

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

## Executive Summary

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Denise C. Herz, Ph.D.  
Amy L. Poland, M.P.A.  
Department of Criminal Justice  
University of Nebraska at Omaha

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Denise C. Herz, Ph.D.  
Amy L. Poland, M.P.A.  
Department of Criminal Justice  
University of Nebraska at Omaha  
Durham Science Center 208  
6001 Dodge Street  
Omaha, NE 68182-0149

Contributing Author: Jeremy Ball, J.D.

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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 21<sup>st</sup> 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

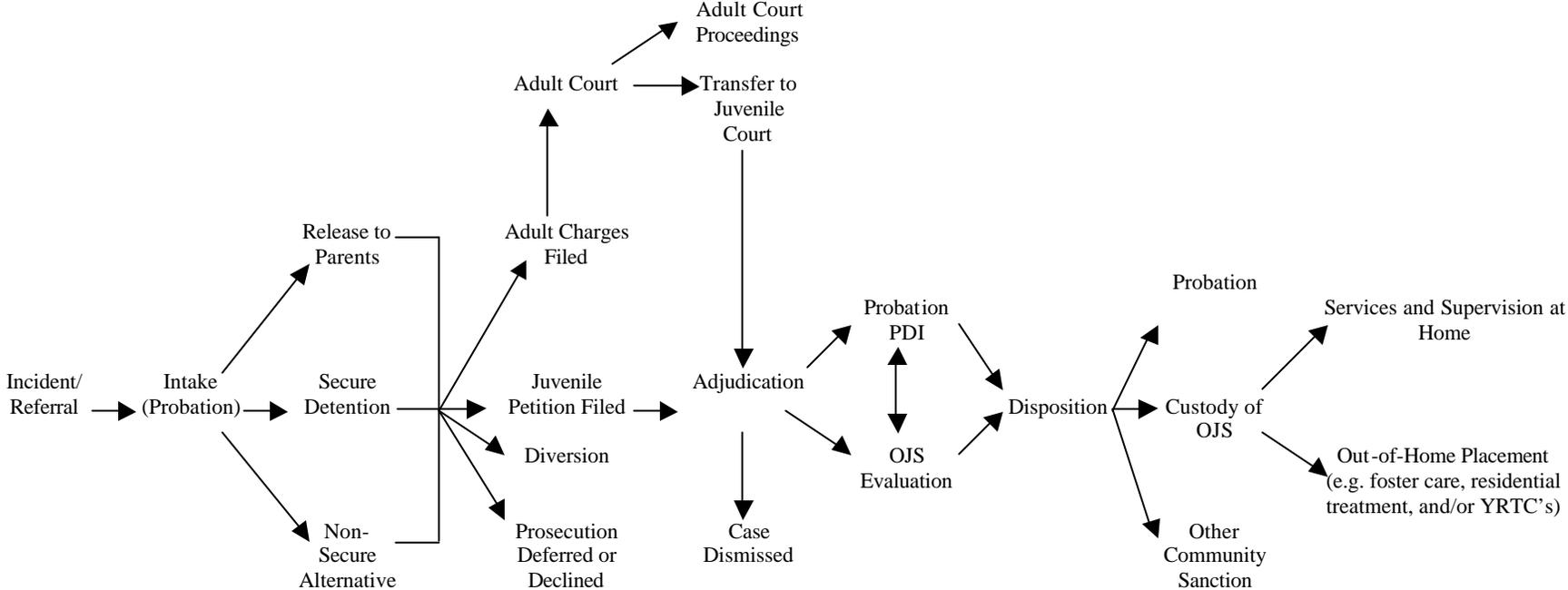
groups, however, is not meant to trivialize the treatment issues that permeate these populations. Rather, their absence signifies their complexity and need for special attention.

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.<sup>1</sup> 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

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<sup>1</sup> 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**

<b>Instrument</b>	<b>N*</b>	<b>No Problem</b>	<b>Caution</b>	<b>Warning</b>
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**

	<b>MAYSI-2 n=34</b>	<b>Adolescent Chemical Dependency Inventory n=86</b>	<b>Simple Screening Instrument n=73</b>
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 20<sup>th</sup> 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 21<sup>st</sup> 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 18<sup>th</sup> 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*

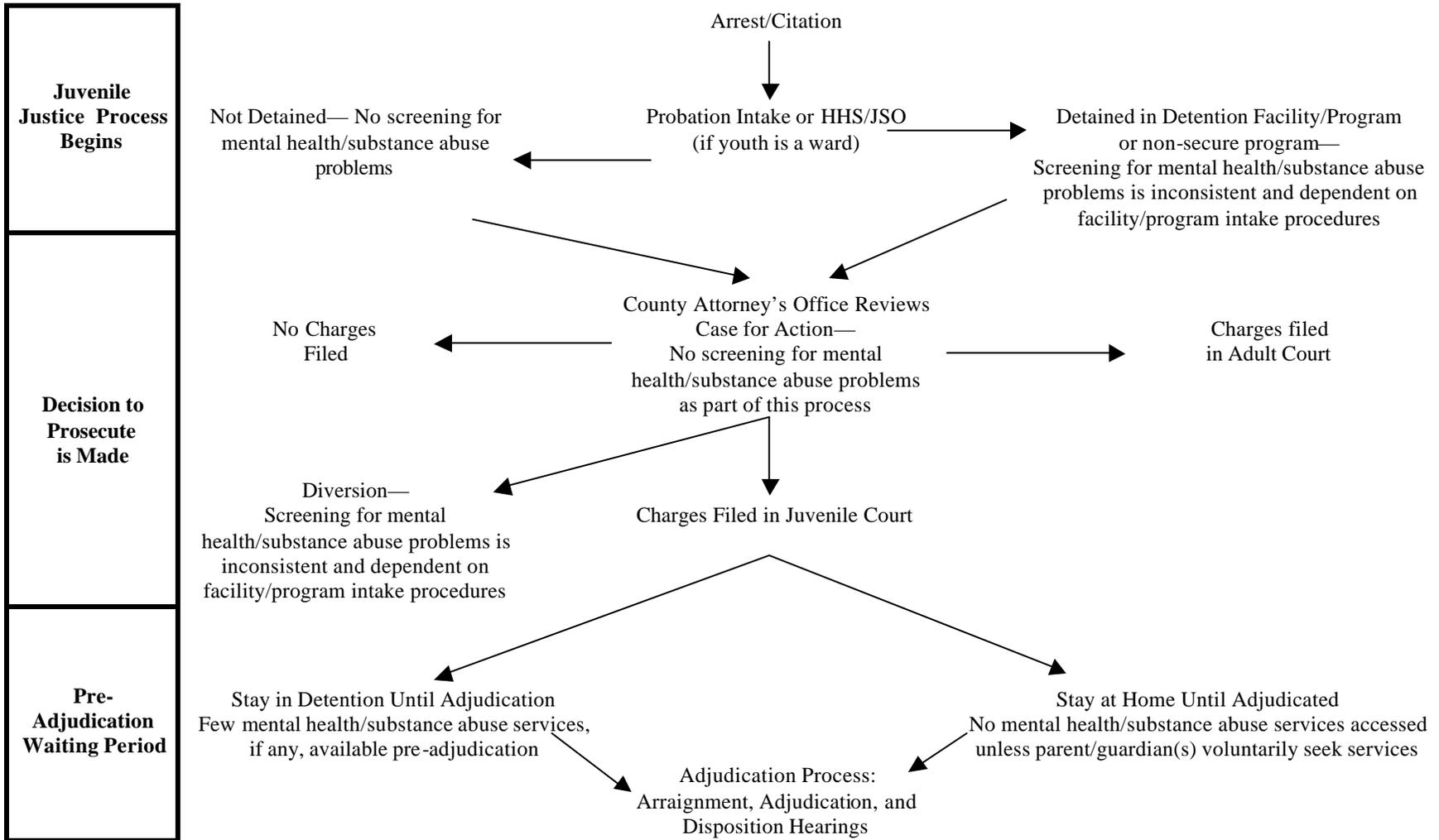
Figure 4.2 shows the ways in which treatment needs are identified and addressed after adjudication (for a more thorough description of these pathways, see the full report).

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.

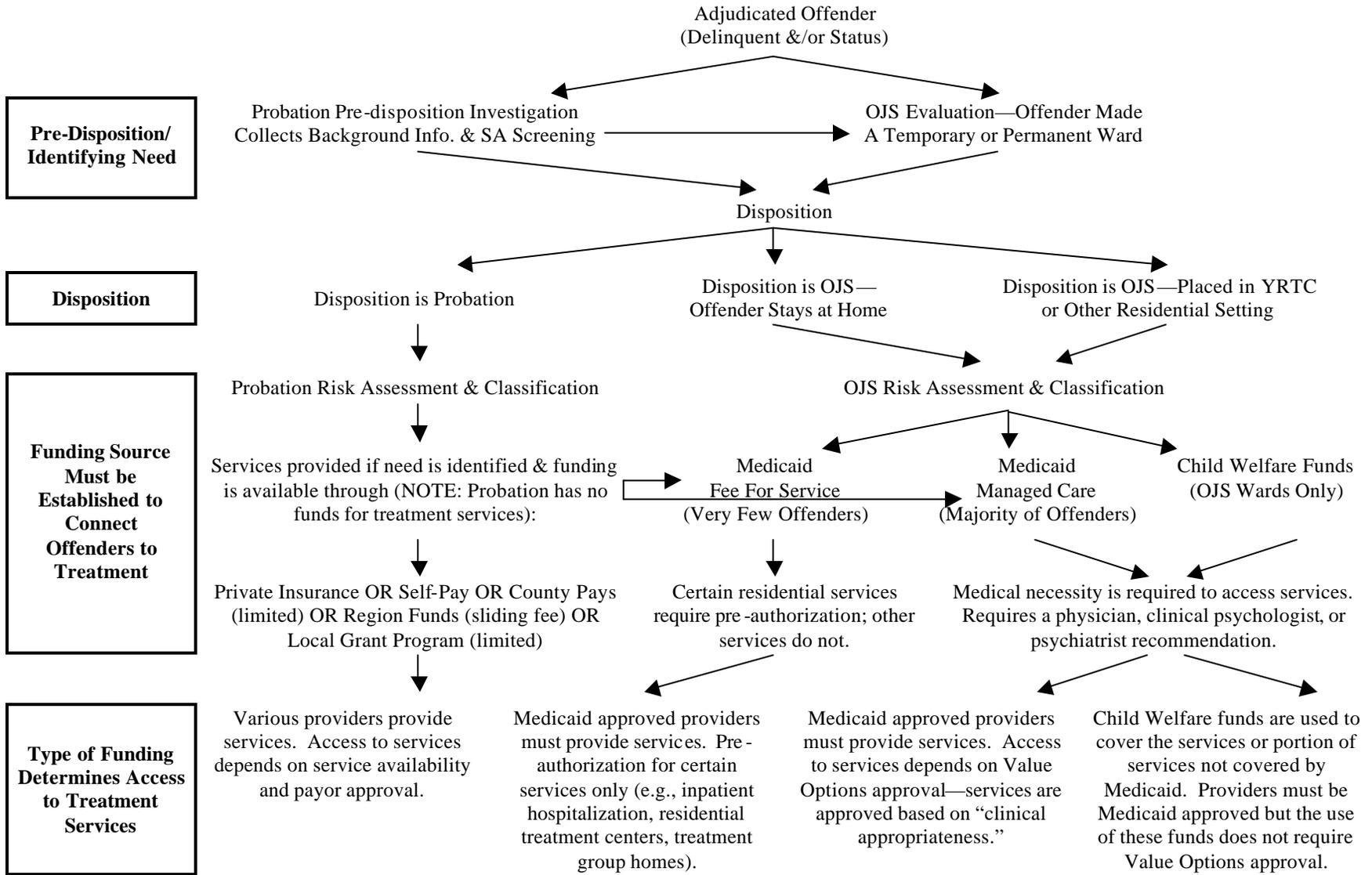
#### Accessing Mental Health and Substance Abuse Services

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).

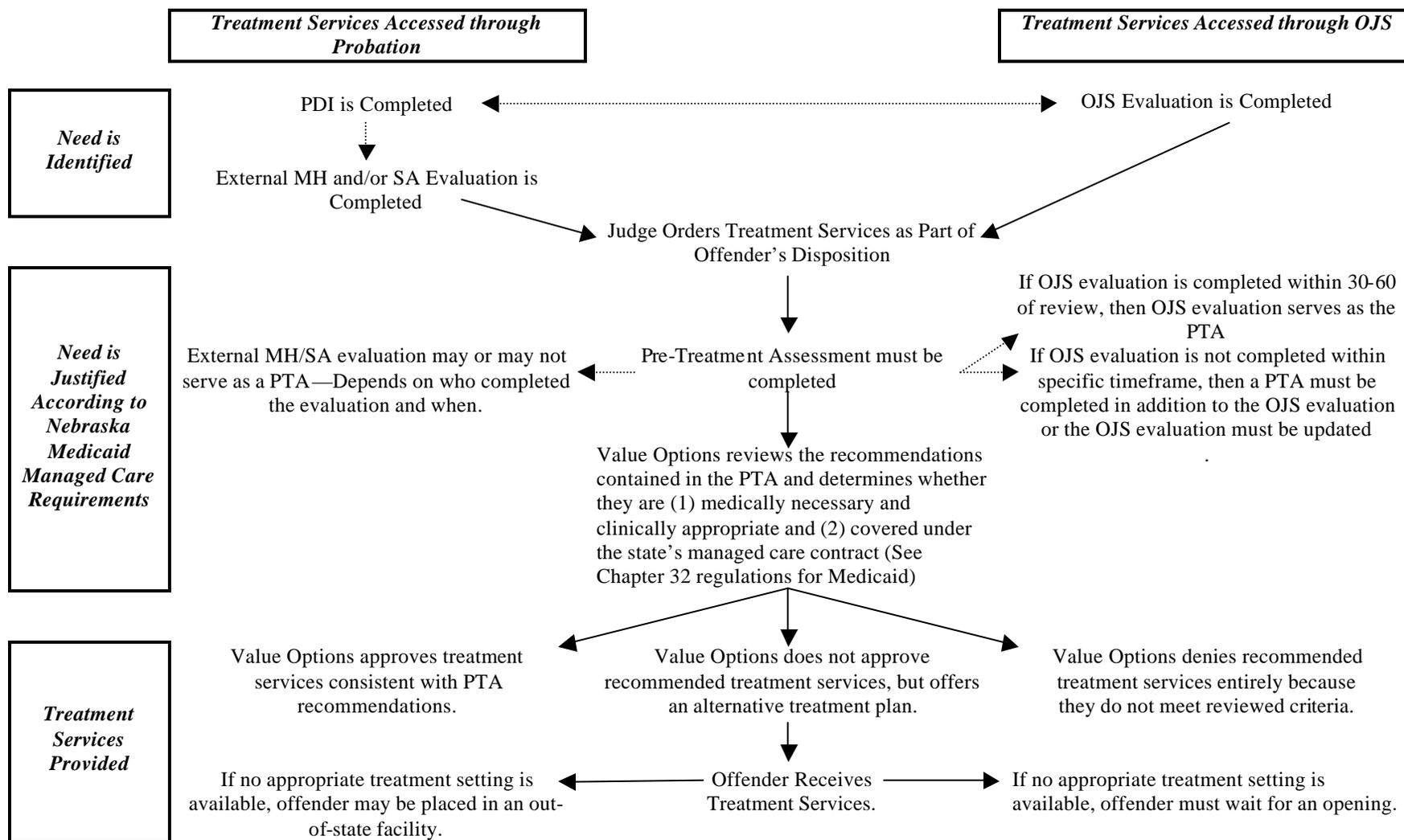
#### *Overall Implications for Juvenile Justice*

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
<b>Focus Groups</b>						
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%
<b>Mailed Surveys</b>						
Judges	45	19	42%	6	5	83%
County Attorneys	93	16	17%	6	5	83%
Public Defenders	3	2 <sup>1</sup>	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 Generally<sup>2</sup>

- 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.

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<sup>2</sup> 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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# Assessing the Need for and Availability of Mental Health Services for Juvenile Offenders

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By:

Denise C. Herz, Ph.D.  
Amy L. Poland, M.P.A.

Department of Criminal Justice  
University of Nebraska at Omaha

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By:

Denise C. Herz, Ph.D.  
Amy L. Poland, M.P.A.

Department of Criminal Justice  
University of Nebraska at Omaha  
Durham Science Center 208  
6001 Dodge Street  
Omaha, NE 68182-0149

Contributing Author: Jeremy Ball, J.D.

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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 21<sup>st</sup> 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.

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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; Rotenberg, 1997, Teplin, 2001). At least 22 states have studied and developed plans to address the problem, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) has funded several studies examining this issue (McKinney, 2001), and the U.S. Department of Health and Human Services (USDHHS) published a comprehensive review of children's mental health issues (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.

