Youth with Mental Illness in the Juvenile Justice System

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Abstract

Within the past ten years, dependence on the juvenile justice system to meet the needs of juvenile offenders with mental health concerns has increased. This research project takes a look at how the worlds of mental health and juvenile justice appears to collide more than ever in the recent past. The persistent overlapping makes the need to analyze and improve the processes/practices for impacted youth a priority for both systems. This research project also seeks to understand the perspective of the juvenile justice decision makers and gain insights on need areas of focus as well as make recommendations to address the mental health needs of youth in the juvenile justice system.

Introduction

The juvenile justice (attorneys, judges, detention, probation, youth corrections facilities, etc.) system is presently faced with the task of providing mental health assessments and treatment services for its youth, as there is greater dependence on the juvenile justice system to do so (Underwood, L., & Washington, A. (2016). The juvenile justice system was originally both rehabilitative and preventative approach, emphasizing the needs and rights of children over the appeal to punish them. The 1980s to the 1990s offered a fascinating shift in the juvenile system's treatment of juvenile offenders. Prior to the 1980s, juveniles were seen as rehabilitative; however, due to a brief surge in violent delinquency, protecting the community became the primary goal. Consequently, the juvenile justice system established an approach that uses a punishment/criminalization perspective over a rehabilitative/medicalization perspective (Underwood, L., & Washington, A. (2016). According to the U.S. Department of Health and Human Services, mental health includes a person's psychological, emotional, and social well-being and affects how a person feels, thinks, and acts. Mental disorders relate to issues or difficulties a person may experience with his or her psychological, emotional, and social well-being. As Stahl and colleagues explained, "each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom" (Stahl, A., Finnegan, R. & Kang W., 2007).

Between 5% and 9% of all children meet the criteria for serious emotional disturbance, including serous mental illness (Friedman et al. 1996), yet as few as 10% of youth with serious mental illness receive adequate treatment (USDSHHS, 2000). Serious mental illnesses are classified as brain disorders by the National Institute of Mental Health, just like epilepsy and autism, and are distinguished from other mental

disorders such as anxiety, adjustment, attention, or conduct disorders by the amount of impairment, including cognitive impairment. Without treatment, these illnesses impair youths' ability to discern reality from delusions or hallucinations which dramatically affects their social, academic, and occupational development. Yet the symptoms of serious mental illnesses, which include problems with judgment and insight, are highly treatable with proper medication and social supports. Untreated, however, these symptoms cause erratic behavior and impaired judgment which place youth with serious mental illness at increased risk of encountering the juvenile justice system. Unlike youth with other mental disorders, youth with serious mental illness are most often incarcerated for relatively minor offenses including disrupting public order or status offenses (acts that would not be a crime if committed by an adult such as truancy, running away, smoking cigarettes or drinking alcohol, curfew violations, and chronic disobedience). Two-thirds of youth with serious mental illness were incarcerated for non-violent offenses, which were often the direct result of the untreated symptoms of their illness (Skowyra & Cocozza, 2007). In other cases, shortages in mental health services leave youth with serious mental illness who have not even committed a crime to wait in juvenile detention facilities until mental health treatment becomes available (GAO 2003; US House of Representatives Committee on Government Reform 2004), a phenomenon which has not been observed among youth with other mental disorders. The Juvenile Justice System, however, was not designed to treat serious mental illness and does not have the capacity or mandate to do so (Skowyra & Cocozza, 2007); consequently, as few as 10% of incarcerated youth with serious mental illness receive treatment (USDHHS 2000). Often, their symptoms are treated as discipline problems, which can worsen their condition and suicide rates of incarcerated youth are 4–5 times that of the general population (Farand et al. 2004; Memory 1989).

Juvenile justice systems use a variety of tools to identify mental health needs, although most fall into one of two categories:

