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Mental Health of Incarcerated Juveniles in Nevada: Final Report

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Mental Health of Incarcerated Juveniles in Nevada

Final Report

Prepared for

the State of Nevada, Trust Fund for Public Health

By

the Nevada Institute for Children's Research and Policy

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PART ONE

An Assessment of the Mental Health of Juvenile Offenders in Nevada

LITERATURE REVIEW

The prevalence of mental health problems in the juvenile offender population is substantially higher than that of the general population (Cocozza & Skowrya, 2000). Studies estimate that one in five juvenile offenders has serious mental health problems, which is nearly twice the rate of occurrence of mental illness in children and adults in the general population (NMHA Fact Sheet #1). However, there have been several methodological problems encountered in previous research. These include the use of inconsistent definitions and measurements of mental illness; the use of biased, non-random samples, a reliance on retrospective case report data, and the use of non-standard measurement instruments (Cocozza & Skowrya, 2000). All these factors can cause confusion on the actual prevalence rates of mental illness in the juvenile offender population. From other studies, tentative estimates of specific disorders prevalent among incarcerated youth are as follows: "50-90% with conduct disorder, up to 46% with attention deficit disorder, 6-41% with anxiety disorders, 25-50% with substance abuse or dependence, 32-78% with affective (emotional) disorders, and 1-6% with psychotic disorders" (Goldstrom et al,).

Substance Abuse & Mental Health

There is an established connection between substance abuse and mental illness. According to Cocozza (2000), one half of juveniles receiving mental health services have a co-occurring substance abuse disorder, and the estimates are even higher in the juvenile offender population. Juvenile offenders who are found to have a substance abuse problem often have co-occurring mental health problems (NMHA Fact Sheet #2).

Further, as many as 75-80% of adolescents receiving inpatient substance abuse treatment have a diagnosable mental health problem (Greenbaum, Foster-Johnson & Petrila, 1996). Appropriate and timely diagnosis and treatment of the mental disorder will improve the juvenile's chances for a successful recovery from the substance abuse problem, but will also reduce the chances for delinquent and violent behavior related to the mental illness.

There are other issues related to substance abuse in this population. Drug users are at a high risk for recidivism and bail violations (Dembo, et. al., 1990). Youths with emotional problems and who have been determined to be socially isolated or lonely generally report higher drug use. There is a clearly established relationship between early physical or sexual abuse and later drug use and delinquency. Further, drug users tend to have higher property crimes, drug delinquency, and status offenses than nonusers. Many of these drug users, about 55% of them, have seen a mental health professional before their entrance into the juvenile justice system. Approximately 16% have experimented with suicide, and many report parental alcohol abuse in their family history. In addition, alcohol use contributes to suicide ideation and often to participation in risky activities that may contribute to contact with the juvenile justice system (Windle, Miller-Tutzauer & Domenico, 1992).

Youth Victimization

Youth victimization clearly exacerbates mental health problems as well as substance abuse problems (Kilpatrick, Saunders, & Smith, 2003). Violent victimization includes witnessing violence as well as by being the target of it. Psychological problems, delinquency and substance abuse and dependence are all emotional consequences of

victimization. Violent victimization is a clear warning signal for future violent offending in juveniles (Shaffer & Ruback, 2002). The prevalence of youth victims of sexual assault, physical assault and physically abusive punishment is much higher in the juvenile detention centers. Some groups are at a higher risk for violent victimization than others (Shaffer & Ruback, 2002). Over 50% of black, Hispanic and American Indian youth have witnessed violence in the home. Older kids (16-17 years old) have a higher incidence of post-traumatic stress disorder (PTSD), substance abuse (especially hard drugs) and delinquency as a result of their victimization. Minority youth often are more likely to suffer from PTSD and substance abuse. Plus, for those youth who have been sexually assaulted, the rates of PTSD are four to five times higher than those who suffered no sexual assault. One study compared abused adolescents and non-abused adolescents with regard to perceived family functioning, showing that abused youth perceived their families as significantly more rigid, less adaptable, less cohesive and less balanced than the non-abused kids. Parents of abused youth were further perceived as less caring and emotionally unavailable (Pelcovitz, et. al., 2000).

