standardized Model; Herz, 2001a).
2. Implement a process that incorporates all juvenile justice agencies, requires information sharing, and utilizes team decision-making.
3. Develop formal linkages between juvenile justice agencies and clearly identify the role and responsibility of each agency with regard to juvenile justice policy, process, and communication.

Access to Treatment

1. Increase treatment capacity throughout the state, especially in rural areas.
2. Create and maintain a continuum of programming options that includes programming for sex offenders and young (less than 12 years old) offenders.
3. Create, maintain, and encourage community-based programming with wrap-around services.
4. Develop incentives for providers to become Medicaid approved providers.
5. Create “placement facilitator” positions that work with providers and detention facilities to decrease the time that an offender must wait for a placement and improve the appropriateness of the placement.

Service Appropriateness

1. Focus on “out of the box” initiatives, designing interventions that “fit” juvenile offender needs.

2. Implement wraparound services (e.g., multi-systemic therapy, team management approaches) throughout the state and across juvenile justice agencies.
3. Formally partner with schools to enhance educational retention and services.
4. Develop mental health and substance abuse treatment programs (community-based and institutional) for offenders—i.e., programming that integrates treatment with behavior modification approaches.
5. Develop programming for mental health problems (i.e., temporary in nature) that do not require a disorder label.
6. Reduce administrative responsibilities for caseworkers and increase contacts between caseworkers and youths, families, and treatment providers.
7. Implement transitional and aftercare programming as standard part of interventions and treatment programming.
8. Develop creative programming and incentives to increase family involvement.
9. Provide initial level of screening for treatment need and services at detention facilities.
10. Standardize language and regulations for substance abuse services in partnership with the Division of Mental Health, Substance Abuse, and Addiction Services.
11. Identify the need for and develop gender and culturally appropriate programming.
12. Implement a continuum of care across Probation and OJS using clear risk/need criteria to determine where an offender should be placed. This includes identifying youths in the juvenile justice system that should be 100% behavioral health clients (i.e., serious emotional disturbance).

Funding

1. Make Medicaid more appropriate for juvenile justice (i.e., services covered, approval process).
2. Reduce barriers to Medicaid funding by implementing behavioral health criteria in place of medical necessity criteria.
3. Streamline service approval process in order to eliminate delays in service provision.
4. Increase state funding for treatment services, making funds available to Probation for treatment services.

5. Ensure that the funding follows the child (i.e., need for service) rather than the services (i.e., service availability).
6. Include Probation in the development of Medicaid Managed Care contract provisions.
7. Create juvenile justice Medicaid liaison positions within Probation and the Office of Juvenile Services.

Accountability

1. Develop goals and objectives as part of a juvenile justice policy and strategic plan.
2. Fund a research arm for juvenile justice to measure system's ability to obtain goals and objectives on a regular basis.
3. Evaluate standardized processes and tools used to identify risks and needs.
4. Require standard reporting for pre-determined measures from all service providers working with juvenile offenders.
5. Implement competency based standards and measures for all juvenile justice service providers.
6. Implement a statewide juvenile justice information system that overlays all juvenile justice agencies.
7. Examine the treatment needs of and access to treatment for juvenile offenders in the adult criminal justice system.

Training

1. Integrate training on substance abuse and mental health problems into current detention facility, Probation and OJS training programs (i.e., all juvenile justice agencies).
2. Provide regular training to juvenile justice personnel as well as providers on how to understand the language and processes that comprise the juvenile justice system.
3. Provide regular training to juvenile justice personnel as well as providers on the purpose, role, and requirements for standardized screening, assessments, and evaluations.
4. Provide regular training to providers on the special needs of and "best practices" for treating juvenile offenders.
5. Provide regular training to all juvenile justice personnel and providers on the Medicaid process.

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