1. Screening. The purpose of screening is to identify youths who might require an immediate response to their mental health needs and to identify those with a higher likelihood of requiring special attention (Vincent 2012). It is like a triage process in a hospital emergency room. Although there are numerous screening instrument options, two commonly used are the Massachusetts Youth Screening Instrument—Version 2 (MAYSI-2; Grisso & Barnum, 2006) and the Diagnostic Interview Schedule for Children (Wasserman, McReynolds, Fisher, & Lucas, 2005). In addition to tools that screen for multiple mental health-related issues, there are also tools that screen for specific problems, such as the Children's Depression Inventory (Kovacs, 1985) or the Suicidal Ideation Questionnaire (Reynolds, 1988), which can help determine if a youth should be monitored for suicide attempts upon entry to detention or residential facility.
2. Assessment. The purpose of assessment is to gather a more comprehensive and individualized profile of a youth. Assessment is performed selectively with those youths with higher needs, often identified through screening. Mental health assessments tend to involve specialized clinicians and generally take longer to administer than screening tools (Vincent, 2012). There are numerous mental

health assessments. One widely studied assessment is the Achenbach System of Empirically Based Assessment (Achenbach & Rescorla, 2001), which includes three instruments completed by youths (Youth Self-Report), parents (Child Behavior Checklist), or teachers (Teachers Report Form).

The relationship between mental health problems and involvement in the juvenile justice system is complex. Although these two problems often go hand and hand, it is not clear that one causes the other. Many youths who offend do not have a mental health problem, and many youths who do have a mental health problem do not offend (Schubert & Mulvey, 2014). There has been research to show how mental health diagnoses and problem behaviors are associated with each other. But as is often emphasized, correlation does not mean causation. In addition, certain risk factors could increase the occurrence of both mental health and problem behaviors in youths. For example, exposure to violence can increase mental health issues, such as post-traumatic stress, in youth and increase the occurrence of delinquent behavior (Finkelhor et al., 2009). Although the research can point to a relationship between mental health issues and juvenile justice involvement, it remains difficult to determine the exact correlation.

The juvenile justice system is facing the trend experienced by the adult criminal justice system- the criminalization of mental illness. Youth facilities have become substitute mental health "hospitals," while also facing the pressure of economic constraints, difficulties recruiting and retaining qualified staff, and the possible shift in focus from a treatment and rehabilitation model to one of custody and control (Cocozza, J. J. & Skowyra, K., 2000). Legally, these facilities are obligated to provide adequate medical and mental health services to offenders in their care. The U.S. Department of Justice, pursuant to the Civil Rights of Institutionalized Persons Act of 1080 and the Violent Crime Control and Law Enforcement Act of 1994, notes that it continues to investigate allegations of systemic abuse and civil rights violations related to the conditions of confinement, including the provisions of adequate mental health services and suicide prevention. The spotlight has now turned to the juvenile justice system. Investigations have resulted in federal lawsuits, consent decrees and settlement agreements which challenge conditions and mandate major program reforms and mental health service improvements at juvenile facilities across the country (Snyder & Sickmund, 2006).

Successful community reentry remains an essential goal of juvenile correctional systems. While success and failure can be statistically tracked and defined. It is important to remember that those figures are created child by child. A substantial number of juveniles need and are entitled to mental health treatment programs delivered by qualified mental health staff to strengthen their ability to make positive life choices. Although statistical data and the needs of these youths are influenced by multiple factors- including family, gender, developmental level, culture, peers and education – researchers have identified several strategies to assist juveniles affected with mental health and/or substance abuse problems to enhance the probability of their risk of reoffending. These strategies include assessment, identification, treatment planning, interventions, and community services coordination (National Alliance on Mental Illness, 2006).

All youths must be screened for mental health problems at initial contact with the juvenile justice system and admission to a residential placement or facility as part of the intake process. The screening should include evaluation for, current risk or history of suicide, mental health problems, substance abuse, medications, aggressive or violent behavior, psychiatric hospitalization, or treatment, and current mental status. This information should be derived from multiple sources (e.g., courts, family, school, previous providers, direct observation, and self-reports). Following the initial assessment, periodic evaluations should be completed for an ongoing assessment of mental health status. Some studies have shown that substance abuse treatment has significantly decreased chance of success if an existing co-occurring mental health disorder remains unknown and untreated (National Alliance on Mental Illness, 2006). The screening tool must be designed and approved by a credentialed mental health professional and implemented by effective training and qualified staff. All direct care staff must initially train and periodically retrained on the signs and symptoms of mental illness, suicide risk behavior, appropriate responses, and referral procedures (National Alliance on Mental Illness, 2006).