Suicide and Mental Health

In addition to substance abuse problems, mental health is also related to suicide, especially for the juvenile offender population. Research estimates that suicide rates in juvenile detention centers are four times higher than the overall youth suicide rate (Hayes, 2000). Almost 80-90% of those adolescents who attempt suicide have a diagnosable psychiatric disorder, which is most commonly a mood disorder such as depression or anxiety (Esposito & Clum, 1999). According to the National Mental

Health Association, approximately 60% of youth involved in the juvenile justice system have a diagnosable affective disorder (NMHA Fact Sheet #1). Further, adolescents who have been diagnosed with a major depressive disorder are 27 times more likely to engage in suicidal behavior (Esposito & Clum, 1999). Suicide rates are twice as high for those with a mood disorder than for those without one (Rohde, Mace & Seeley, 1997). In a sample of juvenile detainees in one research project, 51% of the youth reported some suicidal ideation. Researchers have suggested that low self-esteem and hopelessness, which are common to juvenile offenders, may exacerbate the depression-suicide relationship (Esposito & Clum, 1999). In addition, substance abuse is a more significant risk factor for suicide when comorbid with an affective disorder than without. Further, the presence of conduct disorders may increase the risk for suicide in boys, but decrease the risk for girls (Rohde, Mace & Seeley, 1997).

According to Brent (1995), there are some serious risk factors for youth suicide, such as the co-occurrence of a mental health disorder and a substance abuse problem, impulsive aggression problems, parental depression and substance abuse, family discord and abuse, poor family support, and other life stressors such as interpersonal conflict and loss and disciplinary problems. Just the presence of a psychiatric disorder is a critical risk factor for suicide, but the strongest predictor of future suicide attempts is a past attempt (Rohde, Mace, & Seeley, 1997). Often, prior suicide ideation is exacerbated by incarceration (Brent, 1995). Therefore, it is essential that youth are screened for suicide ideation at facility intake so that staff will know if there is a problem and will be less likely to use isolation as a form of punishment for exhibited behavior problems. There is a further need to train facility staff in the issues surrounding suicide.

Female Offenders and Mental Health

Girls in the juvenile justice system generally have specific needs that are often not addressed by the programs in place for male offenders (NMHA Fact Sheet #3). Girls often exhibit higher rates of mental health problems than boys, with more diagnosed depression and a higher likelihood of suicide attempts. Low self-esteem, negative body image and substance abuse are often contributors. Substance abuse problems are often more acute in the female offender population, with some studies showing 60-87% of female offenders requiring substance abuse treatment. It has also been suggested that many of these female offenders turn to substances through self-medication as a coping mechanism for stress, mental health problems and exposure to trauma and abuse. Many of the adolescent female offenders demonstrate significantly more physical and sexual abuse than boys, with up to 70% of girls reporting such experiences (Evans, 1996).

The Surgeon General, in his Call to Action to Reduce Suicide, encourages early identification of mental health needs across multiple systems and suggests focusing attention on increasing access to and coordination of quality mental health services. For many juvenile offenders, their entrance into the juvenile justice system will be the first time they have been evaluated for mental illness, and it is critical that the assessment is done well so that the youth can get the help he or she needs.

One particular emphasis that must be made is that juvenile offenders often suffer from a multitude of problems culminating in their entrance into the juvenile justice system. They exhibit multiple symptoms and often have multiple diagnoses. This means

that there must be a wide variety of treatments, services and programs available to these youth to address these multiple problems.

Further, juvenile offenders often exhibit deficits in social skills compared to children in the community as a whole. They often act out more than community kids, and almost 20% of them have severe learning disorders. There is a demonstrated link between conduct disorders and mood disorders as well. Youth with behavior problems also tend to exhibit co-existing or consequent emotional problems. Delinquent behavior may overshadow the emotional problems and therefore the emotional disorder may be unrecognized and underreported. (Davis, Bean, Schumacher & Stringer, 1991).

By identifying any mental illness through a simple screening process at the juvenile's entrance into the detention center, the staff has the opportunity to get the offender the care he or she needs and begin the rehabilitation process. It is critical that "youth with mental health disorders who are placed in juvenile correctional facilities receive appropriate treatment" (Cocozza & Skowyra, 2000). Lack of appropriate mental health treatment in adolescence "may lead to further delinquency, adult criminality and adult mental illness" (Lexcen & Redding, 2000) as well as school failure, substance abuse, violence or suicide. Early identification and treatment of adolescent mental illness before an adolescent enters the juvenile justice system reduces a child's risk for these difficulties. However, providing adequate mental health services to those who have become involved in the juvenile justice system will reduce the prevalence of substance abuse and suicide in this population, as well as fostering the development of social skills, academic skills and occupational skills. The skill development opportunities can reduce recidivism and future involvement in the adult criminal justice system.

Terminology

There should be a clarification in terminology about screenings and assessments. Often they are used interchangeably to refer to the testing process. However, Grisso and Underwood (2003) suggest that a "screening" refers to a short triage process designed to identify at-risk youth at intake and refer them for further evaluation. Assessment is the second step, a more comprehensive process with individual attention and a focus on specific needs and problems identified during the screening.