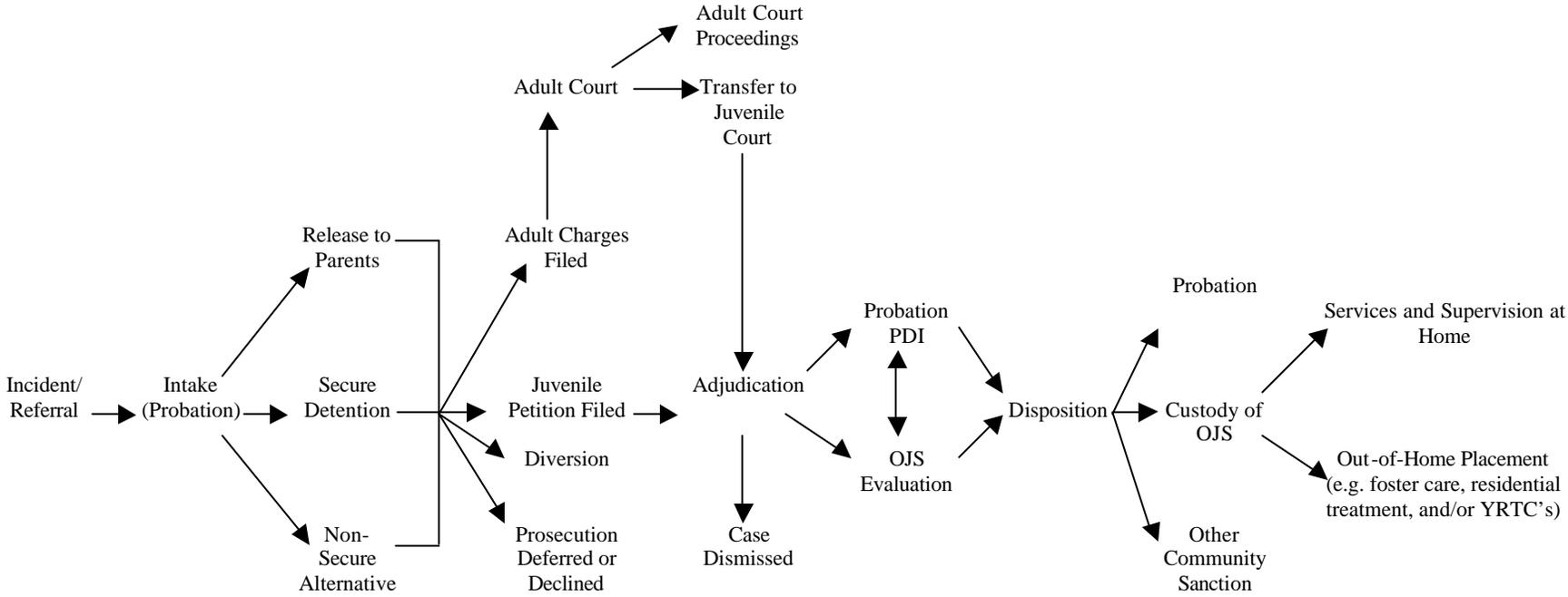
### Description of Nebraska Juvenile Justice

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 juvenile justice process outlined in the Nebraska Juvenile Code (1998). Following an arrest/citation, the decision to detain the offender is made initially by the police officer who contacts a probation intake officer to make the final decision. Offenders who represent a danger to self or the community are then detained until a judge determines whether to release the offender or continue the detention. If the offender was a Health and Human Services (HHS) ward at the time of the arrest/citation, the Office of Juvenile Services (OJS) worker decides whether to detain the youth rather than the probation intake officer. Next, the county attorney's office determines whether to take no action on the charges, handle the charges through diversion, file the charges in juvenile court, or file the charges in adult court. In cases of diversion, offenders participate in a county-approved program in lieu of court processing, and cases processed in the adult court are removed from the juvenile court unless the adult court judge "waives" the case to juvenile court. Cases filed in the juvenile court are then processed or "adjudicated" to determine the youth's responsibility for the charges. If the youth is found "not responsible" for the charges, he/she is released from the court. Conversely, youths found responsible for the charges will receive a disposition (i.e., sentence).

**Figure 1.1: Nebraska Juvenile Offender Case Flow Chart**



Probation and the Office of Juvenile Services play important roles post-adjudication and post-disposition because both agencies provide assessments of youth prior to disposition and are responsible for monitoring the completion of court-ordered dispositions. Probation is housed in the Nebraska Supreme Court and is organized within 16 probation districts across the state. Each district completes pre-disposition investigations used to assist judges' decision-making related to dispositions and supervises youth placed on probation by the court. The Office of Juvenile Services is housed in the Department of Health and Human Services, Protection and Safety Division and is organized across 6 regional areas. OJS personnel facilitate the completion of OJS evaluations (i.e., offender assessments) prior to disposition and oversee placements, provide case management, and supervise offenders placed in the state's custody after disposition.

Although Figure 1.1 denotes the basic steps in the Nebraska juvenile justice process, the process looks slightly different 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. 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.

#### 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-VI; 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). For instance, research indicates that a smaller percentage of offenders (approximately 10-20%) 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.

The definition for mental health problems was taken from the U.S. Surgeon General's report on mental health (DHSS, 1999) because it reflects a public health approach to mental health and defines conditions that need prevention and/or intervention prior to reaching the point of a disorder. The DSM-IV (APA, 1994) definition of mental

health disorders was chosen because the DSM-IV contains the criteria used by clinicians and researchers who diagnose mental health disorders and by many other insurance providers to justify mental health and substance abuse treatment (see Kutchins & Kirk, 1999 for a thorough discussion of this point). Despite its wide application and acceptance, criticisms of the DSM-IV are widely documented especially with regard to its statistical credibility and cultural biases (Kirk & Kutchins, 1992; Kutchins & Kirk, 1999; Mechanic, 1999; Wakefield, 1999). Having acknowledged these weaknesses, the authors of this report chose to use the DSM-IV definition because it provides a common language to discuss mental health disorders among juvenile offenders.

### 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 summarizes extant research on the prevalence of mental health problems and disorders among juvenile offenders, and 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 in Nebraska, the current chapter addresses the following questions:

- What is the relationship between substance abuse, mental health disorders and delinquency?
- What is the prevalence of mental health problems among juveniles?

## The Relationship between Substance Abuse, Mental Health Disorders and Delinquency

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.

At least two types of research provide insight into the relationship between substance abuse, mental health problems, and delinquency. The first stems from research that examines the influence of various factors on delinquency. Such research does not establish an unequivocal causal relationship, but it does document that substance abuse and mental health problems act as risk factors for delinquent behavior (Grisso, 1999; Hawkins, Catalano & Miller, 1992; Huizinga et.al., 2000; Huizinga & Jakob-Chien, 1998; Vander Stoep, Evens, & Taub, 1997). In other words, substance abuse and/or mental health problems increase the likelihood that delinquency and/or problem behavior will occur (Hawkins, Catalano & Miller, 1992). Individuals with substance abuse and/or mental health problems, for example, do not always offend or engage in problem behaviors, but these individuals are more likely to do so than individuals without these problems (Dembo, Dertke, Schmeidler, & Washburn, 1986; Dembo, la Voie, Schmeidler, & Washburn, 1987; Elliott, Huizinga, & Menard, 1989; Evens & Vander Stoep, 1997; Huizinga et al, 2000; Huizinga & Jakob-Chien, 1998; Kandel, Johnson, Bird, Weissman, Goodman, Lahey, Regier, & Schwab-Stone, 1999; Kataoka et al., 2001; Vander Stoep, Evens, & Taub, 1997; Weirson & Forehand, 1995).

This relationship is further reinforced by research that examines the prevalence of substance abuse and mental health disorders among children in the general population compared to juvenile offenders. 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 (see Table 2.1). 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. Table 2.1 contains general prevalence estimates and the ranges produced from these reviews. As shown in this table, the prevalence of substance abuse and mental health disorders is higher among juvenile offenders than children in the general population in each category. 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).

**Table 2.1: Summary of Mental Health Disorder Prevalence Rate Estimates for Youths in the General Population and Juvenile Justice System**

	<b>General Population*</b>	<b>Otto et al. Ranges</b>	<b>Weirson et al.</b>
	MECA		
Overall—Minimal Impairment	21%	n/a	n/a
Overall—Significant Impairment	11%	n/a	n/a
Overall—Extreme Impairment	5%	n/a	n/a
Conduct Disorder	4%	10-91%	90%
Substance Abuse Disorders	2%	13-81%	8-65%
Adjustment Disorders	n/a	4-28%	n/a
Personality Disorders	n/a	2-55%	10-40%
Psychotic Disorders	n/a	1-39%	1-30%

**Table 2.1: Summary of Mental Health Disorder Prevalence Rate Estimates for Youths in the General Population and Juvenile Justice System (Continued)**

	<b>General Population *</b>	<b>Otto et al. Ranges</b>	<b>Weirson et al.</b>
ADD/ADHD	5%	1-38%	0%
Mood/Affective Disorders	6%	1-78%	10-30%
Anxiety Disorders	13%	1-10%	n/a
Depression	5%	27-35%	n/a
Post-Traumatic Stress Disorder	6%	41-41%	n/a
Oppositional Disorder	n/a	n/a	n/a
Mania	n/a	n/a	n/a

\*Taken from Schaffer et al. 1996

The ranges presented in Table 2.1 provide a starting point for estimating the prevalence of mental health disorders among juvenile offenders, but they are not without limitations. Each of the studies used to calculate estimates in Table 2.1 suffers from one or more methodological limitations (Cocozza & Skowrya, 2000; Corrado, Cohen, Hart, & Roesch, 2000; Grisso, 1999; Otto et al., 1992) and all estimates regarding adolescent mental disorders must be considered carefully because they inherently suffer from shortcomings related to diagnosing children and adolescents. Estimating the prevalence of disorders among juvenile offenders is often difficult because the DSM has been revised three times in the last two decades, and some of these changes have directly altered the criteria for diagnosing childhood specific disorders (e.g. attention deficit hyperactivity disorder, conduct disorder, and oppositional defiant disorder). Prevalence measures of mental health disorders are also tenuous because the developmental and contextual changes that characterize childhood and adolescence often prevent stable and accurate measures of mental health problems (Grisso, 1999; USDHHS, 1999). Despite these cautions, the ranges in Table 2.1 document the presence of mental health disorders

among juvenile offenders and the necessity to integrate these issues into a comprehensive juvenile justice policy.

### *Gender and Race Differences*

Does the prevalence of substance abuse and/or mental health problems vary by race and gender? To date, the answer to this question is unclear because studies often produce conflicting results. Historically, minority groups have been under diagnosed in the criminal justice system (Martin, & Grubb, 1990; Meinhardt, & Vega, 1987; Paradis, Horn, Yang, & O'Rourke, 1999) and more likely to receive correctional institution placements than mental health facility placements (Atkins et al. 1999; Fabrega, Ulrich, & Mezzich, 1993; Herz, 2001b; Kaplan & Busner, 1992; Kilgus, Pumariega, & Cuffe, 1995; Lewis, Balla, & Shanok, 1979; Lewis, Shanok, Cohen, Kligfeld, & Frisone, 1980; Lyons et al., 2001; Mason & Gibbs, 1992). Scant research currently examines prevalence differences across race among juvenile offenders but when available, results reveal few, if any, differences.

Female offenders, in contrast, have historically been over diagnosed for deviant behavior and more likely than their male counterparts to receive mental health placements (Barnum, Famularo, Bunshaft, Fenton, & Bolduc 1989; Federle & Chesney-Lind, 1992; Herz, 2001b; Lewis, Shanok, Cohen, Kligfeld, and Frisone 1980; Lewis, Shanok, and Pincus 1982; Phillips & DeFleur, 1982; Westendorp, Brink, Roberson, and Ortiz 1986; Willemsen & van Schie, 1989). Yet recent research indicates that the current gender gap may reflect actual differences in treatment need. Several studies have documented higher prevalence rates for female offenders and correlated these differences to the complex circumstances that often bring female offenders into the juvenile justice

system such as abuse and other traumatic experiences (Casper, Belanoff & Offer, 1996; Cauffman et al, 1998; Dembo, Williams & Schmeidler, 1993; Huizinga et al. 2000; Kataoka et.al., 2001; Prescott, 1997; Prescott, 1998; Timmons-Mitchell et al. 1997). Other studies, in contrast, found no gender differences in the prevalence of substance abuse or mental health disorders across gender (Teplin et.al., 2001; Wasserman & McReynolds, 2001). This debate continues and is often mired in measurement issues; however, the conflicting results may simply reflect varying levels of need at different stages rather than inaccurate estimates.

#### 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). The results of this study were:

- 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*

To further examine the role of mental health problems among Nebraska juvenile offenders, a study was conducted at the pre-disposition investigation (PDI) stage of the juvenile justice process using the Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2: Grisso & Barnum, 2000; see Appendix 2 for a copy of this instrument). The MAYSI-2 was selected for this study because it (1) was designed to identify symptoms of mental health problems; (2) has demonstrated psychometric properties on offender populations (i.e., reliability and validity); (3) is quick and easy to administer, score and interpret; and (4) does not require specific training or the expertise of a mental health

professional (Cocozza & Skowrya, 2000; Grisso and Barnum, 2000; Grisso, Barnum, Fletcher, Cauffman, & Peuschold, 2001).

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. The response format is anchored to “ever in the past” for the items related to the Traumatic Experiences Scale and to the “past few months” for all other items. Table 2.2 provides a brief description of each of the MAYSI-2 scales taken from Grisso and Barnum (2000: p 9). 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).

**Table 2.2: Description of MAYSI-2 Scales \***

<b>Scale Name</b>	<b>Brief Descriptions</b>
Alcohol/Drug Use	<ul style="list-style-type: none"> <li>• Frequency of substance use</li> <li>• Negative consequences of substance use</li> <li>• Risk factors for abuse</li> </ul>
Angry/Irritable	<ul style="list-style-type: none"> <li>• Presence of angry mood and thoughts</li> <li>• Presence of irritability and risk of impulsive reactions</li> <li>• Behavioral expression of anger</li> </ul>
Depressed/Anxious	<ul style="list-style-type: none"> <li>• Manifestations of anxiety and inner turmoil</li> <li>• Presence of a depressed mood</li> </ul>
Somatic Complaints	<ul style="list-style-type: none"> <li>• Experiences bodily discomforts associated with distress</li> <li>• Risk of psychological distress not otherwise evident</li> </ul>
Suicide Ideation	<ul style="list-style-type: none"> <li>• Thoughts and intentions to harm oneself</li> <li>• Risk of suicide attempts or gestures</li> </ul>
Thought Disturbances (Boys Only)	<ul style="list-style-type: none"> <li>• Unusual beliefs and perceptions associated with psychotic behaviors</li> </ul>
Traumatic Events	<ul style="list-style-type: none"> <li>• Lifetime exposure to events such as abuse, rape, observed violence.</li> <li>• Risk of trauma-related instability in emotion/perception</li> </ul>

\*Descriptions taken from Grisso and Barnum, 2000.

### *Data and Methods for Current Study*

Data were collected in 13 Probation Districts throughout the state between July 9, 2001 and September 30, 2001. Following the PDI interview, Probation Officers were asked to give a study booklet to the offender. This booklet contained a consent form for participation, the MAYSI-2 survey, and a background information sheet. If the offender agreed to participate, he/she indicated this choice and completed the MAYSI-2 survey. The Probation Officer then completed the background information sheet from the information collected during the interview. If the offender declined to participate, the choice was noted and the remainder of the booklet was left uncompleted. Data collection was originally set for two months, but to increase the number of completed surveys, the study was extended until the end of September. 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% (see Table 2.3).

**Table 2.3: Pre-Disposition Investigation Mental Health Study Response Rates**

<b>Category</b>	<b>n</b>	<b>%</b>
Youth Approached	357	100%
Youth Refused	115	32%
Youth Agreed	243	68%
Scale Information Missing	11	---
Final Response Rate	232	65%

The MAYSI-2 survey collected information related to substance use and mental health problems and the Background Information Sheet captured offender demographics, adjudicated offense charge, agency screening tool results, previous history in the juvenile justice system, current diagnoses, treatment history, and functioning at home and school. Reliability and validity analyses replicated the results found in Grisso and Barnum

(2000), justifying the use of recommended cut-off points for the current data.<sup>1</sup> 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). By using these 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.<sup>2</sup>

### *Sample Description*

As shown in Table 2.4, the sample was mostly male (64%), White (67%), and older than 14 (76%). The top four adjudicated offenses were theft (22%), alcohol or drug-related charges (22%), assault (15%), and status offenses (10%); 21% of these offenders had been on probation and/or been placed for a prior charge; and 10% of offenders had previously attended some level of treatment. Over one-third of the sample (37%) was eligible for Medicaid, and an offender’s status was unknown in 31% of the cases.

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<sup>1</sup> 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.

<sup>2</sup>The results presented in the following sections are primarily descriptive for the entire sample and across gender. When identifying group differences was desirable, appropriate statistical (e.g., chi-square, t-test, and ANOVA) procedures were performed.

**Table 2.4: Descriptive Information on the Entire Sample (N=232)**

<b>Characteristic</b>	<b>n</b>	<b>%</b>
<b>Gender</b>		
Male	149	64%
Female	83	36%
<b>Race</b>		
White	155	67%
African-American	44	19%
Latino	19	8%
Native American	7	3%
Other	6	3%
Missing	1	0%
<b>Age</b>		
14 and below	56	24%
15 and above	176	76%
<b>Adjudicated Offense Charge</b>		
Theft	51	22%
Alcohol or Drug	50	22%
Assault	34	15%
Status	24	10%
Burglary & Related	18	8%
Traffic	12	5%
Weapon	5	2%
Sexual Assault	3	1%
Robbery	3	1%
Other	30	13%
Missing	2	1%
<b>Probation/Placement in the Past</b>		
Yes—Probation	25	11%
Yes—Placement	19	8%
Yes—Both	8	3%
Don't Know	1	<1%
<b>Previous Treatment</b>		
No	210	90%
Yes	22	10%
<b>Medicaid Eligibility</b>		
Eligible	86	37%
Ineligible	74	32%
Don't Know	73	31%

*Prevalence Results*

1. Prevalence

The cut-off levels and results for each of the MAYSI-2 scales are displayed in Table 2.5 for the entire sample and across gender. As mentioned earlier, caution scores indicate possible clinical significance whereas warning scores indicate immediate need for evaluation and intervention. Based on these results, it appears that 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, slightly less than three-quarters of this sample reported at least one traumatic experience in their life. As shown in this table, 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 2.5: Proportion of Youths at or above the Caution and Warning Cut-Off Scores**

	Caution		Warning	
	Cut-Off Score*	Percent at or above Cut-Off	Cut-Off Score	Percent at or above Cut-Off
<b>Alcohol/Drug Use</b>				
Entire Sample	4-6	11%	7+	3%
Boys Only	4-6	11%	7+	5%
Girls Only	4-6	11%	7+	1%
<b>Angry/Irritable</b>				
Entire Sample	5-7	17%	8+	13%
Boys Only	5-7	15%	8+	11%
Girls Only	5-7	20%	8+	18%

**Table 2.5: Proportion of Youths at or above the Caution and Warning Cut-Off Scores (Continued)**

	Caution		Warning	
	Cut-Off Score*	Percent at or above Cut-Off	Cut-Off Score	Percent at or above Cut-Off
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.

Next, gender differences were examined by comparing the means for each scale in Table 2.6. The results of this analysis indicate 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 scales.