Youths identified upon initial screening as at risk for imminent harm must be protected and referred for immediate evaluation by a credentialed mental health professional. Youths found to have had prior mental health issues, a history of substance abuse, and/or present behaviors associated with a current mental health concern must be referred in a timely manner for appropriate follow-up evaluation and individualized treatment planning by a qualified professional. Studies support that early identification of mental health disorders, partnered with integrated, individualized, evidence-based mental health interventions, increase the likelihood of long-term positive outcomes when initiated at an early age (12 or younger). The lack of identification and intervention increases the risk of continued school failure, limited or nonexistent employment opportunities, unstable social and family relationships, and high-risk behaviors, increasing the potential for chronic criminal behavior into adulthood (National Alliance on Mental Illness, 2006). Treating mental illness is imperative to help reduce criminal justice involvement within the juvenile population. Receiving mental health care will help decrease the likelihood for youth to reoffend, ultimately reducing recidivism rates.

This link between certain mental health problems and delinquency has also been studied for youths in certain subpopulations. Among maltreated youths living in out-of-home care, the presence of a mental health disorder was significantly associated with juvenile justice system involvement, and conduct disorder was the strongest predictor (Yampolskaya & Chuang, 2012). A study of psychiatric-inpatient adolescents found that having a disruptive disorder, a history of aggressive behavior, and using cocaine were all predictors of juvenile justice system involvement (Cropsey, Weaver, & Dupre, 2008). Trauma or exposure to violence may also increase the likelihood of juvenile justice involvement. Multiple studies show a connection between childhood violence exposure and antisocial behavior, including delinquency, gang involvement, substance use, posttraumatic stress disorder, anxiety, depression, and aggression (Wilson, Stover, & Berkowitz, 2009; Finkelhor et al,. 2009). In the Northwestern Juvenile Project, 92.5 percent of detained youths reported at least one traumatic experience, and 84 percent reported more than one (Abram et al,. 2013). Other studies that have looked

at past traumatic exposures in juvenile justice populations have also found high rates (e.g., Romaine et al. 2011; Rosenberg et al. 2014).

Multiple studies confirm that a large proportion of youths in the juvenile justice system have a diagnosable mental health disorder. Studies have suggested that about two thirds of youth in detention or correctional settings have at least one diagnosable mental health problem, compared with an estimated 9 to 22 percent of the general youth population (Schubert & Mulvey, 2014; Schubert, Mulvey, & Glasheen, 2011). The 2014 National Survey on Drug Use and Health found that 11.4 percent of adolescents aged 11 to 17 had a major depressive episode in the past year, although the survey did not provide an overall measure of mental illness among adolescents (Center for Behavioral Health Statistics and Quality, 2015). Similarly, a systematic review by Fazel and Langstrom (2008) found that youths in detention and correctional facilities were almost 10 times more likely to suffer from psychosis than youths in the general population. These diagnoses commonly include behavior disorders, substance use disorders, anxiety disorder, attention deficit/hyperactivity disorder (ADHD), and mood disorders (Chassin, 2008; Gordon & Moore, 2005; Shufelt & Cocozza, 2006; Teplin et al. 2003). The prevalence of each of these diagnoses, however, varies considerably among youths in the juvenile justice system. For example, the Pathways to Desistance study (which followed more than 1,300 youths who committed serious offenses for 7 years after their court involvement) found that the most common mental health problem was substance use disorder (76 percent), followed by high anxiety (33 percent), ADHD (14 percent), depression (12 percent), posttraumatic stress disorder (12 percent), and mania (7 percent) (Schubert, Mulvey, & Glasheen, 2011; Schubert & Mulvey, 2014). A multisite study by Wasserman and colleagues (2010) across three justice settings (system intake, detention, and secure post-adjudication) found that over half of all youths (51 percent) met the criteria for one or more psychiatric disorders. Specifically, one third of youths (34 percent) met the criteria for substance use disorder, 30 percent met the criteria for disruptive behavior disorders, 20 percent met the criteria for anxiety disorders, and 8 percent met the criteria for affective disorder.

Researchers have also found disparities—particularly by race/ethnicity, gender, and age—in who is referred for treatment in the juvenile justice system. Racial disparities exist among mental health diagnoses and treatment in both the community and the juvenile justice system. In the community, researchers have found that youths of color are less likely to receive mental health or substance use treatment (Dembo et al. 1998; Garland et al. 2005). Researchers have also found that minority youths receive fewer services than white youths in the foster care and child welfare populations (Garland & Besinger 1997; Horwitz et al. 2012). Among youths being served by mental health systems, youths of color are more likely to be referred to the juvenile justice system than white youths (Cauffman et al. 2005; Evens & Vander Stoep 1997; Scott, Snowden, & Libby, 2002; Vander Stoep, Evens, & Taub, 1997). Once in the juvenile justice system, minority youths are less likely to be treated for mental health disorders than white youths (e.g., Dalton et al. 2009; Herz 2001; Rawal et al. 2004). According to a 2016 systematic review of articles that examined racial disparities among referrals to mental health and substance abuse services from within the juvenile justice system, most of the studies published from 1995 to 2014 found that there was at least some race effect in determining which youths received services,

even when including statistical controls for mental health or substance use diagnosis or need (Spinney et al. 2016).