In addition, there should also be a distinction made between mental health problems and serious mental disorders. Mental health problems are defined as "signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder" (Herz, 2002, p.5) and mental health disorders are defined as the "array of diagnoses contained in the Diagnostic Statistical Manual of Mental Disorders, Version IV (DSM-IV)" (Herz, 2002, p.5). The distinction is made to understand the role each plays in the system since the necessary intervention or treatment needs differ significantly between mental health problems and serious disorders.

METHODS

Participants

Participants were 660 adjudicated juveniles incarcerated in 12 of Nevada's 13 county and state juvenile detention centers. The Rite of Passage detention center was not included because it is a privately run facility. The final number of participants consisted of 547 males and 113 females.

Protocol

The Human Subjects Protocol for this study was approved on February 13, 2003 by the UNLV Institutional Review Board (OPRS #113F0103-010).

Materials and Procedure

Initial contact with the detention centers was made in January 2003. Contact information for the Chief Juvenile Probation Officers was received from the State Juvenile Justice Commission. A letter introducing the project was faxed to each Officer. A follow-up phone call was made to schedule time in the facility to administer the questionnaires. Each of the 12 detention centers was emailed a parent permission form for parents to sign during visits two to three weeks before researchers were to be in the facility. Researchers traveled to each facility between March and June to administer the questionnaires.

The juveniles who had received parent permission to participate were brought to the facility's classroom in groups of 15-20. When the juveniles were seated in the room, the researcher handed out the packet of questionnaires to each youth. The researcher

introduced the survey and discussed the rules of informed consent with the group.

Participants were told that this was a survey of their attitudes and behaviors which would help the researchers guide program development for the detention centers. Each youth was asked to read and sign the youth assent to participate form attached to the front of the packet. After the youth assent form was signed, the form was torn off the packet and placed in an envelope separate from the one that the packets were in to maintain anonymity.

Demographic Survey

The first packet filled out was a 25-question general demographic survey. The questions were descriptive in nature, asking about basic demographics such as age, sex, ethnicity, and current grade in school. Students were also asked to describe the reason they were here in detention. Other areas of inquiry included household and home life, with questions such as "Which of the following people live in the same household as you", "Are your parent(s)/guardian(s) currently employed". Other questions asked about history of mental illness or treatment, history of substance abuse, suicide, and violence in the home.

Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2)

The next questionnaire presented to the juveniles was the Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2). The MAYSI-2 is a self-report inventory that contains 52 questions with a "yes/no" response format that can be completed in 10 to 15 minutes. For example, question 4 asks "Have you had a lot of problems concentrating

or paying attention?" and question 16 reads "Have you felt like life was not worth living?" The questions create six scales that assess: Alcohol/Drug Use, Anger/Irritability, Depression/Anxiety, Somatic Complaints, Suicidality, and Thought Disturbance (used for boys only). Further, the instrument assesses the youth's experiences with traumatic incidents.

Manifestation of Symptomatology Scale (MOSS)

Next, the juveniles completed the Manifestation of Symptomatology Scale (MOSS). The MOSS is a self-report inventory that contains 124 short statements with a "true/false" response format. The questions describe a range of behaviors and emotional states and can be completed in 20 to 30 minutes. For example, question 21 reads "It is not hard to follow rules" and question 80 reads "I cannot do many things well". The questions create thirteen content scores which examine Suspiciousness, Self-Esteem, Familial Issues, Home Environment Issues, Impulsivity, School Issues, and Compliance. Three summary indexes combine the thirteen content scores to look at the youth's Affective State, Home Environment, and Acting Out behaviors. There are also four validity scores (i.e., Inconsistent Responding, Random Responding, Faking Good, and Faking Bad) which alert the researcher to possible problems with the data.

Limitations of the Data

The data collected in this assessment process have several limitations that must be considered when discussing the results. First, the data are self-report data, and self-report data has some inherent limitations. The responses may be intentionally false, when the

respondent denies or inflates behavior reports in order to be perceived a certain way by the researcher. The responses may be inaccurate due to difficulties remembering events or behaviors, even when the youth is trying hard to be accurate. Further, the youth may respond randomly due to deliberate lack of caring or inconsistently due to inattention. The data are not validated in any way to check for accuracy. Further, the data only represent completed assessments from 660 adjudicated youth between the ages of 12 and 18 currently serving time in detention in one of the 12 publicly funded facilities in Nevada. The data should not be used to extrapolate to the general population of teenagers. These youth represent almost the complete population, rather than a sample.

The MOSS scales have four built-in scales to assist the researcher or psychologist in determining the validity of a juvenile's scores on the other scales. The first two are the Faking Good/Faking Bad scales. These scales examine whether the respondent is answering positively in an effort to appear better, or whether they are pretending to be worse than they are for attention's sake. The second two were designed to show patterns of inconsistent responding or random responding when answering questions.