**Table 2.6: Comparison of Scale Means across Gender Groups**

	Boys	Girls	t-Value	Probability Level
Alcohol/Drug Use				
Mean	1.51	1.18	1.23	.20
Std. Deviation	2.04	1.80		
Angry/Irritable				
Mean	2.95	3.85	-2.36	.02
Std. Deviation	2.74	2.87		

**Table 2.6: Comparison of Scale Means across Gender Groups (Continued)**

	<b>Boys</b>	<b>Girls</b>	<b>t-Value</b>	<b>Probability Level</b>
<b>Depressed/Anxious</b>				
Mean	1.23	1.98	-2.73	.01
Std. Deviation	1.77	2.11		
<b>Somatic Complaints</b>				
Mean	1.85	2.35	-2.05	.04
Std. Deviation	1.76	1.84		
<b>Suicide Ideation</b>				
Mean	.34	1.00	-3.46	.00
Std. Deviation	.99	1.53		

Differences in the prevalence of mental health problems were also compared across race. In contrast to gender comparisons, the results contained in Table 2.7 show that average scale scores 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. Although not significant at the  $p < .05$  level, a marginal difference was also found for the Depressed/Anxious scale, indicating that Latino offenders had a slightly higher scale mean than any other group.

**Table 2.7: Comparison of Scale Means across Race/Ethnicity**

	<b>White (n=155)</b>	<b>African- American (n=44)</b>	<b>Latino (n=19)</b>	<b>F-Value</b>	<b>Probability Level</b>
<b>Alcohol/Drug Use</b>					
Mean	1.59	.89	.84	3.13	.04
Std. Deviation	2.11	1.26	1.61		
<b>Angry/Irritable</b>					
Mean	3.30	3.55	3.21	.15	.86
Std. Deviation	2.87	2.89	2.95		
<b>Depressed/Anxious</b>					
Mean	1.32	1.86	2.16	2.52	.08
Std. Deviation	1.85	2.06	2.46		

**Table 2.7: Comparison of Scale Means across Race/Ethnicity (Continued)**

	<b>White (n=155)</b>	<b>African- American (n=44)</b>	<b>Latino (n=19)</b>	<b>F-Value</b>	<b>Probability Level</b>
<b>Somatic Complaints</b>					
Mean	2.10	1.82	2.32	.63	.53
Std. Deviation	1.89	1.48	1.77		
<b>Suicide Ideation</b>					
Mean	.49	.82	.89	1.74	.18
Std. Deviation	1.20	1.30	1.70		

## 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 (see Table 2.8). 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.

**Table 2.8: Co-Morbidity Rates among Male and Female Offenders**

	<b>Using Caution Cut-Offs</b>	<b>Using Warning Cut-Offs</b>
<b>At least <u>Two</u> of the MAYSI-2 Scales</b>		
Boys	24%	9%
Girls	28%	13%

Tables 2.9 and 2.10 further clarify the presence of co-morbidity by displaying the percentage of offenders that fell in the caution or warning categories for two scales. For instance, Table 2.9 shows that 8% of offenders scored above these cut-off points for both

Alcohol/Drug Use and Angry/Irritable, 17% scored high for both Angry/Irritable and Depressed/Anxious, 16% scored high for Depressed/Anxious and Somatic Complaints, and so on. These findings demonstrate that the most common occurrence of co-morbid problems was between Angry/Irritable and Somatic Complaints (21%). More generally, it appears that co-morbidity was more likely to occur between Angry/Irritable, Depressed/Anxious, Somatic Complaints, and Suicide Ideation symptoms than between Alcohol/Drug Use and any of the remaining scales.

**Table 2.9: Morbidity and Comorbidity Rates among Offenders in the Entire Sample**

	<b>Alcohol/ Drug</b>	<b>Angry/ Irritable</b>	<b>Depressed/ Anxious</b>	<b>Somatic Complaints</b>
Angry/Irritable	8%			
Depressed	5%	17%		
Somatic Complaints	9%	21%	16%	
Suicide Ideation	4%	11%	11%	12%

Table 2.10 displays the same information male and female offenders separately. The results are similar to the entire sample, but the prevalence of co-morbidity involving Angry/Irritable, Depressed/Anxious, Somatic Complaints, and Suicide Ideation were amplified for female offenders. Twenty-three percent of female offenders scored high on Angry/Irritable and Depressed/Anxious compared to 13% of male offenders; 18% of female offenders scored high on Angry/Irritable and Suicide Ideation compared to 7% of male offenders; 22% of female offenders scored high on Depressed/Anxious and Somatic Complaints compared to 13% of male offenders; and 22% of female offenders scored high on Somatic Complaints and Suicide Ideation compared to only 7% of male offenders.

**Table 2.10: Morbidity and Comorbidity Rates among Male Offenders (n=149) and Female Offenders (n=83)**

	<b>Alcohol/ Drug</b>	<b>Angry/ Irritable</b>	<b>Depressed/ Anxious</b>	<b>Somatic Complaints</b>	<b>Suicide Ideation</b>	<b>Thought Disturb. (Boys)</b>
	%	%	%	%	%	%
Alcohol/Drug		9%	5%	8%	3%	6%
Angry/Irritable	7%		13%	17%	7%	12%
Depressed	6%	23%		12%	5%	12%
Somatic	10%	28%	23%		7%	15%
Suicide	5%	18%	22%	22%		5%

\*Correlations for Boys found on the upper diagonal and correlations for Girls found on the lower diagonal.

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 2.11, 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 2.11: Comparison of Problem Alcohol/Drug Use across Screening Tools**

<b>Instrument</b>	<b>N*</b>	<b>No Problem</b>	<b>Caution</b>	<b>Warning</b>
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 2.12 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 2.12). 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 2.12: Co-occurrence Rates by Substance Abuse Instrument**

	<b>MAYSI-2 n=34</b>	<b>ACDI n=86</b>	<b>SSI n=73</b>
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, Offending, and 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, previous experience in the juvenile justice system, problems at school, and family conflict. Table 2.13 displays how problem use and/or mental health problems are distributed across offense type. As shown in this table, problem use and/or mental health problems permeate all offense categories but appear 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.

**Table 2.13: Distribution of Offenses Committed by Offenders Exceeding One or More MAYSI Cut-Off Points**

	<b>Entire Sample</b>	<b>Male Offenders Only</b>	<b>Female Offenders Only</b>
	n=120	N=69	n=51
<b>Distribution across Offense Type</b>			
Theft	24%	19%	31%
Alcohol/Drug	22%	23%	22%
Assault	15%	12%	20%
Status	9%	6%	14%
Burglary & Related	8%	13%	2%
Traffic	3%	6%	
Weapon	2%	3%	2%
Sexual Assault	1%	1%	
Robbery	2%	3%	
Other	12%	14%	10%
Total	100%	100%	100%

Gender differences are apparent when past experience in the juvenile justice system, school problems, and family conflict were considered (Tables 2.14 and 2.15). Although male offenders were equally as likely to have past experience in the juvenile justice system regardless of mental health problems (25% compared to 28%), female offenders with one or more mental health problems were more likely to have experience in the system (22%) than their counterparts without mental health problems (6%).

**Table 2.14: Past Experience with the Juvenile Justice System among Male and Female Offenders**

Past Experience	Entire Sample N=231		Male Offenders n=148		Female Offenders n=83	
	No MH Problem	1+ MH Problem	No MH Problem	1+ MH Problem	No MH Problem	1+ MH Problem
No	78%	77%	72%	75%	94%	78% <sup>1</sup>
Yes	22%	23%	28%	25%	6%	22%

<sup>1</sup> Indicates that differences are statistically significant ( $p < .10$ ).

Similar results were found with regard to school problems. 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 2.15: 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%
Family Problems						
No	59%	37%*	58%	39%*	62%	35%*
Yes	41%	63%	42%	61%	38%	65%

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

## Discussion

Previous research indicates that substance abuse and mental health problems are risk factors for delinquency and that offenders are more likely to suffer from a mental health disorder than children in the general populations. Data were collected at the pre-disposition stage of the juvenile justice process to document the role of substance abuse and mental health problems among juvenile offenders in Nebraska. Findings indicated that 52% of this sample had mental health and/or substance abuse symptoms. Higher prevalence rates were found for Angry/Irritable (40%), Somatic Complaints (35%) and Depressed/Anxious (23%) while lower rates (14%) were reported for Alcohol/Drug Use and Suicide Ideation. No gender differences were found for Alcohol/Drug Use, but female offenders scored higher than male offenders on all remaining scales. In contrast to gender comparisons, average scale scores differed across race/ethnicity only in the case of Alcohol/Drug Use, with White offenders scoring higher.

This study also examined the distribution of mental health and substance abuse problems with regard to co-morbidity. More than one third of both male and female offenders scored in the problem range for at least two MAYSI-2 scales. Co-morbidity was more likely to occur between Angry/Irritable, Depressed/Anxious, Somatic Complaints, and Suicide Ideation symptoms and was higher among female offenders than male offenders. The results regarding the co-occurrence of substance abuse with another mental health problem demonstrated the impact of using different screening tools. Probation's screening tools produced higher estimates of potential substance and lower estimates of co-occurrence than those from the MAYSI-2 instrument. In other words, the Probation tools appeared to be a more sensitive measure of substance abuse, and

offenders identified by these tools were more likely to only have a substance abuse problem rather than multiple mental health problems.

Finally, the relationship between substance abuse and/or mental health problems and other offender characteristics was examined. The presence of substance abuse and/or mental health problems was distributed across all offense categories but was concentrated among offenders charged with theft, alcohol/drug offenses, and assault. Offenders with substance abuse and/or mental health problems were more likely to experience family conflict, and female offenders with substance abuse/mental health problems were more likely to have previous juvenile justice contact and experience school problems than females without problems.

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

In 1899, the Illinois State Legislature established the first juvenile court, which created a specialized system to “diagnose” and “treat” juvenile problem behaviors (i.e., delinquent and status offending; Conrad & Schneider, 1992; Ferdinand, 1991; Rothman, 1980). Realization of this goal fell short, however, as juvenile courts relied on probation officers rather than psychiatric or psychological professionals to guide intervention (Rothman, 1980). As juvenile justice evolved throughout the 20<sup>th</sup> 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” (see Appendix 3A for a copy of this survey). Juvenile Justice Specialists were chosen because they arguably know their state’s juvenile justice system and its ability to deliver treatment services to juvenile offenders; however, Specialists were encouraged to pass the survey to an appropriate state representative if they did not know the information requested in the survey. Two to three follow-up calls were used to elicit participation yielding 26 completed surveys (46% response rate), of which 24 were from states and 2 were from commonwealths. Juvenile Justice Specialists completed 39% of these surveys and a different representative completed the remaining surveys.

### 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. As displayed in Table 3.1, 30% of these 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.

**Table 3.1: Summary of Agencies/Services Located within A Juvenile Justice Administration (N=26)\***

<b>Number of Agency/Services</b>	<b>N (%)</b>
0-1	8 (30%)
2-3	7 (27%)
4-5	9 (35%)
6	2 (8%)

\* Agencies specified in the survey included: Probation, Correctional Facilities, Youth Residential Facilities, Mental Health Services, Substance Abuse Services, and Drug Treatment Court Programs.

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. To more clearly understand the impact of these barriers, each one must be defined and assessed with regard their current role in juvenile justice systems throughout the United States.

### Obstacles and Solutions to Building Effective Systems of Care

#### *Lack of Interagency Collaboration*

The lack of collaboration, or partnering, within and between juvenile justice, social service, and behavioral health agencies hinders systems of care because conflicting philosophies, guidelines, and terminology often preclude the integration of agency services to address gaps in any one agency (Dechillo, Koren, & Mezera, 1996: p. 390; see also Barnum & Keilitz, 1992; Bazelon Center for Mental Health Law, 2000; Cellini, 2000; Kamradt, 2000; Modlin et. al., 1976; Saxe et al., 1988; Stroul, 1996a, 1996b; Stroul & Friedman, 1996). Table 3.2 illustrates the extent to which formal linkages exist across juvenile justice agencies. Most of the states represented in this study reported

formal linkages between agencies at the state level (80%), county level (73%), and county/state levels (73%), but it is clear from these findings that these linkages were more likely to occur “some of the time.” Of those with formal linkages, only 38% of the state linkages, 19% of the county linkages, and 15% of the linkages between state and county agencies occurred “a lot.”

**Table 3.2: Summary of Survey Responses Related to System Collaboration (N=26)**

Formal Agency Linkages Exist at the...	n (%) Reporting:	
	“Some”	“A Lot”
State Level	11 (42%)	10 (38%)
County Level	14 (54%)	5 (19%)
(Between) State and County Levels	15 (58%)	4 (15%)

The lack of interagency collaboration reduces the likelihood that agencies will share important information about the offender (Cellini, 2000; Kamradt, 2000; Redding, 2000). Without sharing this information, agency personnel as well as service providers must operate without important knowledge of previous interventions and the offender’s level of risk to self and the community (Redding, 2000). Not only does this create a dangerous situation for agency personnel, treatment staff, and other program clients but it also casts doubt on whether the current treatment programming is “appropriate” (Kamradt, 2000; Stroul & Friedman, 1996).

Improving collaboration through information sharing requires juvenile justice agencies to resolve interagency conflicts and build on each other’s strengths to overcome their own weaknesses. By establishing this type of interaction, agencies enhance their communication and establish a foundation from which accurate identification and appropriate services become possible (Barnum & Keilitz, 1992; Coccozza & Skowrya, 2000; Redding, 2000; Roberts, 1994; Stroul & Friedman, 1996). A starting point in this

process is to develop comprehensive treatment plans based on information from all juvenile justice agencies. Next, key juvenile justice agencies need to share an information system that captures offenders’ case histories and the progress made on their current case/treatment plans.

Table 3.3 contains state representative responses to items related to the use of coordinated case plans and interagency communication. Although coordinated case plans and information sharing were characteristic of a majority of the states, the use of coordinated case plans (73%) was more prevalent than information sharing across juvenile justice agencies (57%). In both cases, however, these activities occurred “some of the time” more often than “a lot.” Management information systems also existed in over half the states: 54% of the states used information systems to connect juvenile justice agencies, and 61% used information systems to connect juvenile justice agencies with social service agencies. Information systems were not used regularly by all of these states, but a larger proportion of states used these information systems regularly (i.e., “a lot”) than irregularly (i.e., “some of the time”).

**Table 3.3: Summary of Survey Responses Related to Collaboration and Organizational Location of Juvenile Justice Agencies (N=26)**

Item	n (%) Reporting:	
	“Some”	“A Lot”
Mental health/substance abuse treatment plans are coordinated with juvenile justice care plans.	15 (58%)	4 (15%)
Information on clients is consistently shared across agencies.	11 (42%)	4 (15%)
A management information system is in place to connect all juvenile justice agencies.	6 (23%)	8 (31%)
A management information system is in place to connect all juvenile justice agencies with social service agencies.	4 (15%)	12 (46%)

### *Inconsistent Screening and Evaluation*

Screening and evaluation play a critical role in matching offender needs to appropriate treatment programming. Screening refers to an initial assessment by juvenile justice professionals to identify whether further evaluation by a mental health and/or substance abuse professional is necessary. Evaluations (also referred to as Assessments) are more thorough examinations by mental health and/or substance abuse professionals to determine whether treatment is necessary and if so, what level of care is appropriate (Herz, 2001a). Screening processes typically vary across juvenile justice agencies or do not occur at all, and evaluation processes are subject to the evaluators' discretion. In states where screening and evaluation processes are in place across agencies, the processes are often inadequate because the tools are too long, too complicated to administer, and/or have limited evidence of reliability and validity (Cocozza & Skowyr, 2000). Consequently, the lack of standardization establishes a subjective pathway to identify offender treatment needs and makes it difficult to assess the actual need in the population, the accuracy of the evaluations completed, and the appropriate use of treatment and resources (Barnum & Keilitz, 1992).

To be used effectively, the screening process should be standard across agencies, tested for reliability and validity, and used to justify the need for further evaluation (Barnum & Keilitz, 1992; Cellini, 2000; Whitbeck, 1992). The evaluation process should contain consistent elements and a standard reporting process for treatment recommendations. By implementing these features, the process of identifying the need for treatment and accessing appropriate services is applied equally to offenders and limited resources are used more effectively. Additionally, it enables the state to forecast

the overall need for mental health and substance abuse services and respond better to offender treatment needs (Barnum & Keilitz, 1992; Cocozza, 1992).

Table 3.4 summarizes state representative responses related to screening for mental health and substance abuse and treatment need. Approximately three-quarters of surveyed states used mental health screening instruments (73%) and substance abuse screening instruments (78%) to identify treatment need and over half of these states used instruments “a lot” of the time (54% and 58% respectively). Overall, the use of standardized screening processes was nearly identical for mental health (73%) and substance abuse (69%); however, standardized processes were used less consistently (i.e., “a lot”) than the instruments alone (38% and 42%).

**Table 3.4: Summary of Survey Responses Related to Screening for Treatment Need (N=26)**

Item	n (%) Reporting:	
	“Some”	“A Lot”
Juvenile justice agencies use mental health screening instruments to identify offenders’ treatment need.	5 (19%)	4 (54%)
Juvenile justice agencies use substance abuse screening instruments to identify offenders’ treatment need.	5 (19%)	15 (58%)
Juvenile justice agencies screen for mental health treatment needs using a standardized process.	9 (35%)	10 (38%)
Juvenile justice agencies screen for substance abuse treatment needs using a standardized process.	7 (27%)	11 (42%)

### *Availability of Treatment*

#### 1. Availability of Services across Juvenile Justice Agencies

Once the need for treatment is identified, an effective system of care depends on the juvenile justice system’s ability to access treatment as soon as possible in the juvenile justice process. Juvenile justice agencies, however, can only access treatment if the services are available, which raises two questions: (1) to what extent do all juvenile

justice agencies access treatment services, and (2) are there enough services available to adequately address offender substance abuse and mental health treatment needs? The responses contained in Table 3.5 provide some insight into these questions. Sixty-nine percent of states represented in the survey reported that mental health and substance abuse treatment was available at all stages of the juvenile justice system, but only 15% reported that these services were available “a lot.” Substance abuse treatment was more available than mental health treatment generally (81%: 69%) and appeared to be more consistent (i.e., “a lot”) than mental health treatment (27%: 15%).

Responses were less positive with regard to adequacy. Less than half of state (35%) representatives believed that mental health treatment services were adequate to meet the offender need, and approximately half thought substance abuse services were adequate (49%). Very few of these respondents, however, reported that substance abuse (11%) or mental health (4%) services were adequate on a regular basis.