Methods

The population of interest for this study consisted of current Department of Juvenile Justice employees who are actively involved in the juvenile justice system such as juvenile probation officers, senior probation officers, juvenile probation officer supervisors, assistant chief probation officers, chief probation officers, and the Office of Health Services. Other stakeholders such as Assistant State Attorneys, Public Defenders, and Judges were also included in this study. This survey was designed to gather demographic information pertaining to gender identity, age ranges, and career fields. Additional questions were used to establish whether or not the juvenile justice system is the most appropriate system to manage mental illness in youth, reasons youth with mental illness enter the juvenile justice system, and others. The 12 question survey (see appendix A) was formatted and created on SurveyMoney.com and the link was forwarded to all probation officers, senior probation officers, juvenile probation officer supervisors, assistant chief probation officers, chief probation officers, and the Office of Health Services within the Florida Department of Juvenile Justice. The link was also sent to other stakeholders such as Assistant State Attorneys, Public Defenders, and Judges on February 1, 2022 with a completion date of February 18, 2022. The questions were single response questions and was voluntary and anonymous.

Results

The survey was sent to 2 probation circuits (2 and 5) and the office of Health Services. In all 103 surveys were distributed and a total of 62 surveys were completed. The surveys can be found in Appendix 1. The ten (10) questions asked in the survey ranged from yes/no questions to rating scale questions. All questions were answered by all individuals surveyed, with the exception of question one (1) with one individual skipping the question.

The first survey question asked the participants their gender identity. The results of the study affirmed that 22 of individuals surveyed were male (35.48%) and 40 were females (64.52%).

The survey question number two (2) asked the participants their age range. The results of the study confirmed that there were 10 participants between the ages of 21-29 (15.9%), 18 between the ages of 30-39 (28.6%), 13 between the ages of 40-49 (20.6%), 13 between the ages of 50-59 (20.6%), and 9 between the ages of 60 and older (14.3%).

The survey question number three (3) asked the participants their career fields. The results of the study confirms that 5 of the participants work in the social services field (7.9%),1 works in law enforcement (1.6%), 2 works within the judiciary (3.2%), 43 works

in the probation field (68.3%), 4 works as a state attorney (6.4%), 1 works as a public defender (1.6%), and 7 works as a community stakeholder (11.1%).

The survey question number four (4) asked the participants what is the most common mental illness in youth. The results of the survey confirmed 19 of participants believe Depression (30.2%), 8 believes Anxiety (12.7%), 34 believes ADHD (54%), 0.00% believes schizophrenia, 2 believes other (3.2%).

The survey question number five (5) asked the participants do they believe the juvenile justice system is the most appropriate system to manage mental illness in youth. The results of the survey confirmed that 5 of the participants said yes (8%), 46 said no (73%), and 12 was unsure (19%).

The survey question number six (6) asked the participants do they think mental illness contributes to criminal behavior. The results of the survey confirmed that 55 said yes (87%), 4 said no (6.4%), and 4 was unsure (6.4%).

The survey question number seven (7) asked the participants what was the root cause of youth with mental illness entering the juvenile justice system. The results of the survey confirm that 17 believed it is a lack of appropriate community services (27%), 13 believes it is over criminalization (20.6%), 28 believes it is a lack of awareness of mental illness service needs (44.4%), and 5 believes it is other (8%).

The survey question number eight (8) asked the participants what was the biggest challenge that the juvenile justice system faces in addressing the needs of youth with mental illness. The results of the survey confirms that 23 believes it is a lack of appropriate services (36.5%), 5 believes it is a lack of qualified professionals (7.9%), 12 believes that it is a lack of treatment facilities/beds (19.1%), 11 believes that it is a lack of awareness of mental health services/needs (17.5%), and 12 believes it is other (19.1%).