**Table 3.5: Summary of Survey Responses Related to the Availability of Treatment Services (N=26)**

<b>Item</b>	<b>n (%) Reporting:</b>	
	<b>“Some”</b>	<b>“A Lot”</b>
Mental health treatment services are provided at all stages of the juvenile justice system.	14 (54%)	4 (15%)
Substance abuse treatment services are provided at all stages of the juvenile justice system.	14 (54%)	7 (27%)
Mental health treatment services are available to adequately address treatment need among juvenile offenders.	8 (31%)	1 (4%)
Substance abuse treatment services are available to adequately address treatment need among juvenile offenders.	10 (38%)	3 (11%)

## 2. Availability of Funding

The availability of treatment services throughout the juvenile justice system is frequently contingent on an agency's ability to pay for services. Since mental health and substance abuse treatment services are low priorities for funding, juvenile justice agencies often seek funding through external sources such as Medicaid (Stroul & Friedman, 1996). Use of Medicaid funds often complicates juvenile justice processing because these funds are regulated by policies, procedures, and terminology different from the juvenile justice system (Barnum & Keilitz, 1992). Consequently, Medicaid regulations drive the availability of treatment services rather than individual need, which significantly decreases a system's ability to address a range of treatment needs appropriately (Barnum & Keilitz, 1992; Redding, 2000; California Legislature Senate Select Committee of Developmental Disabilities and Mental Health, 2000).

Table 3.6 illustrates the role of Medicaid among various states. As shown in this table, all types of funds are used across these states, but more states reported using state funds (69%) and Medicaid funds (70%) than federal, non-Medicaid funds (61%). Furthermore, states relied on Medicaid funds more often (i.e., "a lot":35%) than state funds (27%).

**Table 3.6: Summary of Survey Responses Related to Funding for Treatment Services (N=26)**

Type of Funds Used for Treatment Services	n% Reporting:	
	"Some"	"A Lot"
State Funds	11 (42%)	7 (27%)
Medicaid Funds	9 (35%)	9 (35%)
Federal, Non-Medicaid Funds	11 (42%)	5 (19%)

Using Medicaid to improve offenders' access to treatment is feasible if states create ways to blend funding from various sources and Medicaid regulations are flexible

with regard to behavioral health services (Stroul & Friedman, 1996). According to the state survey, it appears that only a few states have streamlined funding streams or integrated flexibility into Medicaid. Forty-six percent of state representatives reported that their state used blended funding, but it was used “a lot” in only 8% of these states. Additionally, Medicaid coverage in 42% of the states was based on medical necessity (see Chapter 4, pg. 67 for an explanation of medical necessity). Only one state representative (4%) reported that medical necessity did not apply to their state and 54% of the respondents did not know how to respond.

#### *Availability of Appropriate Services*

##### 1. Community-Based

Community-based treatment is an important characteristic of an effective system of care because it provides structured alternatives to residential treatment while preserving the family and community context within which the youth is placed (Cocozza & Skowyra, 2000; USDHHS, 1999; Friesen & Huff, 1996; Henggeler, 1994, 1997; National Mental Health Association, 2000; Redding, 2000; Saxe et. al., 1988; Stroul, 1996a, 1996b; Stroul & Friedman, 1996; Stroul & Goldman, 1996). Juvenile offenders with substance abuse and mental health problems are often placed in out-of-home placements such as residential treatment centers, psychiatric inpatient treatment, and correctional facilities because of safety rather than treatment need (Borduin, 1994; Friedman, 1994; Henggeler, 1997; Redding, 2000). However, these offenders rarely receive transitional services to help integrate them back into the community and retain the treatment effect. This is compounded by the fact that correctional institutions are not always equipped to handle or treat mental health and substance abuse problems.

As part of the state survey, respondents were asked about the use of out-of-home placements and community-based services for mental health services. As shown in Table 3.7, 50% of the respondents indicated that out-of-home placements were used for mental health treatment, but only 15% of these states reported using placements “a lot” of the time. Sixty-one percent of the respondents believed that out-of-home and community-based programming were used appropriately, but 50% of these responses fell into the “some of the time” category.

**Table 3.7: Summary of Survey Responses Related to Appropriate Treatment (N=26)**

Item	n (%) Reporting:	
	“Some”	“A Lot”
Out-of-home placement is used for mental health service more than community-based services.	9 (35%)	4 (15%)
Both out-of-home placement and community-based services are appropriately used to address mental health problems.	13 (50%)	3 (11%)

## 2. Comprehensive Treatment—Family, Community, and School

Comprehensive treatment refers to broad-based programming that includes elements of family-, community-, and school-based interventions to increase the likelihood that families and communities are preserved and to improve the long-term effect of treatment (Henggeler, 1994; Jordan & Hernandez, 1990; National Mental Health Association, 2000; Roberts, 1994). Family-based treatment plays a significant role in effective treatment because the youth’s problems often stem from dysfunctional family settings, and without addressing these issues, the treatment is less effective (Henggeler, 1997; Redding, 2000; Roberts, 1994; Rodrigue, 1994; Whitbeck, 1992). In some cases, treatment programs fail to involve parents or guardians or hold them accountable for their child’s treatment regimens, but in other cases, parent/guardian(s) simply refuse to participate in programming despite program staff efforts to include them (Henggeler,

1997; Redding, 2000; Roberts, 1994). Unless state law gives the court authority to require parents' participation, there is no way to mandate parent/guardian participation in treatment. Conversely, when parents are involved in their child's treatment, they often lack the necessary skills to effectively advocate for their children with school officials, mental health providers, and juvenile justice professionals (Henggeler, 1997; Redding, 2000; Roberts, 1994).

Similar to family-based programming, integrating the community and school into treatment programming plays a critical role in effective treatment because it provides offenders with new skills to cope with and change the environment that contributed to their problem behaviors rather than simply removing them from it. The extent to which providers include family and educational programming is reflected in Table 3.8.

Overall, mental health and substance abuse treatment providers appeared to involve families in treatment programming (84%) than educational programming (58%), but educational programming was more consistent than family involvement. Whereas educational programming was split between "some of the time" and "a lot," a larger proportion family involvement was reported to occur "some of the time" than "a lot."

**Table 3.8: Summary of Survey Responses Related to Treatment Programming (N=26)**

Item	n (%) Reporting:	
	"Some"	"A Lot"
Mental health/substance abuse treatment providers involve families in youths' treatment program.	13 (50%)	9 (35%)
Mental health/substance abuse treatment providers involve school or educational programming in youths' treatment programs.	8 (31%)	7 (27%)

### 3. Offender Specific Programming

A significant barrier to treating mental health and substance abuse among offenders is the absence of integrated (i.e., behavior health and correctional) programming to address the special needs of offenders (Borduin, 1994; Friedman, 1994). Simply addressing an offender's mental health and substance abuse problems will not, in most cases, eliminate the behavior that brought the youth into the juvenile justice system. Although some juvenile offenders suffer from serious emotional disorders (i.e., early bipolar, schizophrenia, and personality disorders) that require extensive psychiatric care, mental health and substance abuse problems contribute to, rather than cause, offending for most offenders. Some youths, for instance, need more correctional programming than behavioral health programming because of a high number of social and environmental risk factors and relatively low levels of mental health problems and alcohol/drug use. Conversely, many offenders with long histories of offending and mental health problems and/or substance abuse may need more intensive behavioral health treatment in combination with intensive correctional programming. Without balancing behavioral health and correctional treatment relative to an offender's needs and risks, the juvenile justice system reduces the likelihood of positive outcomes (i.e., no re-offending and positive social functioning) and increases the extent to which youth behaviors are medicalized or labeled as medical problems suitable for medical treatment alone.

Multi-systemic therapy (MST) represents one program that that incorporates behavioral health and correctional programming (see Appendix 3B for the Nine Principles of MST). This therapeutic intervention targets chronic and/or violent juvenile offenders with mental health and/or substance abuse problems who are at-risk for an out

of home placement (Henggeler, 1997). MST incorporates risk and protective factors related to delinquency into the treatment plan for offenders. In other words, MST works to alleviate the presenting risk factors while strengthening a youth and family's protective factors (Henggeler, 1997). Goal-oriented treatment plans are developed in collaboration with the youth and his/her family, incorporating the strengths of the family and the risk and protective factors related to peers, school and the community. Treatment is then flexible in its effort to address the risk and protective factors affecting the youth and family. In sum, MST attempts to promote behavior change in the youth as well as assisting the parents in providing more structure and discipline for the youth.

Another example of effective programming for offenders is wraparound programming (Appendix 3C lists the Essential Elements of Wraparound Programming). Although wraparound programming was not originally designed for offenders, its principles correspond to the notion of integrated programming and its method has been adopted by juvenile justice systems throughout the nation (Dennis, 1999). Wraparound is a philosophy of care based on a planning process that involves the child and family and all other key stakeholders in the child's life to identify the necessary community services and supports needed to achieve a positive outcome (Golden, 1999). By definition, wraparound services are community-based, strength-based, culturally competent and flexible in both approach and funding. Services are integrated and team driven with the child and family integral members of the team. The team and relevant agencies are committed to replacing formal services with informal community supports in order to improve psychosocial functions of youth and their family in the youth's home and community so that out-of-home placements are less often used (Henggeler, 1997).

Underlying both MST and wraparound programming is the strength-based approach to intervention (see Appendix 3D for the Assumptions of the Strength Based Perspective). The strength-based perspective reframes the current situation to focus on the positive aspects or strengths that may help the youth change his/her future behavior rather than focusing on the deficits responsible for a youth's delinquent acts (i.e., the medical model of treatment; Clark, 1996; Saleebey, 1992). Interventions are based on the youth's and family's problem solving abilities and both the problem and intervention are discussed from the perspective of the youth and his/her family. Framing the problem in this way speeds up the problem-solving process and increases youth and family cooperation. This approach has advantages in juvenile justice. Because the family generates the problems and solutions, the perspective is more culturally sensitive than others. Additionally, strength-based approaches can reduce the costs of service provision by reducing the need for out-of-home placements, and they are easily integrated into other strategies and programs currently in place in the juvenile justice system (Clark, 1996).

Unfortunately, the state survey did not include questions about multi-systemic treatment, but it did ask state representatives about mental health and substance abuse providers' ability to treat offenders and the extent to which mental health services included wraparound services and strength-based treatment. Table 3.9 shows that while fifty-four percent of respondents believed that mental health and substance abuse providers were equipped to handle juvenile offender populations, only 8% of these responses fell into the "a lot of the time" category. Wraparound services were widely used by states included in the study. Over three-quarters of respondents (77%) felt that

wraparound services were included in mental health treatment, but once again, did not occur regularly since only 8% of the affirmative responses were in the “a lot of the time” category. Fifty-eight percent of state representatives believed that mental health services were strength-based and only 4% indicated that mental health services were strength-based “a lot.”

**Table 3.9: Summary of Survey Responses Related to Treating Offenders (N=26)**

Item	n (%) Reporting:	
	“Some”	“A Lot”
Mental health/substance abuse treatment providers are equipped to handle juvenile offender populations.	12 (46%)	2 (8%)
Mental health services for juvenile offenders often include wrap-around services.	18 (69%)	2 (8%)
Mental health services for juvenile offenders are strength-based.	14 (54%)	4 (15%)

### 3. Gender and Culturally Appropriate Treatment

Another barrier to providing offenders with appropriate treatment is the lack of gender and culturally specific programming (USDHHS, 1999; Friedman, 1994; Isaacs, 1992; Redding, 2000; Roberts, 1994). Since many programs do not incorporate age, gender, and culturally appropriate techniques, treatment is often general and fails to recognize important differences between different groups. In particular, gender specific programming with attention to issues such as sexual abuse, pregnancy, and parenting are lacking as are programs that incorporate important cultural differences, including language, into treatment programming (Prescott, 1998; Redding, 2000; Roberts, 1994; Stroul & Friedman, 1996; USDHHS, 1999). There are several ways to improve gender and cultural competency of treatment such as recruiting and hiring minority staff, training staff on cultural diversity, developing programs with a specific cultural emphasis,

offering bi-lingual treatment services, and involving key minority community leaders and support groups in the treatment program (Stroul & Friedman, 1996).

According to the State Survey responses displayed in Table 3.10, a similar proportion of states incorporated gender-based (57%) and culturally competent programming into mental health and substance abuse treatment programs. Both types of programming were more likely to occur “some of the time” rather than “a lot,” but gender-based programming appeared more consistent (23%) than culturally-competent programming (15%). In contrast, states were less likely to offer non-English speaking services (31%) and only one state (4%) did so “a lot.”

**Table 3.10: Summary of Survey Responses Related to Gender and Culturally Appropriate Treatment Services (N=26)**

<b>Item</b>	<b>n (%) Reporting:</b>	
	<b>“Some”</b>	<b>“A Lot”</b>
Mental health/substance abuse services incorporate gender-based programming.	9 (35%)	6 (23%)
Mental health/substance abuse services incorporate culturally-competent programming.	11 (42%)	4 (15%)
Mental health/substance abuse services incorporate non-English speaking programming.	7 (27%)	1 (4%)

*Program Evaluation*

Effective treatment reflects the improvement of mental health, reduction of criminal activity, or both, but several factors inhibit the evaluation of treatment programming (Stroul & Friedman, 1996). For instance, programs are often implemented without any connection to theory and plausible interventions; consequently, programs often lack clear goals and objectives specific to substance abuse and mental health (Gottfredson, 1984; Jordan & Hernandez, 1990; California Legislature Senate Select Committee of Developmental Disabilities and Mental Health, 2000). This is further

complicated by the conflicting goals (accountability v. rehabilitation) that often arise and stagnate communication between juvenile justice personnel and treatment providers, (Barnum & Keilitz, 1992; Friesen & Huff, 1996; Redding, 2000). Limited funding for programming also reduces the system's commitment to evaluation especially when funds are insufficient to cover implementation and evaluation costs. Similarly, many states do not maintain a research arm responsible for overseeing and monitoring the effectiveness of programs used to "treat" and rehabilitate offenders, which reduces the consistency and sometimes the quality of evaluations conducted. Consistent and quality evaluations provide states the opportunity to improve program effectiveness and determine "what works" for different populations. Over half (57%) of the surveyed states reported that evaluations were used to measure the effectiveness of mental health programming. Although program evaluation did not occur often (11%), this finding indicates that states recognize the importance of evaluation and are actively integrating it into program implementation.

#### The Role of Treatment "Best Practices" across Juvenile Justice Systems

Until now, the role of "best practice" approaches in state juvenile justice systems has been discussed generally. A more specific way to examine this issue is to compare states according to the number of best practice approaches currently implemented in their 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 3.11, 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%, 5 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 21<sup>st</sup> out of 26 states/commonwealths.

**Table 3.11: 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%

**Table 3.11: 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
12	Republic of Palau	23%	47%	13%	17%
13	Nevada	23%	40%	23%	13%
14	Wyoming	13%	50%	7%	30%
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. As shown in Table 3.12, most states implemented best practices in the past 5 years; consequently, many of these changes were difficult or impossible to evaluate.

**Table 3.12: Comparison and Rankings for Successful Best Practices Experiences across States**

Rank	State	Number of Changes in Past 5 Years	% Possible Best Practices (N=30)	Changes Available to Evaluate	Avg. Success of Best Practices*
1	South Dakota	16	53%	10	3.90
2	Republic of Palau	22	73%	19	3.79
3	Puerto Rico	21	70%	22	3.76
4	Delaware	23	77%	23	3.74

**Table 3.12: Comparison and Rankings for Successful Best Practices Experiences across States (Continued)**

Rank	State	Number of Changes in Past 5 Years	% Possible Best Practices (N=30)	Changes Available to Evaluate	Avg. Success of Best Practices*
5	Wyoming	11	37%	11	3.73
6	North Carolina	19	63%	7	3.71
7	Virginia	27	90%	17	3.56
8	Alabama	23	77%	22	3.45
9	South Carolina	25	83%	25	3.44
10	Florida	28	93%	28	3.43
11	Kansas	19	63%	19	3.42
12	Hawaii	9	30%	3	3.33
12	Idaho	18	60%	3	3.33
12	North Dakota	15	50%	15	3.33
13	Indiana	21	70%	7	3.29
14	Connecticut	25	83%	25	3.24
15	Nevada	9	30%	9	3.22
16	Missouri	26	87%	24	3.21
17	Arizona	11	37%	11	3.09
18	Nebraska	11	37%	1	3.00
19	Illinois	22	73%	21	2.95
20	Washington	14	47%	9	2.89
21	Oklahoma	6	20%	5	2.80
22	Wisconsin	27	90%	23	2.65
23	Tennessee	14	47%	14	2.57
24	Vermont	5	17%	1	2.00

\*Averages based on rankings for changes that could be evaluated only.

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 18<sup>th</sup> 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. The circuitous nature of this process is not surprising when one considers the different organizational structures that comprise juvenile justice systems and the growing reliance on Medicaid to pay for treatment services. 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?