The survey question number nine (9) asked the participants what can the juvenile justice system do to better assist youth who come into the system with mental illness. The survey confirms that ten (10) believes that implement earlier identification processes for quicker connections to appropriate services (15.87%),12 believes create better partnerships with community and other system stakeholders to more effectively use resources available to address mental illness (19.1%),14 believes that hiring more qualified staff to work within the court process and bridge the gaps to services (22.2%), 22 believes more treatment facilities specifically for youth with mental illness (34.9%), and 5 believes other (7.9%).

The survey question number ten (10) asked participants does youth with mental illness receive adequate mental health services while subject to the Department of Juvenile Justice supervision. The result of the survey confirms that 16 replied yes (25.4%),15 replied no (23.8%), and 32 replied unsure (50.8%).

Discussion

The survey was designed to gain insight into the persistent overlapping of mental illness and the juvenile justice system from juvenile probation officers, state's attorneys, public defenders, judges, and community stake holders makes the need to analyze and improve the processes/practices for impacted youth a priority for both systems. The survey seeks to understand the perspective of juvenile justice decision makers and gain insights on the need areas of focus. Also, numerous books, magazines, and articles have been written on the topic of mental illness in the juvenile justice system. Upon review of the responses to the survey as well as my research of many books, magazines, and articles it appears that evidence-based treatment services, such as wraparound services and various types of therapy, are more efficacious when they are centered in the community rather than use of these treatments within the system. I was a little surprised that out of 103 surveys that were distributed, only 62 respondents completed the survey which is a response rate of 60.2%.

In reviewing data from the survey, 50.8% of respondents were unsure if youth receive adequate mental health services while subject to the Department Juvenile Justice supervision. This is not surprising, due to many of the respondents not being aware of all the mental health services that are available in the community. It's also not surprising that 73% of respondents believe that the juvenile justice system is not the most appropriate system to manage mental illness in youth. During my research for this paper, I found that the juvenile system may worsen youths' existing mental health problems for many reasons. For example, there is inconsistency across some of the decision points of the juvenile justice system in providing referrals to treatment, appropriately screening, assessing, and treating juveniles with mental health conditions. Throughout my research I found that there is indeed a persistent overlapping of mental illness and the juvenile justice system. This requires all stakeholders including the judiciary, probation officers, law enforcement, parents/guardians, etc. to all be on the same page if there is any chance of making a positive impact in youth who enter the juvenile justice system with a mental illness.

Recommendations

There are several recommendations that emerged from this study. Some of the recommendations will be easier to accomplish than others, but still should be given some consideration in order to address the mental health needs of youth in the criminal justice system. Recommendations include the following:

1. Individuals who provide mental health treatment and educational instruction in secure settings need a thorough understanding of the unique needs and evidence-based practices related to this population.

2. Provide evidence-based mental health and substance abuse screening to youth committed to secure facilities, provide effective mental health treatment while in detention, and link youth to follow-up services upon release on a consistent basis.

3. Ensure schools are equipped with adequate mental health services and clinicians that can provide assessment, screening and counseling services and referrals to additional community resources as well.

4. Divert youth from incarceration and facility commitment whenever possible and when public safety allows by investing in evidence-based programs as alternatives to incarceration, like Functional Family Therapy, Thinking for a Change, and Aggression Replacement Training.

5. Multiple systems bear responsibility for justice-involved youth and all mental health services provided to youth in contact with the juvenile justice system should respond to issues of gender, ethnicity, race, age, sexual orientation, socio economic status and faith.

6. Services and strategies aimed at improving the identification and treatment of youth with mental health needs in the juvenile justice system should be routinely evaluated to determine their effectiveness in meeting desired goals and outcomes.

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References

Abram, K.M., Teplin, L.A., King, D.C., Longworth, S.L., Emanuel, K.M., Romero, E.G., McClelland, G.M., Dulcan, M.K., Washburn, J.J., Welty, L.J. & and Olson, N.D. (2013). *PTSD, trauma, and comorbid psychiatric disorders in detained youth.* Juvenile Justice Bulletin. Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Achenbach, T.M., & Rescorla, L.A. (2001). *Manual for the ASEBA School-Age* Forms & Profiles. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

Cauffman, E., Scholle, S.H., Mulvey, E. & Kelleher, K.J. (2005). Predicting first time involvement in the juvenile justice system among emotionally disturbed youth receiving mental health services. *Psychological Services 2*(1), 28–38.

Cocozza, J. J. (2005). *Diverting youth with mental health needs from the juvenile justice system*. Presentation to the GAINS TAPA Center for Jail Diversion Easy Access Net/Teleconference.