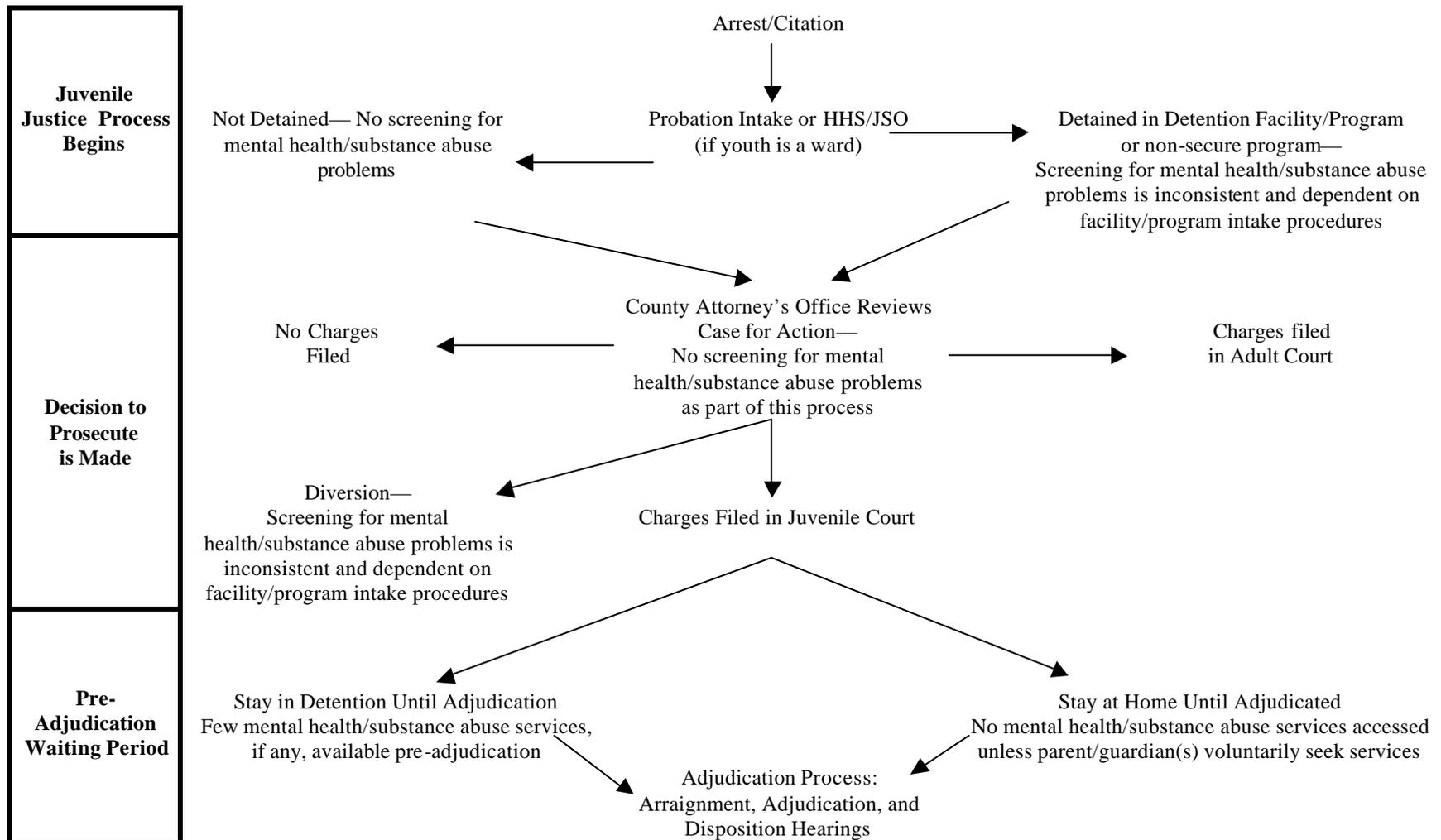
Figures 4.1 and 4.2 illustrate the ways in which treatment needs are identified and addressed throughout the Nebraska juvenile justice process. Specifically, Figure 4.1 documents this process for offenders prior to adjudication (i.e., before an offender is processed through the juvenile court and found responsible for the charges) and Figure 4.2 represents the ways in which treatment needs may be identified and addressed by the juvenile court after adjudication.

### Identifying the Need for Treatment

#### *Pre-Adjudication*

Following an arrest/citation, the law enforcement officer either detains the offender or releases him to a parent/guardian (see Figure 4.1). Released offenders will not be screened for mental health or substance abuse problems unless their parent/guardian voluntarily seeks help through private pay, private insurance, or public behavioral health services (i.e., Region offices). Whether detained offenders are screened depends on the facility or program in which they are held. Since counties carry the financial burden for pre-adjudication detention, state law does not mandate a screening process nor does it establish formal linkages between detention facilities/programs and state-based juvenile justice agencies (i.e., Office of Probation Administration and OJS). Consequently, screening for mental health and substance abuse problems is neither consistent nor standard across detention facilities/programs. Furthermore, how screening is completed and how the information is used to access intervention depends on the facility/program's policies and procedures, resources, and linkages to community-based treatment services.

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



Following the detention decision, the County Attorney's Office reviews the case and decides whether to (1) not charge the youth; (2) informally process the charges using diversion; or (3) formally charge the offender in adult or juvenile court. Mental health and substance abuse problems play no formal role in this decision-making, but such problems may impact this decision informally. For example, the county attorney may exclude an offender with a history of serious mental health and/or substance abuse problems from diversion despite legal eligibility; opt to formally charge the offender in order to access treatment; or drop the charges if the offender's family has the resources to access treatment.

If the attorney views diversion as an acceptable option, the offender may be screened depending on the individual diversion program guidelines. Like pre-adjudication detention, counties carry the financial responsibility for diversion and although counties are legally permitted to start diversion programs (section 29-3602 of the Revised Statutes of the State of Nebraska), they are not required to operate one nor are they required to adhere to any guidelines, program standards, or reporting standards. In some diversion programs, offenders are screened for mental health and substance abuse problems as a part of the intake process, but the extent to which this information is linked to further evaluation and services is dependent upon the diversion program's interest in and ability to provide such services.

To some extent, implementing and coordinating screening for mental health and substance abuse problems prior to adjudication is difficult 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*

Once a juvenile is adjudicated and found responsible for the charges, the judge has the option of ordering a pre-disposition investigation (PDI) and/or an Office of Juvenile Services (OJS) evaluation. In Separate Juvenile Court jurisdictions, judges order a pre-disposition investigation for almost all offenders and if further investigation is needed, an OJS evaluation is also ordered. In other areas of the state, many judges order OJS evaluations instead of PDIs, and in some cases, judges do not order either a PDI or OJS evaluation. The processes described in this section and displayed in Figure 4.2 characterize the procedures required by state administrators of Probation and OJS. As state-based agencies, individual Probation and OJS offices must follow these procedures, but each office may implement them differently and put additional policies and procedures in place that change the nature of the process slightly.

#### 1. Pre-Disposition Investigation (PDI)

Pre-disposition investigations are conducted by probation officers and include the administration of the Adolescent Chemical Dependency Inventory (ACDI: Risk and Needs Assessment, Inc., 1993) and structured interviews with the youths and their

parent/guardians. The ACIDI provides an initial assessment of substance abuse problems, and structured interviews capture social and background information such as school performance and behavior, mental health and substance abuse treatment history, living situation and family conflict. Although the PDI process does not include a specific screening process or tool for mental health problems, the ACIDI captures limited information on adjustment and distress related factors, and a conscious effort is made to identify signs and symptoms related to mental health problems during the structured interview. In turn, this information provides the basis for probation recommendations to judges regarding the need for further evaluation and appropriate disposition outcomes. Judges then use their discretion to order a mental health and/or substance abuse evaluation based on this information and any other information available to them. If further evaluations are necessary, judges will typically order an OJS evaluation unless the county of adjudication or the parent/guardian(s) can pay for one.

## 2. OJS Evaluation

OJS evaluations are professional assessments of the offender's social and family history, medical history and condition, psychological functioning, educational level, and drug and alcohol use, which are used to determine treatment needs and risk to the community. The Lincoln Regional Center and private providers contract with OJS to conduct these evaluations. Judges order OJS evaluations based on their personal assessment of need, PDI recommendations (if completed), prior history of mental health and substance abuse problems, and/or information from family, school, law enforcement, and attorneys. According to section 43-413(3) of the Nebraska Juvenile Code (1998), judges must also order an OJS evaluation for any offender placed into the permanent

custody (i.e., as a disposition) of OJS. Thus, access to OJS evaluations is based on statutory requirements and subjective decision-making rather than a consistent, standard screening process of all offenders processed through the juvenile justice system. Additionally, the information collected from the PDI is not always accessed by or provided to OJS caseworkers or evaluators, creating the potential for duplication since a substantial amount of the information collected in the OJS evaluations is also collected in the PDI (e.g., educational information, social and family information).

To begin the OJS evaluation process, a judge must make the offender a temporary or permanent OJS ward. Once the order for an OJS evaluation is made, an OJS evaluation coordinator is responsible for arranging the evaluation with the Lincoln Regional Center or an OJS-contracted evaluator. Completion of an OJS evaluation often takes several months from the time it is ordered. During this time, the judge can order the offender to remain in detention or at home depending on his danger to self and the community.

### 3. Neither PDI nor OJS Evaluation is Ordered

Although judges typically order a PDI and/or an OJS evaluation, a small proportion of adjudicated offenders complete neither (e.g., bench probation cases) and therefore, are not screened for mental health and substance abuse problems and do not access treatment services during or as a result of the juvenile justice process.

#### Accessing Mental Health and Substance Abuse Services

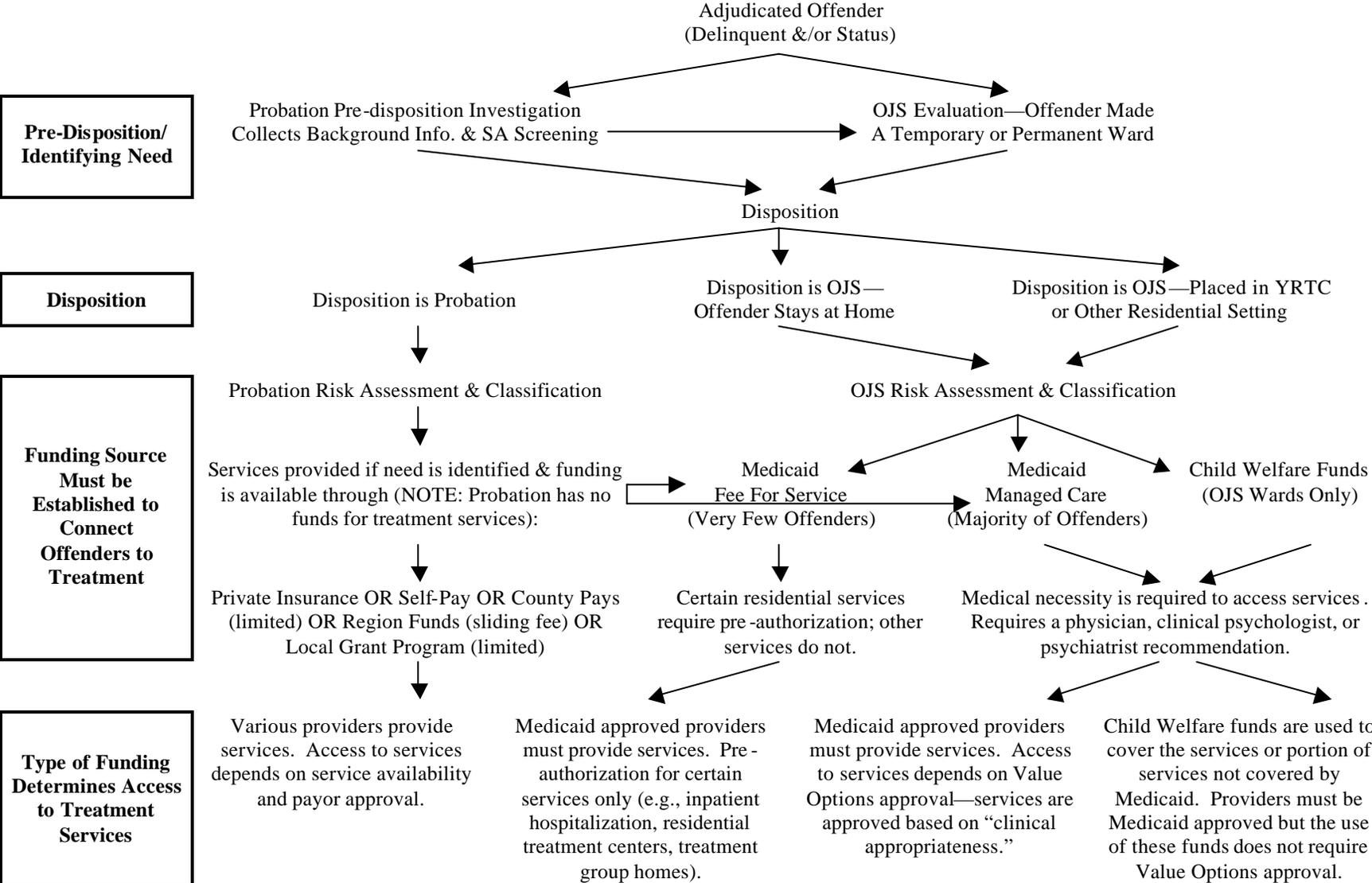
If mental health and substance abuse treatment services are delivered through the juvenile justice system, they must be based on evaluation recommendations and made part of the offender's disposition order. Offenders on probation as well as offenders

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 either 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. To access services in some areas, Probation and OJS work with their Behavioral Health Region, which are statutory organizations created to provide mental health and substance abuse services with the Division of Mental Health, Substance Abuse, and Addiction Services.

#### 1. Probation

Substance abuse treatment often occurs as part of probation especially when the county or family can pay for the treatment services, but mental health treatment is less consistently ordered as part of probation. Despite Probation's role in monitoring substance abuse treatment, officers have little control over the quality or quantity of treatment that a probationer receives because these decisions are often dictated by the program delivering the services or the agency paying for the services. If the county pays for the services, Probation or the court can dictate where offenders receive treatment, but when the family or insurance pays for the services, they chose the providers. Medicaid clients must access services from Medicaid-approved providers, and Region-contracted providers must provide the services when treatment costs are supplemented by Region funds. As noted in Figure 4.2, Probation can access treatment for offenders through Medicaid if the youth is eligible for coverage, but historically, Probation has not used Medicaid (except in certain areas) because it is complicated and requires probation officers to become well versed in an area set outside of their expertise.

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



## 2. OJS

If an OJS evaluation recommends treatment, judges may order OJS custody as a disposition to access the services needed. Once a youth is made a ward of the state, an OJS caseworker or Juvenile Services Officer (JSO) is responsible for implementing the evaluation recommendations. During this time, offenders remain at home or in a group home, youth shelter, or county-based detention facility. Waiting periods for appropriate treatment programming vary but often last several months due to long-waiting lists and the Medicaid approval process. Medicaid provides the primary payment source for treatment services for OJS; therefore, the Nebraska Medicaid Managed Care Program defines the treatment services available to offenders.

### *Who Provides Services to Offenders*

#### 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. Providers who treat offenders through private insurance may or may not meet Value Options, OJS, or Region criteria. The majority of mental health and substance abuse programs accessed by the juvenile justice system are not built for offenders; rather, offenders are added to the traditional program clientele. Some providers have started building programs for offenders because of the high number of referrals they receive and the special needs of this population (e.g., behavioral problems).

#### 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). Historically, the YRTC's have had limited funds to service their populations adequately; however, passage of the 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.

### 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. Each resident receives 48 hours of direct service every week including group counseling, individual counseling and therapy, and Alcoholics Anonymous meetings.

### 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 (i.e., a short term-crisis intervention and medication stabilization program staffed with medical psychiatric staff who assess and treat youth that suffer from major mental illness in an acute phase), residential treatment (i.e., 24-hour a day treatment addressing the mental health problems of individuals and teaching social and living skills), sex offender treatment (i.e., a community based long-term treatment program aimed at the treatment of individuals who have had sexual offenses) and Office of Juvenile Services evaluations. A substance abuse counselor is available for substance abuse treatment, but the LRC currently does not provide treatment for offenders with dual diagnoses.

## 5. 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 for youths and their families. Specifically, Professional Partner Programs are based on a strength-based, wraparound philosophy to provide individualized, family-centered, community-based services defined by need. These services are designed to treat youths who have a serious emotional disorder and are at risk of getting removed from home, committing a crime, failing high school, or other problem behavior. The program uses the team approach to unite individuals important in the child's life and culture and access treatment services, when necessary. The extent to which Region services are accessed by the juvenile justice system, however, depends on the local relationships between Regions and juvenile justice agencies.

#### 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. Families First and Foremost promotes 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. To date, the Families First and Foremost Planning Team has worked with OJS to simplify the intake process and to utilize community-based providers when possible. The project also plans to open an assessment center in January 2002.

#### 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. Some of these children are also involved in the juvenile justice system. The project is based on the wraparound philosophy (see Chapter 3, pg. 43 for more description of this philosophy) and maintains a no reject/no eject policy. Each child and family is part of a team of professionals and non-professionals who develop an individual treatment plan based on the needs of the child and family and least restrictive placements. This project also formalizes collaboration between the HHS Central Service Area and Region III Behavioral Health Services. Employees of both agencies involved in the project have been cross-trained in protection and safety issues and the wraparound process.

## 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. Each state must follow federal guidelines for Medicaid but can exercise various options that widen or constrict a state's application of Medicaid. Nebraska, for instance, controls its costs by limiting behavioral health services to children and administering Medicaid through a managed care system (Managed Care Plan Act, 1993). Additionally, Nebraska bases treatment approval on medical necessity (i.e., medical model application of Medicaid), which requires a physician, psychologist, or psychiatrist to verify the recommended services as necessary to the individual's basic health needs.

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), 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 consider another renewal in the summer 2002. These contracts are monitored through the Medicaid Office 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, and child welfare funds are 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 several reasons. First, 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. Secondly, a number of offenders processed in the juvenile justice system need some type of treatment services and many are eligible for Medicaid coverage because their families' income or ability to provide medical care (i.e., Kids Connection). Finally, and perhaps most importantly, 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.

*How Are Services for Offenders Accessed through Medicaid?*

Before services are accessed through Medicaid, an offender must have a pre-treatment assessment, which is a comprehensive review of psychosocial, medical, educational, and legal histories, the presenting problem and diagnosis, a mental status exam, and any other evaluations deemed necessary (i.e., substance abuse, psychiatric, sex offender risk—see Figure 4.3). Although the similarities between the pre-treatment assessment and OJS evaluation are numerous, Value Options will not accept an OJS

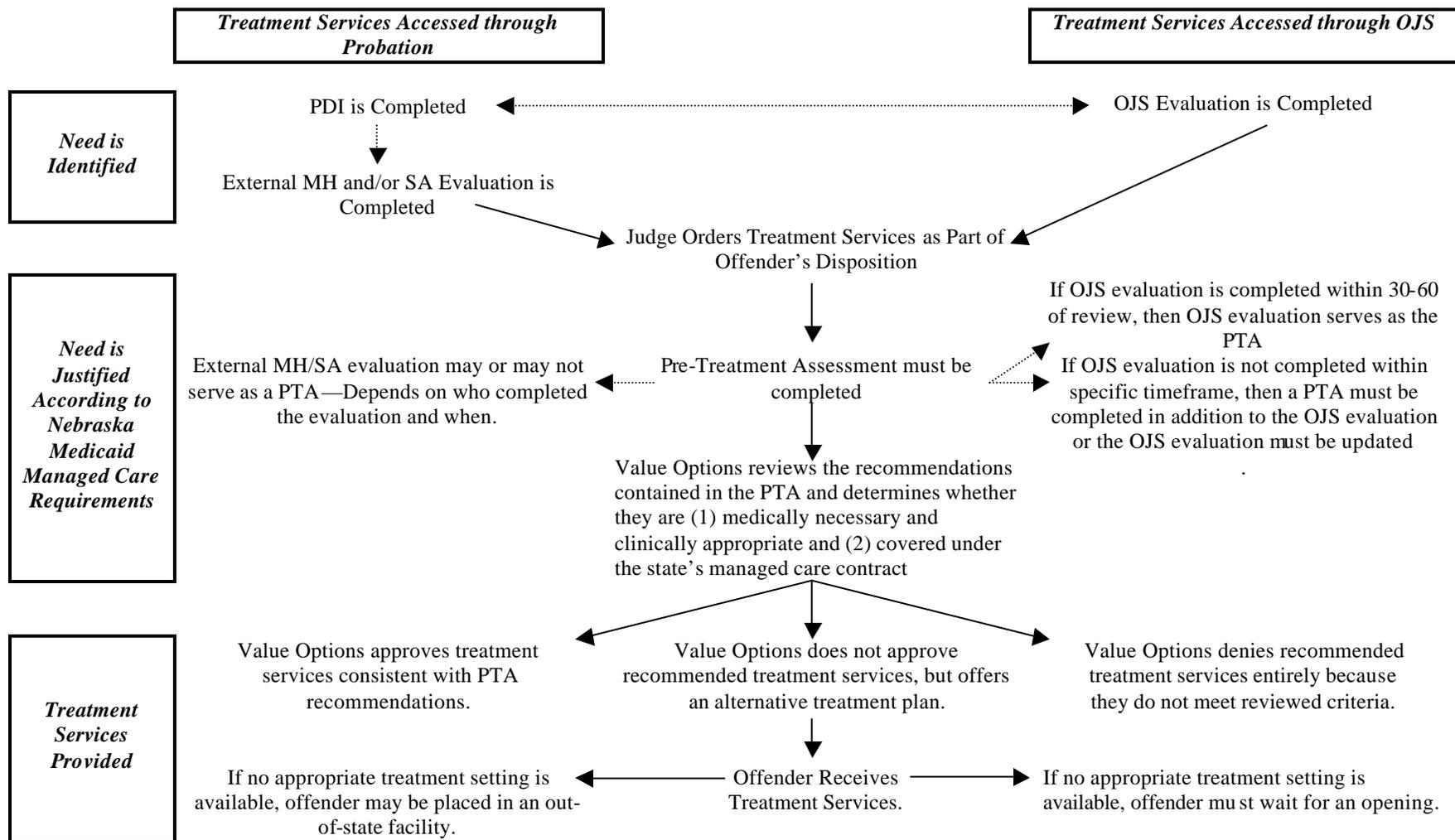
evaluation as a pre-treatment assessment if it was conducted outside of an accepted time frame (30-60 days before treatment). Given the delays in juvenile justice processing, this time frame is often exceeded, which requires either a new pre-treatment assessment or an update of the OJS evaluation. This situation creates substantial duplication and potentially decreases the reliability of the information because the offender and his/her family must answer the same questions several times on different occasions without moving forward in the process (see Figure 4.3).

After the pre-treatment assessment is completed, Value Options reviews the information to determine whether the recommendations are medically necessary and clinically appropriate, or in other words, whether the recommendations are:

1. Necessary to meet the basic health needs of the client and consistent with the behavioral health condition or diagnosis (as listed in the Diagnostic and Statistic Manual published by the American Psychiatric Association);
2. Consistent with national guidelines and standards of practice;
3. Of demonstrated value (i.e., supported by evidence demonstrating the treatment intervention can be expected to produce its intended effects on behavioral health outcomes);
4. Cost effective in addressing the diagnosis;
5. Determined by the diagnosis, not necessarily by the credentials of the service provider;
6. Not primarily for the convenience of the client or the provider;
7. Delivered in the least restrictive setting that will produce the desired results in accordance with the needs of the client.

Upon review, Value Options approves the recommendations that meet these criteria, offers alternative recommendations, or denies the recommended services entirely. Coverage for offenders often becomes problematic because the state contract with Value Options (i.e., the Nebraska Medicaid Managed Care Program) only covers mental health or substance abuse treatment services, excluding any other therapeutic (family and transitional services) or correctional/supervision services. When treatment

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



plans recommend both treatment and non-treatment services, for example, OJS must pay for the non-treatment services with child welfare funds or leave them unfulfilled.

When recommended treatment services are denied by Value Options, offenders can still access those services, but the county in which the case is adjudicated or OJS must pay for the services. In some cases, judges commit offenders to placements directly (i.e., direct placements) without Value Options approval. If the offender is then placed in the custody of OJS, OJS is responsible for the cost; otherwise, the county is financially responsible.

#### *Overall Implications for Juvenile Justice*

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

Secondly, 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 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.

Finally, the Nebraska Medicaid Managed Care Program limits Nebraska's ability to implement a juvenile justice system of care balanced between treatment need and risk because it 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. Furthermore, the current Medicaid contract with Value Options does not cover family services, transitional services, or correctional services. Therefore, 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. Estimates of the number of decision-makers involved in identifying the need for and accessing treatment services are displayed in Table 4.2. These estimates are conservative because they exclude other services such as school contacts, trackers, electronic monitoring, and family and social programming and assume (1) one person for each agency contact; (2) three evaluators per OJS evaluation; and (3) one placement (i.e. one person). Based on these estimates, a significant number of individuals impact the fate of an offender. 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).

**Table 4.1: Number of Decision-Makers Involved in Processing an Offender, Identifying MH/SA Need, and Accessing Services**

Processing Outcome	Pathway to Treatment Services		
	PDI Only	OJS Evaluation Only	Both PDI & OJS Evaluation
Diversion	n/a	n/a	n/a
Probation			
Not Detained	8	n/a	11
Detained	10	n/a	13

**Table 4.1: Number of Decision-Makers Involved in Processing an Offender, Identifying MH/SA Need, and Accessing Services (Continued)**

Processing Outcome	Pathway to Treatment Services		
	PDI Only	OJS Evaluation Only	Both PDI & OJS Evaluation
OJS			
Community Supervision			
Not Detained	n/a	10	11
Detained	n/a	12	13
Placement in a Youth Residential Treatment Center or Another Placement			
Not Detained	n/a	11	12
Detained	n/a	13	14

The number of decision-makers may not matter if they interact efficiently to address offender accountability and treatment needs effectively. To provide a starting point for this discussion, Table 4.3 contains a “collaboration” ranking between agencies identified earlier by area. Collaboration rankings are estimates based on documented agency collaboration as well as self-reports derived from phone interviews, focus groups, and surveys conducted with the various decision-makers and service providers involved in the juvenile justice process. Agency interaction was coded “1” for little to no communication/interaction, “2” for Informal communication & collaboration, and “3” for formal communication & collaborative services. When information was insufficient to estimate the level of collaboration, the relationship was coded with a “\*”.

**Table 4.2: Collaboration Between State Agencies Involved in the Juvenile Justice Process**

	Courts	Probation	OJS Service Area	Region Office	Value Options
Area 1					
Probation Districts	3	---	*	*	1
Western Service Area	1	0	---	2	2
Region I	2	3	3	---	*
Providers	1	2	*	*	*
Area 2					
Probation Districts	3	---	*	*	1
Southwest Service Area	2	2	---	1	*
Region II	2	1	1	---	*
Providers	1	*	*	1	*

**Table 4.2: Collaboration Between State Agencies Involved in the Juvenile Justice Process (Continued)**

	Courts	Probation	OJS Service Area	Region Office	Value Options
<b>Area 3</b>					
Probation Districts	3	---	2	3	1
Central Service Area	1	2	---	3	3
Region III	3	3	3	---	*
Providers	1	*	2	2	*
<b>Area 4</b>					
Probation Districts	3	---	*	3	1
Northern Service Area	2	2	---	2	*
Region IV	2	3	2	---	*
Providers	1	3	2	*	*
<b>Area 5</b>					
Probation Districts	3	---	*	3	1
Southeast Service Area	2		---	3	*
Region V	2	3	2	---	*
Providers	1	3	*	1	*
<b>Area 6</b>					
Probation Districts	3	---	2	*	1
Eastern Service Area	2	2	---	*	*
Region VI	2	2	2	---	*
Providers	1	*	*		*

\* Agency interaction was coded “1” for little to no communication/interaction, “2” for Informal communication & collaboration, and “3” for formal communication & collaborative services. When information was insufficient to estimate the level of collaboration, the relationship was coded with a “\*”.

A review of the results contained in Table 4.3 produces at least two conclusions. First, they confirm that interagency collaboration exists throughout the state but that it 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. 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 following statement in section 43-246(1) indicates the general purpose of juvenile justice system:

Nebraska Juvenile Code (1998): To assure the rights of all juveniles to care and protection and a safe and stable living environment and to development of their capacities for a health personality, physical well-being, and useful citizenship and to protect the public interest.

The Office of Probation Administration offers a second mission statement that relates to the role that Probation plays within juvenile justice:

Probation: To provide investigations to the court, enhance community safety, promote accountability and provide services through risk-reducing supervision.

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:

HHS/Protection & Safety (OJS): To promote safety, permanency, and well-being for children, youth, families and communities in Nebraska by supporting our customers, direct service staff, as well as efficiently and effectively responding to legislation and agency leadership demands.

Finally, a fourth, more comprehensive mission statement was produced by a 1992 juvenile justice work group, the Youth Services Planning Commission, and submitted to Governor Ben Nelson:

Nebraska's Juvenile Justice Service System: The mission of the juvenile justice service system in Nebraska is to provide individualized supervision, care and treatment in a manner consistent with public safety to those youth under the age of eighteen at the time of referral who violate the law. Further, the juvenile justice service system shall promote prevention efforts through the support of programs and services designed to meet the needs of those youth who are identified as being at risk of violating the law and those whose behavior is such that they endanger themselves or others (Martin, 1993).

Although these mission statements differ to some extent, they do 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:

- 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

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. To identify focus group participants, 124 letters containing the purpose of the study were sent to various agencies to solicit their participation. In sum, 65 individuals (52%) attended the meetings, representing 58 agencies or 65% of the agencies invited (see Table 5.1). When the overall individual participation was calculated for each group, some of the groups had low response rates (i.e. OJS/YRTC's had a 37 percent response rate and detention had a 39 percent response rate). These initial rates were adjusted to reflect the areas of the state and/or agencies represented. The adjusted response rates (ranging from 50 to 85 percent for each group and 65 percent overall) show that the groups assembled were, for the most part, representative of the entire state. With the exception of the largest group invited (mental health providers), only one or two areas/agencies were not represented in their respective focus groups.

Given the size of the state and number of individuals in each of these groups, a total of seven focus groups were held at the University of Nebraska—Kearney (5) and Mahoney State Park (2). 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 Appendix 5 A for a list of questions used to frame discussions).

Upon the completion of the focus group meetings, notes were assimilated and themes were identified.

**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 <sup>1</sup>	85%
Probation	13	12	92%	13	11 <sup>2</sup>	85%
OJS/YRTC's	19	7	37%	9	7 <sup>3</sup>	78%
MH Providers	57	28	49%	48	24	50%
Region Personnel	17	11	65%	6	5 <sup>4</sup>	83%
Total	124	65	52%	89	58	65%
Mailed Surveys						
Judges	45	19	42%	6	5 <sup>5</sup>	83%
County Attorneys	93	16	17%	6	5 <sup>6</sup>	83%
Public Defenders	3	2 <sup>7</sup>	n/a	3	1	33%
Total	141	37	26%	15	11	73%

<sup>1</sup>At least 4 detention facility representatives attended the service provider focus group rather than the detention facility group.

<sup>2</sup>Probation Districts 1 (Chadron) and 12 (Pawnee City) were not represented at the focus group.

<sup>3</sup>Northern and Central Service Areas were not represented at the focus group.

<sup>4</sup>Region 2 was not represented at the focus group.

<sup>5</sup>Surveys were received from judges in all services areas except for the Western Service Area.

<sup>6</sup>Surveys were received from county attorneys in all service areas except for the Northern Service Area.

<sup>7</sup>Surveys were sent to the County Public Defender in Douglas, Sarpy, and Lancaster Counties. The cover letter requested that the survey be distributed to attorneys in his office. A response rate cannot be computed because we do not know how many attorneys were given a copy of the survey.

## 2. Surveys

Following the focus group meetings, surveys were 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). The response rates for judges was 42%, 17% for county attorneys, and only 33% for public defenders; however, these rates are misleading because not all county attorneys and judges handle juvenile offenders. When areas of the state were considered, 83% of these areas were represented for both judges

and county attorneys, and public defender surveys were completed in one of the areas, resulting in a 33% response rate for this group. 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.

### *Results*

#### 1. Agency Roles

##### a. Detention Facilities and Programs

Mental health and substance abuse problems among offenders substantially impact the operation of detention facilities, but these facilities/programs have few resources to address these problems and have little influence in the court with regard to these issues. This precarious role is largely due to their position as a county-based service and no formal connection to state-based juvenile justice agencies. As county-based services, funds are not typically allocated for screening juvenile offenders or for providing services to juvenile offenders. When screening does occur at intake, facilities and programs are more likely to screen for substance abuse than mental health problems (see Table 5.2). Consequently, personnel are not adequately trained to identify or handle mental health problems. Mental health and substance abuse professionals are rarely part of the detention personnel (e.g., West Nebraska Juvenile Services), and if facilities contract with behavioral health professionals, the number of offenders who need services overwhelms the services and time available (e.g., Douglas County Youth Center).

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. As shown in Table 5.2, both detention personnel as well mental

health providers were concerned about the waiting periods, which can and do last several months. During this time, few if any treatment services are available because counties do not have the resources to fund programming and Medicaid regulations exclude offenders in correctional settings from coverage regardless of their ward status (see section 416.211 of the Code of Federal Regulations).

**Table 5.2: Focus Group and Survey Feedback on the Role of Detention Facilities and Programs**

	<b>Detention</b>	<b>Probation</b>	<b>OJS/YRTC's</b>	<b>Mental Health Providers</b>	<b>Regions</b>	<b>Public Defenders</b>	<b>County Attorneys</b>	<b>Judges</b>
	N=7	N=12	N=7	N=28	N=11	N=2	N=16	N=19
Personnel are poorly trained to identify and respond appropriately to mental health problems.	X			X				
Detention facilities/programs more likely to screen for substance abuse problems than mental health problems, except suicide, at intake.	X			X				
Mental health and substance abuse treatment is extremely limited in detention facilities/programs. Professional staff is not available (due to cost) or overwhelmed.	X			X				
Many youth must wait for a placement in detention—this limits the “window of opportunity” to reach a youth. Several months of waiting in a facility is not uncommon, which causes safety concerns for both the facility and the youth.	X			X				
Medicaid regulations exclude provision of services while offender is in detention facility and funds are extremely limited to pay for professional staff and services at the county level.	X			X				

**b. Probation**

Based on the responses displayed in Table 5.3, it seems clear that Probation (via the Pre-Disposition Investigation) offers a starting point for identifying substance abuse and mental health problems among offenders. Probation, judges, county attorneys, and

public defenders viewed this process as a consistent, standard process that provides comprehensive information to start the evaluation process. Respondents also felt that Probation was better at handling and monitoring substance abuse problems because officers had 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; rather, Probation is dependent upon other sources of funding such as private pay and county funds to provide their clients with needed services. Overall, judges and county attorneys reported that working with Probation was “easy” because of their direct connection to the courts and the legal system; conversely, judges, probation officers, and OJS officers saw the philosophical differences between Probation and OJS as barriers to handling offenders efficiently and effectively.

**Table 5.3: Focus Group and Survey Feedback on the Role of Probation**

	Detention	Probation	OJS/YRTC's	Mental Health Providers	Regions	Public Defenders	County Attorneys	Judges
	N=7	N=12	N=7	N=28	N=11	N=2	N=16	N=19
Uses a consistent format, information and screening tools. Starts the evaluation and treatment process by making recommendations to the judge. Family, school, background information, previous evaluations		X				X	X	X
More likely to and better at handling and monitoring substance abuse than mental health problems.		X				X	X	X
Officers have no expertise or training in mental health problems and are not set up to make referrals for mental health evaluations.		X				X	X	X
Since Probation has no funds to provide services, officers can only provide direction.		X					X	X
Easy to work with because directly linked to the courts and juvenile justice process							X	X
Philosophical differences between Probation and OJS create barriers to handling offenders efficiently and effectively.		X	X					X

c. OJS

All groups identified OJS as the primary pathway to services, and believed 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 (see Table 5.4). In turn, OJS workers stressed the impact of this trend on caseload size and their frustration with the insufficient time they could devote to case management. Adding to this frustration were the challenges and inefficiencies presented with mixed (abuse/neglect and delinquency) caseloads in some areas, often precluding the opportunity to specialize and gain experience with the juvenile justice system and handling offenders. Mental health providers also indicated that high caseloads and mixed caseloads reduced the OJS worker's ability to know the offender and actively participate in the treatment plan.

Although a few judges felt that OJS workers were well trained in this area, OJS workers felt that their expertise for handling mental health and substance abuse problems among offenders was limited due to insufficient training and high turnover rates. Additionally, OJS workers as well as judges found that service area policies varied widely, creating substantial inconsistencies in handling offenders across the state and barriers to collaboration across service areas. Finally, several groups expressed their concern and irritation over the perception that services were driven by cost rather than offender need.