Cocozza, J.J. & Skowyra, K. (2000). Youth with mental health disorders: Issues and emerging responses. *Juvenile Justice*, *7*(1), 3-13. Washington, D.C.: OJJDP.

Cropsey K. L., Weaver, M.F. & Dupre, M.A. (2008). Predictors of involvement in the juvenile justice system among psychiatric hospitalized adolescents. *Addictive Behaviors 33*(7), 942–49.

Dalton, R.F., Evans, L.J., Cruise, K.R., Feinstein, R.A. & Kendrick. R.F. (2009). Race differences in mental health service access in a secure male juvenile justice facility. *Journal of Offender Rehabilitation 48*(3),194–209.

Erickson, C.D. (2012). Using systems of care to reduce incarceration of youth with serious mental illness. *American Journal of Community Psychology, 49*(3-4), 404-416. https://doi.org/10.1007/s10464-011-9484-4

Evens, C.C., & Vander Stoep, A. (1997). Risk factors for juvenile justice system referral among children in a public mental health system. *Journal of Mental Health Administration 24*(4), 443–55.

Farand, L., Chagnon, F., Renaud, J., & Rivard, M. (2004). Completed suicides among Quebec adolescents involved with juvenile justice and child welfare services. *Suicide and Life-Threatening Behavior*, *34*(1), 24–35.

Garland, A. F., & Besinger, B.A. (1997). Racial/Ethnic differences in court referred pathways to mental health services for children in foster care. *Children and Youth Services Review 19*(8), 651-66.

Gordon, J.A., & Moore, P.M. (2005). ADHD among incarcerated youth: An investigation on the congruency with ADHD prevalence and correlates among the general population. *American Journal of Criminal Justice 30*(1), 87–97.

Grisso, T. & Barnum, R. (2006*). Massachusetts youth screening instrument, youth version 2: User's manual and technical report*. Sarasota, Fla.: Professional Resource Press.

Herz, D. C. (2001). Understanding the use of mental health placements by the juvenile justice system. *Journal of Emotional Behavioral Disorders 9*(3), 172–81.

Kovacs, M. (1985). The children's depression inventory (CDI)*. Psychopharmacology Bulletin 21*(4), 995–98.

National Alliance on Mental Illness. (2006). *Facts on children's mental health in America*. Arlington, Va.: National Alliance on Mental Illness.

Memory, J. M. (1989). Juvenile suicides in secure detention facilities: Correction of published rates. *Death Studies*, *13*(5), 455–463.

Rawal, P., Romansky, J., Jenuwine, M. & Lyons, J.S. (2004). Racial differences in the mental health needs and service utilization of youth in the juvenile justice system. *Journal of Behavioral Health Services and Research, 31*(3), 242–54.

Reynolds, W.M. (1988). *Suicidal ideation questionnaire professional manual.* Odessa, Fla.: Psychological Assessment Resources.

Romaine, C. L. R., Goldstein, N.E.S., Hunt, E. & DeMatteo, D. (2011). Traumatic experiences and juvenile amenability: The role of trauma in forensic evaluations and judicial decision making. *Child & Youth Care Forum 40*(5), 363–80.

Rosenberg, H.J., Vance, J.E., Rosenberg, S.D., Wolford, G.L., Ashley, S.W. & Howard, M.L. (2014). Trauma exposure, psychiatric disorders, and resiliency in juvenile-justice-involved youth. *Psychological Trauma: Theory, Research, Practice, and Policy, 6*(4), 430–37.

Schubert, C.A., & Mulvey, E.P. (2014). *Behavioral health problems, treatment, and outcomes in serious youthful offenders.* Juvenile Justice Bulletin. Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Schubert, C.A., Mulvey, E.P., & Glasheen, C. (2011). Influence of mental health and substance use problems and criminogenic risk on outcomes in serious juvenile offenders. *Journal of American Academy of Child & Adolescent Psychiatry 50*(9), 925–37.

Scott, M.A., Snowden, L. & Libby, A.M. (2002). From mental health to juvenile justice: What factors predict this transition?" *Journal of Child and Family Studies 11*(3), 299–311.

Shufelt, J.L., & Cocozza, J.J. (2006). *Youth with mental health disorders in the juvenile justice system*: *Results from a multistate prevalence study*. *Research and Program Brief*, 1–6. Delmar, N.Y.: National Center for Mental Health and Juvenile Justice.