**Table 5.4: Focus Group and Survey Feedback on the Role of the Office of Juvenile Services (OJS)**

	<b>Detention</b>	<b>Probation</b>	<b>OJS/YRTC's</b>	<b>Mental Health Providers</b>	<b>Regions</b>	<b>Public Defenders</b>	<b>County Attorneys</b>	<b>Judges</b>
	N=7	N=12	N=7	N=28	N=11	N=2	N=16	N=19
Growing reliance on OJS to pay for evaluations and treatment services.	X	X	X	X	X	X	X	X
High caseloads and increased responsibilities require OJS workers to focus less on case management and more on administrative duties.			X	X			X	
Mixed caseloads (offenders and abuse/neglect cases) are difficult to manage and preclude specialization by OJS workers.			X	X				
OJS workers, especially traditional HHS/CPS workers, are not always adequately trained or have the experience to effectively handle offenders.		X	X	X				X
Policies across service areas are different, creating inconsistencies in how offenders are handled.		X	X	X				X
OJS is dependent on managed care and decisions are often based on cost rather than need/appropriateness.	X	X	X	X		X	X	X

d. Providers and Regions

In general, the results presented in Table 5.5 indicate that providers felt removed from the juvenile justice process in many respects even though they play a critical role in the juvenile justice system of care. Similarly, Regions did not feel they had a role in the court process except in certain areas where a different relationship had developed informally. For both providers and Region personnel, interaction with Probation and OJS was for separate services (i.e., outpatient v. inpatient) and was dependent on the informal relationships built between agencies in specific areas.

**Table 5.5: Focus Group and Survey Feedback on the Role of Mental Health Providers and Region Personnel**

	Detention	Probation	OJS/YRITCs	Mental Health Providers	Regions	Public Defenders	County Attorneys	Judges
	N=7	N=12	N=7	N=28	N=11	N=2	N=16	N=19
Interaction with court limited largely to direct placements. Providers often feel separate from juvenile justice even though they are part of the juvenile justice system of care.				X				
Greatest involvement with Probation is for outpatient services and evaluations, and greatest involvement with OJS is for residential placements.		X	X	X				
In general, Regions have more contact with HHS Child Protective Services than with OJS.					X			
Relationship to court, Probation, and OJS depends on Region and Region’s involvement in court related activities and services.		X	X		X			

## 2. Identifying Need

As shown in Table 5.6, no standardized process is used to determine which offenders needed further evaluation (i.e., an OJS evaluation) or to determine what type of evaluation is necessary (i.e., mental health vs. substance abuse). Judges, county attorneys, and public defenders, for instance, reported that their decisions were based on personal impressions of need as well as information from the family, school, the youth’s attorney, and/or Probation PDI reports. Additionally, judges and county attorneys reported that the offender’s current and past behaviors as well as law enforcement observations were considered.

Various groups thought the absence of a standardized process was due to a lack of agreement across and within agencies. For instance, Probation currently screens for substance abuse and for limited mental health problems, but this screen is only administered if the judge orders a PDI for an offender. Additionally, OJS does not screen

for further evaluation because judges order the evaluations directly, and Probation and OJS do not share information consistently.

**Table 5.6: Focus Group and Survey Feedback on Identifying the Need for Mental Health and Substance Abuse Treatment**

	Detention	Probation	OJS/YRTCs	Mental Health Providers	Regions	Public Defenders	County Attorneys	Judges
	N=7	N=12	N=7	N=28	N=11	N=2	N=16	N=19
System relies largely on OJS evaluations to identify a need for mental health treatment.	X	X	X	X	X	X	X	X
There is no standardized process to determine which offenders need further evaluation. Recommendations and orders for evaluations are determined in an arbitrary manner and are based on discretionary decision-making.	X	X	X	X	X	X	X	X
No agreement across agencies on how to standardize screening and evaluations for substance abuse or mental health.	X	X	X	X	X			
If agency uses a screening tool, the type of tool and administration is inconsistent across geographical areas and between agencies.	X	X	X	X	X			

Given that OJS evaluations play a key role in identifying the need for services, respondents commented on the problems related to the current process (see Table 5.7). Although various opinions about OJS evaluations surfaced, each of the respondent groups stressed one common theme: cost savings outweighs the quality of the evaluations. Specifically, providers noted that evaluation recommendations often relate to availability and cost rather than actual need and judges added their concern that evaluations often dictated specific placements rather than a level of service. Providers, judges and public defenders also identified long waiting periods as obstacles to identifying need and accessing services quickly and efficiently.

A contributing factor to these issues is the role Medicaid managed care plays in this process. In particular, mental health providers believed that the low reimbursement

rates offered by Value Options (Medicaid managed care provider), the lack of competency-based measures, and the fragmentation in the evaluation process either caused or amplified the problems related to OJS evaluations. Additionally, many offenders and their families must go through the evaluation process more than once to access services because previous evaluations completed outside of a particular timeframe (i.e., 30-60 days prior to approval for treatment) are not accepted by Value Options. Finally, providers noted that certified alcohol and drug abuse counselor diagnoses and treatment recommendations were not recognized without the approval of a psychiatrist, psychologist, or physician (i.e., medical necessity), which in turn, limited the number of appropriate substance abuse services available to wards and other offenders who accessed treatment through Medicaid.

**Table 5.7: Focus Group and Survey Feedback on the Problems Related to OJS Evaluations**

	<b>Detention</b>	<b>Probation</b>	<b>OJS/YRTC's</b>	<b>Mental Health Providers</b>	<b>Regions</b>	<b>Public Defenders</b>	<b>County Attorneys</b>	<b>Judges</b>
	N=7	N=12	N=7	N=28	N=11	N=2	N=16	N=19
Quality is questionable due to conflicting recommendations; conflicts often due to multiple evaluators without sharing the information or working together to develop clear, appropriate recommendations.	X	X		X		X	X	X
Recommendations often relate to availability and cost rather than actual need.				X				
Evaluations often dictate placements rather than treatment need—should be focused on treatment need and not on specific placements.				X	X			
Reimbursement rates impact quality by rushing evaluators to complete them quickly. Unacceptable lengths will not be reimbursed by Value Options.				X	X			
Once evaluations are ordered, psychiatric evaluations are difficult because of a limited number of evaluators and long waiting lists.			X			X	X	X

**Table 5.7: Focus Group and Survey Feedback on the Problems Related to OJS Evaluations (Continued)**

	<b>Detention</b>	<b>Probation</b>	<b>OJS/YRTC's</b>	<b>Mental Health Providers</b>	<b>Regions</b>	<b>Public Defenders</b>	<b>County Attorneys</b>	<b>Judges</b>
	N=7	N=12	N=7	N=28	N=11	N=2	N=16	N=19
No mechanism to measure the quality of the evaluation or the competency of the evaluators				X				
Limited use of substance abuse professionals because of Medicaid regulations (i.e., Medicaid only accepts recommendations from clinical psychologists, psychiatrists, and physicians).	X			X				
Evaluations do not follow the offender, causing duplication of effort.	X				X	X		

### 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 (see Table 5.8). 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. Providers further stressed that these factors significantly contribute to the use of multiple placements, inappropriate placements, and at times, out of state placements. Compounding this problem, detention representatives and mental health providers felt that they did not always receive full disclosure (i.e., full background information to identify safety concerns and risks) on OJS wards, creating dangerous situations for not only the offender but also for facility residents as well. For instance, respondents believed that the lack of full disclosure led to 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. Furthermore, respondents in every group felt that many of the problems related to inappropriate placements were amplified by the complexities inherent in the Value Options approval process.

**Table 5.8: Focus Group and Survey Feedback on Access to Services**

	<b>Detention</b>	<b>Probation</b>	<b>OJS/YRITCs</b>	<b>Mental Health Providers</b>	<b>Regions</b>	<b>Public Defenders</b>	<b>County Attorneys</b>	<b>Judges</b>
	N=7	N=12	N=7	N=28	N=11	N=2	N=16	N=19
Many service areas do not have a continuum of care, particularly for acute care, intensive outpatient treatment, and dual diagnosis services, young offenders (<12), sex offenders, and offenders with conduct disorder and ADHD.	X	X	X	X	X	X	X	X
Some providers reluctant to take offenders and quick to eject them from their programs for behavior problems.	X		X	X	X			
Unavailability of residential placements and providers' unwillingness to accept offenders prompts the use of inappropriate, multiple and out-of-state placements.	X	X	X	X	X			
Low reimbursement rates provided through Value Options stymies growth in capacity and development of a system of care. More incentive to offer high-level residential services rather than lower level and transitional services.				X	X			
Placements are not always given full disclosure about the offender from OJS or the court on direct placements, which creates safety risks for the facility and the youth.	X			X				
Value Options refusal to approve placement, unavailability of appropriate residential placements and providers' unwillingness to accept offenders results in placement in appropriate settings (i.e., offenders of different seriousness mixed in same setting, multiple problem youth placed in a foster home).	X	X		X				
Older youths get caught in the system cracks and receive few if any services.				X	X			

#### 4. Payment for services

Based on the focus group and survey responses displayed in Table 5.9, payment for services presents another significant barrier to accessing services throughout Nebraska. 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. Although Medicaid is a resource for services, accessing it is a complicated process that eludes many agencies, including HHS/OJS workers on many occasions. The complexity of accessing Medicaid through the Value Options approval produces the perception that managed care is not accountable for their decisions, prompting high levels of frustration among all entities and discouraging agencies who could use these funds from doing so (e.g., Probation). In sum, 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.

Several respondents expressed concern related to Value Options' role in this process (see Table 5.9). First, the role of medical necessity was viewed as problematic because it created a barrier to accessing services. Secondly, Medicaid managed care was thought to be incompatible with accessing appropriate treatment for offenders because it did not cover services critical to the needs of this population and facilitating effective treatment such as transitional, family, and wrap around services. Finally, the delays related to the Value Options approval process were unacceptable, prolonging treatment and contributing to inappropriate and ineffective treatment.

**Table 5.9: Focus Group and Survey Feedback on Payment for Treatment Services**

	<b>Detention</b>	<b>Probation</b>	<b>OJS/YRTC's</b>	<b>Mental Health Providers</b>	<b>Regions</b>	<b>Public Defenders</b>	<b>County Attorneys</b>	<b>Judges</b>
	N=7	N=12	N=7	N=28	N=11	N=2	N=16	N=19
Not affordable for non-wards without resources. Places a drain on county, state (child welfare), and Region funds.		X	X			X	X	X
Private insurance is often inadequate to cover needed services and/or refuses to pay if the youth is made a ward of the state.			X				X	X
Complexities of Medicaid and Value Options limit utility for accessing treatment for offenders.		X	X					
It seems difficult to hold Value Options accountable for their decisions because the state contract is complicated and it is difficult to get information from them.				X	X			
Funding drives what services are available to the offender rather than offender need for particular services.				X	X			X
If Value Options decides treatment is not medically necessary, Medicaid will not pay for the services; medical necessity creates a barrier to accessing appropriate services.	X		X		X			
Managed care is incompatible with accessing appropriate services for offenders. For instance, transitional, family, and wrap around services are not covered by Medicaid but play an important role in the treatment.		X	X	X	X			
Difficult to access services for any type of offender through Value Options. Delays occur often while waiting for approval. Value Options approval for level of service often depends on the offender's history with treatment (i.e., no inpatient until they have failed outpatient).			X	X				
When Value Options does not approve, cost shifts to child welfare and Region funds.					X			

### 5. Ability to Treat Offenders

Judges, county attorneys, and public defenders reported that the quality of treatment was contingent on individual providers (see Table 5.10). 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. In particular, probation officers felt that offenders were able to manipulate some providers, fostering more distrust between Probation and those providers than communication.

Many providers believed that offenders could not be treated effectively without home-based programming (e.g., wrap-around services) and transitional services, which are not readily available because Medicaid does not cover these types of services and state funds (i.e., child welfare) are limited. The lack of home-based services (i.e., wrap-around services) and integrated services was particularly concerning to respondents because of the high prevalence of conduct disorder. According to providers, adequate services to handle the behavior problems of these offenders are not readily available.

Respondents were also concerned that families do not always play an integral part in the treatment process, and believed that this occurred for several reasons. First, the court has little authority over parents in delinquency and status offense cases and cannot require them to attend treatment under a threat of penalty. Secondly, out-of-state placements often prohibit families from participating in the process because of long distances and limited family resources to make the trip once or on a regular basis. Finally, family-based services are not covered in the Nebraska Medicaid Managed Care contract with Value Options.

**Table 5.10: Focus Group and Survey Feedback on Treating Juvenile Offenders**

	Detention	Probation	OJS/YRTC's	Mental Health Providers	Regions	Public Defenders	County Attorneys	Judges
	N=7	N=12	N=7	N=28	N=11	N=2	N=16	N=19
Quality and ability to work with juvenile offenders depends on the provider.					X	X	X	X
Providers could benefit from more training/information on treating offenders. Some providers are not equipped to handle offenders.		X		X	X		X	X
Offenders are able to manipulate some providers who are not used to working with offenders. Some providers protect the offender, making Probation the enemy.		X						
Lack of an integrated response between treatment and correctional supervision (e.g., graduated sanctions). Consequences within treatment need to be immediate and linked to the community.				X	X			
Lack of transitional and wrap-around (i.e., home-based) services reduces the overall effectiveness of treatment—return home becomes more difficult than necessary. Problematic because these services are not covered by Medicaid.	X		X	X	X			
Family is rarely involved or included in treatment, especially in out-of-state placements.	X		X		X			
Difficult to involve parents because the courts have no jurisdiction over them. Some parents take no responsibility or accountability for their children.	X		X					

## 6. System Generally<sup>1</sup>

At the end of focus group discussions, respondents were asked how the juvenile justice system generally contributed to the problems listed in Tables 5.2-5.10. Their responses are displayed in Table 5.11. 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

<sup>1</sup> 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.

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. This process can take a substantial amount of time, reducing the window of opportunity for intervention. Conflicts in philosophies and policies and procedures across juvenile justice agencies were also identified as a system problem. These conflicts, in turn, contributed to the system fragmentation and the absence of communication and collaboration across juvenile justice agencies and with 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.

The geographic nature of relationships between juvenile justice agencies and local Regions contributed to treatment delivery fragmentation as well. Although Regions provide a potential avenue to services, especially home-based, wrap-around services, some Region personnel indicated that few Probation and OJS personnel knew that these services were available and as a result, did not actively partner with their Region office to develop a delivery system that ensured the availability of a continuum of services. Related to knowledge and understanding of available services, 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 (see Table 5.11). Similarly, these 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.

**Table 5.11: Focus Group Feedback Overall System Barriers**

	<b>Detention</b>	<b>Probation</b>	<b>OJS/YRTCs</b>	<b>Mental Health Providers</b>	<b>Regions</b>
	N=18	N=13	N=19	N=57	N=17
System is reactive, crisis driven, rather proactive and focused on prevention.	X	X			X
Need more front-end, pre-adjudication screening. Diversion offers this opportunity but there are currently no standardized guidelines for these programs.		X			X
Conflict in agency philosophies creates conflict in practice.				X	X
Fragmentation (lack of communication and collaboration) between Probation and OJS services prevents system effectiveness and efficiency.	X	X	X	X	X
Juvenile justice agencies do not know what the Regions offer and what they can do for offenders.					X
Judges and Probation do not understand mental health language and treatment process.				X	X
Providers, Region personnel and OJS workers do not understand juvenile justice language and process unless they specialize in that area.				X	X
Attempt to shelter offenders from delinquency label has inadvertently subjected them to different labels.				X	
In many cases, the offender’s problem is a reaction to the experiences in the system (i.e., conduct disorder, attachment disorder).				X	
Politics and resources are key barriers to accessing services to offenders.				X	
Competitiveness between providers has limited their ability to unite for reform to benefit all providers and youths.	X			X	

Mental health providers pointed out that merging OJS into HHS was, in part, to shelter offenders from labeling and stigma; yet, they felt that the OJS process potentially replaced delinquency labels with different and sometimes more labels, which produced a different type of stigma. They further believed that offenders’ experiences in the system

potentially contributed to their mental disorders or in some cases caused them (i.e., conduct disorder and adjustment disorder diagnoses).

## 7. The Role of Geography and Offender Characteristics

Focus group and survey participants were asked to identify any geographical and/or race, ethnicity and gender differences with regard to identifying need and accessing services for juvenile offender in Nebraska (see Table 5.12). All the groups except public defenders from a more urban location noted that the availability of services for mental health and substance abuse services was bleaker in rural areas than in more urban areas. Additionally, several groups noted that relationships between various agencies were largely dependent on the geography. For example, the extent to which judges use probation more or less than OJS varies by location as does the extent to which Probation and OJS work collaboratively.

**Table 5.12: Focus Group and Survey Feedback on The Role of Geography**

	Detention	Probation	OJS/YRITCs	Mental Health Providers	Regions	Public Defenders	County Attorneys	Judges
	N=7	N=12	N=7	N=28	N=11	N=2	N=16	N=19
Lack of services particularly bad in rural areas. Long distances between treatment and home reduce likelihood of attendance and effectiveness	X	X	X	X	X		X	X
State policies and procedures should be flexible with regard to urban and rural differences.	X	X	X	X	X		X	X
Extent to which judges uses probation and/or OJS varies by location.		X	X					X
Extent to which relationship with Value Options is good or bad varies across location.			X	X				
Extent to which Probation and OJS collaborate and work with providers varies across location. This includes interaction with Regions as well.		X	X	X	X			X

With regard to race, ethnicity and gender, many respondents believed that the lack of bi-lingual and culturally specific programming was problematic (see Table 5.13). The lack of culturally based services was particularly critical on reservations, where quality services are minimal and youth experienced unusually high rates of social problems on a daily basis. Public defenders believed that minority behaviors were viewed as behavior problems rather than mental health or substance abuse problems; judges felt that minority families were less willing to involve outside agencies for help, and county attorneys believed that minority families had fewer financial resources available forcing them into the system to access services. Finally, several 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.

**Table 5.13: Focus Group and Survey Feedback on the Role of Offender Characteristics**

	<b>Detention</b>	<b>Probation</b>	<b>OJS/YRTC's</b>	<b>Mental Health Providers</b>	<b>Regions</b>	<b>Public Defenders</b>	<b>County Attorneys</b>	<b>Judges</b>
	N=7	N=12	N=7	N=28	N=11	N=2	N=16	N=19
Lack of culturally-specific programming and bi-lingual services.		X		X	X			X
Virtually no Native American services (mental health & substance abuse) within the state; youths must be sent out of state for culturally-based services.	X		X	X				
Treatment on reservations is poor, and these areas face high rates of social problems that reduce the effectiveness of treatment.				X				
Minority families are less likely to involve outside agencies.								X
Minority behavior is viewed as a behavior problem not mental health or substance abuse problem.						X		
Minority offenders seem to have less medical insurance coverage or other financial resources available.							X	
None							X	X

## 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 issues include:

1. The lack of a coordinated juvenile justice policy and the fragmentation across juvenile justice agencies;
2. The lack of a standardized screening, assessment, and evaluation process that is accepted and used by all juvenile justice decision-makers and providers;
3. The lack of Probation resources for services, and limited resources at the county and state (i.e., child welfare/OJS funds) levels for services;
4. Growing reliance on OJS to access evaluations and services;
5. The juvenile justice system's dependence on Medicaid to pay for services;
6. The incompatibility of the current administration of Medicaid with effective treatment for offenders;
7. The reactive nature of the system and focus on the back-end of the system without equal attention and resources devoted to prevention and the front-end of the system;
8. The lack of a coordinated service delivery system that integrates correctional services with appropriate mental health and substance abuse services;
9. The lack of cross-training for all personnel involved in identifying need and providing treatment services as well as a lack of training on mental health and substance abuse problems; and
10. An amplified lack of services in rural areas.