Skowyra, K. R., & Cocozza, J. J. (2007). Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system. Delmar, NY: Policy Research Associates.

Snyder, H.N. & Sickmund, M. (2006). *Juvenile offenders and victims*: 2006 national report. Washington, D.C.: Officer of Juvenile Justice and Delinquency Prevention.

Spinney, E., Yeide, M., Feyerherm, W., Cohen, M., Stephenson, R., & Thomas, C. (2016). Racial disparities in referrals to mental health and substance abuse services from the juvenile justice system: A review of the literature. *Journal of Crime and Justice, 39*(1), 153–73.

Underwood, L., & Washington, A. (2016). Mental illness and juvenile offenders. *International Journal of Environmental Research and Public Health, 13*(2), 228. doi:10.3390/ijerph13020228

US Department of Health and Human Services (USDHHS). (2000). *Report of the surgeon general's conference on children's mental health: A national action agenda.* Washington DC: Department of Health and Human Services.

Vander Stoep, A., Evens, C.C. & Taub, J. (1997). Risk of juvenile justice system referral among children in a public mental health system. *Journal of Mental Health Administration, 24*(4), 428–42.

Vincent, G. M. (2012). *Screening and assessment in juvenile justice systems: Identifying mental health needs and risk of reoffending*. Washington, D.C.: Technical Assistance Partnership for Child and Family Mental Health.

Wasserman, G.A., McReynolds, L.S., Fisher, P. & Lucas, C. P. (2005). Diagnostic interview schedule for children: Present state voice version. In T. Grisso, G. Vincent, and D. Seagrave (eds*.). Mental Health Screening and Assessment in Juvenile Justice*. New York, N.Y.: Guilford Press, 224–239.

Wilson, H.W., Stover, C.S. & Berkowitz, S.J. (2009). Research review: The relationship between childhood violence exposure and juvenile antisocial behavior: A meta-analytic review. *Journal of Childhood Psychology and Psychiatry 50*(7), 769-79*.*

Yampolskaya, S., & Chuang, E. (2012). Effects of mental health disorders on the risk of juvenile justice system involvement and recidivism among children placed in out-of-home care. *American Journal of Orthopsychiatry, 82*(4)*,* 585-93.

Appendix

The worlds of mental health and juvenile justice appears to be colliding more often than ever in the recent past. The persistent overlapping makes the need to analyze and improve the processes/practices for impacted youth a priority for both systems. this survey seeks to understand the perspective of juvenile justice decision makers and gain insights on the need areas of focus.

1. What is your gender identity?
   A. Male
   B. Female
   C. Other

2. What is your age range?
   A. 21- 29
   B. 30- 39
   C. 40- 49
   D. 50-59
   E. 60 or older

3. What is your career field?
   A. Social Services
   B. LEO
   C. Judicial
   D. Probation
   E. Prosecutor
   F. Defense
   G. Other (Please Provide Career Field)

4. What is the most common mental illness in youth?
   A. Depression
   B. Anxiety
   C. ADHD
   D. Schizophrenia
   E. Other (Please List)

5. Do you believe the juvenile justice system is the most appropriate system to manage mental illness in youth?
   A. Yes
   B. No
   C. Unsure

6. Do you think mental illness contributes to criminal behavior?
   A. Yes
   B. No
   C. Unsure

7. What is the root cause of youth with mental illnesses entering the juvenile justice system?
   A. Lack of Appropriate Community Services
   B. Over Criminalization of Mental Illness Symptoms
   C. Lack of Awareness of Mental Illness Services/Needs
   D. Other (Please Explain)

8. What is the biggest challenge that the juvenile justice system faces in addressing the needs of youth with mental illness?
   A. Lack of Appropriate Services
   B. Lack of Qualified Professionals
   C. Lack of Treatment Facilities/Beds
   D. Lack of Awareness of Mental Illness Services/Needs
   E. Other (Please Explain)

9. What can juvenile justice system do to better assist youth who come into the system with mental illness?
   A. Implement earlier identification processes for quicker connections to appropriate services
   B. Create better partnerships with community and other system stakeholders to more effectively use the resources available to address mental illness
   B. Hire more qualified staff to work within the court process and bridge the gaps to services
   C. More treatment facilities specifically for youth with mental illness
   D. Other (Please Explain)

10. Does youth with mental illness receive adequate mental health services while subject to Department of Juvenile Justice supervision?
   A. Yes
   B. No
   C. Unsure