These findings are not necessarily new; in fact, many of these problems 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 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, a process that the Task Force and subcommittee members developed to improve the consistency and accuracy of screening, risk assessment, and evaluation across justice agencies, and improve access to appropriate treatment throughout the justice process.

Similarly, the Department of Health and Human Services produced two reports that addressed the delivery of services to HHS wards (i.e., OJS wards). The first report, the *Children, Youth, and Families Services Integration Team Report* (2000) documents the problems facing the HHS delivery system and recommends initiatives to institute a constant intake/screening process throughout the state, provide more training, and create a strength-based system based on the wrap-around philosophy and family-centered services. The *Nebraska Family Portrait* (2001) builds on this report offering concrete activities to change the delivery of services by the Protection and Safety Division and outcome measures to demonstrate the effectiveness of these changes.

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, as demonstrated in Table 5.14, 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.

**Table 5.14: Summary of Nebraska Family Portrait Assumptions and Outcome Measures**

	Total	Family Portrait Refers Specifically to:			
		Offender-Related Issues		Abuse/Neglect, Foster Care, or Adoption Issues	
<b>Assumptions/Issues to be Addressed</b>					
Safety	10	1	10%	2	20%
Permanency	11	1	9%	3	27%
Well-Being	5	1	20%	0	
Policy and Practice	7	1	14%	1	14%
Training	6	0		1	17%

**Table 5.14: Summary of Nebraska Family Portrait Assumptions and Outcome Measures (Continued)**

	Total	Family Portrait Refers Specifically to:			
		Offender-Related Issues		Abuse/Neglect, Foster Care, or Adoption Issues	
Quality Assurance	6	4	67%	0	
Information Systems	15	2	13%	0	
Overall	60	9	15%	7	12%
<b>System Outcomes</b>					
Safety	13	1	8%	6	46%
Permanency	11	1	9%	3	27%
Well-Being	5	1	20%	0	
Policy and Practice	7	1	14%	1	14%
Training	6	0		1	17%
Quality Assurance	6	4	67%	0	
Information Systems	15	2	13%	0	
Overall	63	8	13%	11	17%
<b>Child &amp; Family Outcomes</b>					
Overall	12	0		1	10%

The situation was identical when system outcome measures were considered, and none of the child and family outcomes were directly related to offenders. Distributions are not entirely different for other categories of wards, but slightly more issues and outcome measures specifically identified services for abuse/neglect children, foster care children, and/or adopted children as the target for change. 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. Without continued reform and coordination throughout the system, isolated developments will amplify system fragmentation, inconsistency, and inefficient care, and cast doubt on Nebraska's ability to implement a juvenile justice system of care that improves the well-being of offenders and ensures public safety.

## Chapter 6: Creating a Coordinated Approach to System Change

The purpose of this report was to (1) examine the prevalence of mental health problems and access to mental health services in Nebraska’s juvenile justice system and (2) develop 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 if 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. Prioritize juvenile justice policy at the state level and ensure that all legislative changes are consistent with a strategic plan based on this policy.

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 Probation and OJS training programs.
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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## Appendix 2

# Massachusetts Youth Screening Instrument-2

# Appendix 3 A

## State Survey

## Appendix 3 B

### Nine Principles of Multisystemic Therapy

## Appendix 3 C

# Essential Elements of Wraparound Programming

## Appendix 3 D

### Assumptions of Strength-Based Perspective

# Appendix 5 A

## Focus Group Questions

# Appendix 5 B

## Survey Questions

## **Nine Principles of Multisystemic Therapy**

1. The primary purpose of assessment is to understand the fit between the identified problems and their broader systemic context.
2. Therapeutic contacts should emphasize the positive and should use systemic strengths as levers for change.
3. Interventions should be designed to promote responsible behavior and decrease irresponsible behavior among family members.
4. Interventions should be present-focused and action-oriented, targeting specific and well-defined problems.
5. Interventions should target sequences of behavior within and between multiple systems that maintain identified problems.
6. Interventions should be developmentally appropriate and fit the developmental needs of the youth.
7. Interventions should be designed to require daily or weekly effort by family members.
8. Intervention effectiveness is evaluated continuously from multiple perspectives, with providers assuming accountability for overcoming barriers to successful outcomes.
9. Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts.

(Henggeler, 1997)

## **Essential Elements of Wraparound Programming**

1. Wraparound efforts must be based in the community.
2. Services and supports must be individualized, built on strengths, and meet the needs of children and families across the life domains in order to promote success, safety, and permanency in home, school, and community.
3. The process must be culturally competent.
4. Families must be full and active partners in every level of the wraparound process.
5. The wraparound approach must be a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized service plan.
6. Wraparound teams must have flexible approaches with adequate and flexible funding.
7. Wraparound plans must include a balance of formal services and informal community and family resources.
8. The community agencies and teams must make an unconditional commitment to serve their children and families.
9. A service/support plan should be developed and implemented based on an interagency, community-neighborhood collaborative process.
10. Outcomes must be determined and measured for each goal established with the child and family as well as for those goals established at the program and system levels.

(Dennis, 1999)

## **Assumptions of Strength Based Perspective**

1. Respecting client strengths.
2. Clients have many strengths.
3. Client motivation is based on fostering client strengths.
4. The social worker is a collaborator with the client.
5. Avoiding the victim mindset.
6. Any environment is full of resources.

(Saleebey, 1992)

## **Detention Facilities**

### Need

1. In your opinion, what is the percentage of juvenile offenders in your facility who need mental health services? Substance abuse services?
2. In your opinion, how well do detention facility staff identify and respond to mental health problems among youth? Substance abuse problems?
3. What ways do you currently have at your disposal to measure the need for mental health services among juvenile offenders at your facility? Substance abuse services?
4. How consistently are these methods used within your facility? Are these methods standard across detention facilities?
5. What is the impact of mental health problems on your facility? Substance abuse problems?
  - a. Safety/security (management, discipline)
  - b. Length of stay
  - c. Success in facility
  - d. Any others?

### Services

6. What role do mental health services play within your facility? Substance abuse services? Is this role consistent across detention facilities?
7. How would you describe your facility's willingness and capacity to provide mental health services to juvenile probationers? Substance abuse services?
8. How often do you access HHS/OJS for evaluations & services? How often do you access the Nebraska Behavioral Health System (i.e., regions)?
9. How would you describe the state's willingness and capacity to provide mental health services to juvenile offenders? Substance abuse services?
10. How would you describe mental health providers' ability to handle and treat juvenile offenders (i.e., Are they providing effective treatment; why or why not)? Substance abuse providers?
11. In your opinion, what are the consequences of the systems' shortcomings (if any) to provide mental health services? Substance abuse services?

### Overall

12. Overall, what are the obstacles to providing mental health services to juvenile offenders? Substance abuse services?
13. Overall, what would make the system better at identifying mental health and substance abuse treatment needs and providing appropriate services?

## Probation

### Need

1. In your opinion, what is the percentage of juvenile offenders on Probation who need mental health services? Substance abuse services?
2. In your opinion, how well do Probation Officers identify and respond to mental health problems among youth? Substance abuse problems?
3. What ways do you currently have at your disposal to measure the need for mental health services among juvenile offenders? Substance abuse services?
4. How consistently are these methods used? Are these methods standard across probation districts?
5. What impact do mental health problems have on Probation success? Substance abuse problems?

### Services

6. What role do mental health services play within probation? Substance abuse services? Is this role consistent across districts?
7. How would you describe Probation's willingness and capacity to provide mental health services to juvenile probationers? Substance abuse services?
8. How often do you access HHS/OJS for evaluations & services? How often do you access the Nebraska Behavioral Health System (i.e., regions)?
9. How would you describe the state's willingness and capacity to provide mental health services to juvenile offenders? Substance abuse services?
  - a. How would you describe mental health providers' ability to handle and treat juvenile offenders (i.e., Are they providing effective treatment, why or why not)? Substance abuse providers?
  - b. In your opinion, what are the consequences of the systems' shortcomings (if any) to provide mental health services? Substance abuse services?

### Overall

10. Overall, what are the obstacles to providing mental health services to juvenile offenders? Substance abuse services?
11. Overall, what would make the system better at identifying mental health and substance abuse treatment needs and providing appropriate services?

## **HHS/OJS & YRTC**s

### Need

1. In your opinion, what is the percentage of juvenile offenders on parole and at the YRTCs who need mental health services? Substance abuse services?
2. In your opinion, how well do OJS staff identify and respond to mental health problems among youth? Substance abuse problems?
3. What ways do you currently have at your disposal to measure the need for mental health services among juvenile offenders? Substance abuse services?
4. How consistently are these methods used in your service area? Are these methods standard across service areas?
5. What is the impact of mental health problems on parole and YRTC success? Substance abuse problems?
6. How often do you work with the Nebraska Behavioral Health System (i.e., regions) to coordinate evaluations and services?

### Services

7. What is the role of mental health services within parole and the YRTCs? Substance abuse services? Is this role consistent across service areas?
8. How would you describe OJS and YRTCs willingness and capacity to provide mental health services to juvenile probationers? Substance abuse services?
9. How often do you access evaluations & services for OJS wards?
10. How often do you coordinate programming or collaborate with Probation?
11. How would you describe mental health providers' ability to handle and treat juvenile offenders (i.e., Are they providing effective treatment; why or why not)? Substance abuse providers?
12. In your opinion, what are the consequences of the systems' shortcomings (if any) to provide mental health services? Substance abuse services?

### Overall

14. Overall, what are the obstacles to providing mental health services to juvenile offenders? Substance abuse services?
15. Overall, what would make the system better at identifying mental health and substance abuse treatment needs and providing appropriate services?

## **Mental Health Service Providers**

### Relationship to Juvenile Justice

1. On average, how many of your mental health treatment referrals are juvenile offenders? Substance abuse treatment referrals?
2. Are you consistently aware of your client's interaction with the juvenile justice system? Why or why not?
3. How would you describe the procedures used to assess mental health treatment need among juvenile offenders in terms of adequacy, consistency, and general quality? Substance abuse treatment need?

### Treating Juvenile Offenders

4. When a client is a juvenile offender, does your agency assess his/her progress with the supervising agency (Probation, OJS) on a regular basis?
5. Does treating juvenile offenders present specific challenges to providers? How does this affect treatment progress and success?
6. Are the following features adequate in Nebraska? Why or why not?
  - a. Level of service options for offenders?
  - b. Capacity for offenders?
  - c. Payment for offenders?
  - d. Any others?
7. What are the biggest obstacles to effectively treating the mental health needs of juvenile offenders in Nebraska? Substance abuse needs?
8. Do providers have specific needs in the following areas:
  - a. Information (generally and/or specifically) on offenders?
  - b. Training on treating juvenile offenders?
  - c. Communication/relationship to probation? HHS/OJS?
9. In your opinion, what are the consequences of the systems' shortcomings (if any) to provide mental health services? Substance abuse services?

### Overall

10. Overall, how would you describe the juvenile justice system's ability to assess need and provide mental health services to juvenile offenders? Substance abuse services?
11. Overall, how would you describe providers' ability to provide effective treatment to juvenile offenders?
12. Overall, what would make the system better at identifying mental health and substance abuse treatment needs and providing appropriate services?

## Regions

### Relationship to Juvenile Justice

1. How often do you work with the juvenile court (i.e., judges) to coordinate evaluations and services for juvenile offenders? Is this consistent across regions?
2. How often do you work with HHS/OJS to coordinate evaluations and services for juvenile offenders? Is this consistent across regions?
3. How often do you work with Probation to coordinate evaluations and services for juvenile offenders? Is this consistent across regions?
4. What role do you think your region could and should play in each of these areas?
5. How knowledgeable is your staff about juvenile offenders and the juvenile justice system?

### Region Services

6. What ways do you currently have at your disposal to measure the need for mental health services among juvenile offenders? Substance abuse services?
7. How consistently are these methods used with your region? Are these methods standard across service areas?
8. How would you describe mental health providers' ability to handle and treat juvenile offenders (i.e., Are they providing effective treatment, why or why not)? Substance abuse providers?
9. In your opinion, what are the consequences of the systems' shortcomings (if any) to provide mental health services? Substance abuse services?

### Overall

10. Overall, how would you describe your region's ability to assess need and provide mental health services to juvenile offenders? Substance abuse services?
11. Overall, how would you describe the juvenile justice system's ability to assess need and provide mental health services to juvenile offenders? Substance abuse services?
12. Overall, what would make the system better at identifying mental health and substance abuse treatment needs and providing appropriate services?

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

**Judges' Survey**

County(s) Served: \_\_\_\_\_

To what extent do you deal with juvenile offenders?	Not at All	Very Little	Sometimes	Most of the Time	All of the Time
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1. How do you identify whether an offender has mental health problems and needs further evaluation?
2. What are the strengths and weaknesses of the current mental health evaluation process?
3. What is Probation's role with regard to identifying and handling juvenile offenders with mental health problems? What are the strengths and weaknesses of this role?
4. What is Probation's role with regard to identifying and handling juvenile offenders with substance abuse problems (if different from mental health problems)? What are the strengths and weaknesses of this role?
5. What is the Office of Juvenile Services' role with regard to identifying and handling juvenile offenders with mental health problems? What are the strengths and weaknesses of this role?
6. What is the Office of Juvenile Services' role with regard to identifying and handling juvenile offenders with substance abuse problems (if different from mental health problems)? What are the strengths and weaknesses of this role?
7. What impact do mental health problems have on handling juvenile offenders and achieving a "successful outcome" (i.e., no recidivism)?
8. How would you describe access to mental health services for juvenile offenders? How would you describe access to substance abuse services (if different)?
9. How would you describe the payment options for mental health services for juvenile offenders? How would describe payment options for substance abuse services (if different)? What are the strengths and weaknesses of these options?

10. How would you characterize mental health providers' ability to treat juvenile offenders? How would you characterize substance abuse providers' ability (if different)?
11. Overall, what would make the system more effective and efficient at addressing mental health and substance abuse needs of juvenile offenders?
12. What geographical differences characterize the process of identifying and accessing mental health and substance abuse services for juvenile offenders?
13. What are the race, ethnicity, and gender issues surrounding the identification and access to mental health and substance abuse services for juvenile offenders?

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

**County Attorneys' Survey**

County(s) Served: \_\_\_\_\_

To what extent do you deal with juvenile offenders?	Not at All	Very Little	Sometimes	Most of the Time	All of the Time
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14. How do you identify whether an offender has mental health problems and needs further evaluation?
15. What are the strengths and weaknesses of the current mental health evaluation process?
16. What is Probation's role with regard to identifying and handling juvenile offenders with mental health problems? What are the strengths and weaknesses of this role?
17. What is Probation's role with regard to identifying and handling juvenile offenders with substance abuse problems (if different from mental health problems)? What are the strengths and weaknesses of this role?
18. What is the Office of Juvenile Services' role with regard to identifying and handling juvenile offenders with mental health problems? What are the strengths and weaknesses of this role?
19. What is the Office of Juvenile Services' role with regard to identifying and handling juvenile offenders with substance abuse problems (if different from mental health problems)? What are the strengths and weaknesses of this role?
20. What impact do mental health problems have on handling juvenile offenders and achieving a "successful outcome" (i.e., no recidivism)?
21. How would you describe access to mental health services for juvenile offenders? How would you describe access to substance abuse services (if different)?
22. How would you describe the payment options for mental health services for juvenile offenders? How would describe payment options for substance abuse services (if different)? What are the strengths and weaknesses of these options?

23. How would you characterize mental health providers' ability to treat juvenile offenders? How would you characterize substance abuse providers' ability (if different)?
24. Overall, what would make the system more effective and efficient at addressing mental health and substance abuse needs of juvenile offenders?
25. What geographical differences characterize the process of identifying and accessing mental health and substance abuse services for juvenile offenders?
26. What are the race, ethnicity, and gender issues surrounding the identification and access to mental health and substance abuse services for juvenile offenders?

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

**Public Defenders' Survey**

County(s) Served: \_\_\_\_\_

To what extent do you deal with juvenile offenders?	Not at All	Very Little	Sometimes	Most of the Time	All of the Time
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27. How do you identify whether an offender has mental health problems and needs further evaluation?
28. What are the strengths and weaknesses of the current mental health evaluation process?
29. What is Probation's role with regard to identifying and handling juvenile offenders with mental health problems? What are the strengths and weaknesses of this role?
30. What is Probation's role with regard to identifying and handling juvenile offenders with substance abuse problems (if different from mental health problems)? What are the strengths and weaknesses of this role?
31. What is the Office of Juvenile Services' role with regard to identifying and handling juvenile offenders with mental health problems? What are the strengths and weaknesses of this role?
32. What is the Office of Juvenile Services' role with regard to identifying and handling juvenile offenders with substance abuse problems (if different from mental health problems)? What are the strengths and weaknesses of this role?
33. What impact do mental health problems have on handling juvenile offenders and achieving a "successful outcome" (i.e., no recidivism)?
34. How would you describe access to mental health services for juvenile offenders? How would you describe access to substance abuse services (if different)?
35. How would you describe the payment options for mental health services for juvenile offenders? How would describe payment options for substance abuse services (if different)? What are the strengths and weaknesses of these options?

36. How would you characterize mental health providers' ability to treat juvenile offenders? How would you characterize substance abuse providers' ability (if different)?
37. Overall, what would make the system more effective and efficient at addressing mental health and substance abuse needs of juvenile offenders?
38. What geographical differences characterize the process of identifying and accessing mental health and substance abuse services for juvenile offenders?
39. What are the race, ethnicity, and gender issues surrounding the identification and access to mental health and substance abuse services for juvenile offenders?