RESULTS

The data set includes responses and test scores from 660 youth detained or incarcerated in 12 public detention facilities in Nevada. The data were collected at one point in time for each facility during the spring of 2003. It is estimated that less than 50 youth were not included in the data collection. Thus, the sample should provide a reasonable estimate of the prevalence of each factor at that time.

Descriptive statistics, primarily frequencies, were calculated for each of the variables. Inferential statistical tests such as correlations, regression analysis and analysis of variance, were used where appropriate, to examine the data in greater detail. A description of the data and a summary of the major findings are presented below. Note that the frequency distributions include percents rather than counts. This is to better represent the estimated prevalence of a particular variable of interest.

The Scope of the Mental Health Problem in Nevada

In order to create an overview of the mental health problems in Nevada's juvenile delinquents, the scales were combined for each juvenile. All MAYSI-2 and MOSS scores have a cut-off point for "acceptable" and for at-risk scores coded as "caution" or "warning". All scores at or below the cut-off point, i.e., in the "acceptable" range were assigned a zero (0). All scores above the cut-off point, i.e., in the "at risk" range were assigned a one (1). A summary score of all 0's and 1's was calculated for each individual. Summary scores ranged from 0 to 6 depending on the test. A score of 0 means the individual scored in the acceptable range on all test components. Scores between 1 and 3 indicate the individual scored in the at-risk range in one, two, or three

areas and probably should be evaluated further. Scores between 4 and 6 indicated the individual scored in the at-risk range in four, five or all six areas and may have serious mental health issues.

It must be stated that this research does not substitute for a comprehensive assessment and diagnosis by a mental health professional. The tools used in the research are screening tools designed to identify signs of mental health problems and to assist facility staff in determining which juveniles need further assessments and treatment.

Without the Drug Scales

In order to have comparison numbers for the Drug-Included scales, the second set of numbers was calculated without the substance abuse scales included. The numbers were calculated using both the MOSS and the MAYSI-2 scales, though the scales were not combined.

The MAYSI-2 scales were calculated for boys and girls separately, because there is one subscale in the screening tool that applies only to males. For boys, without the drug scale included in the calculations, our research shows that 95% of the adjudicated boys showed signs of a mental health disorder with a mere five percent of participants showing no sign of mental illness. Further analysis shows that 49% of those youth fall into the middle (or "Caution") range, where further assessment is necessary, while the remaining 47% fall into the high ("Warning") stage, meaning that these juveniles should be provided with immediate mental health services. The girls show a much different picture. While there are more delinquent girls than boys demonstrating no signs of mental health problems (9%), the split in the Caution and Warning categories differ

greatly. For boys, the division between these categories was approximately equal. For girls, only 35% fall into the Caution field, and 55% fall into the Warning category. This shows that there is a greater need for immediate services to be provided to girls in detention.

The percentages calculated using the MOSS scales without the drug scale show 78% of kids having a mental health problem, with 48% falling into the Caution category and 30% in the Warning category.

Including the Drug Scales

Working on the premise that substance abuse problems can contribute to or exacerbate existing mental health problems, the first set of numbers was calculated with the substance abuse scales included. The numbers were calculated using both the MOSS and the MAYSI-2 scales, though the scales were not combined.

The MAYSI-2 scales were calculated for boys and girls separately, because there is one subscale in the screening tool that applies only to males (the Thought Disturbance scale). If you include the drug scale in the analysis, only 3% of boys demonstrate no signs of mental illness as compared to 5% without the drug scales. Further, the “Caution” category is much smaller, compared to the original number, with only 35% falling into this category. The “Warning” category includes 63% of the participants. This backs up existing research which suggests that substance abuse exacerbates mental health problems. For the girls, there were 5% showing no signs of mental health problems, suggesting that some of the girls simply have a substance abuse problem. The “Caution” category included 26% of respondents, a reduction of approximately 10% from

the non-drug calculations, and the “Warning” category included 68% of the girls. The large increase in the number of girls and boys falling into the warning category after the substance abuse scales are included in the calculation demonstrates a need for substance abuse treatment programs in detention. It also shows that many of the youth have co-occurring substance abuse and mental health disorders, something that must be taken into account during program development.

The percentages calculated using the MOSS scales with the drug scale included are comparable to those calculated with the MAYSI. Only 3% of kids show no mental health problems, 67% fall into the Caution category, and 30% fall into the Warning category. This suggests that the 30% of problems identified with the MOSS are serious and unaffected by the drug scale, and therefore require more in-depth assessments and immediate treatment.

Facilities

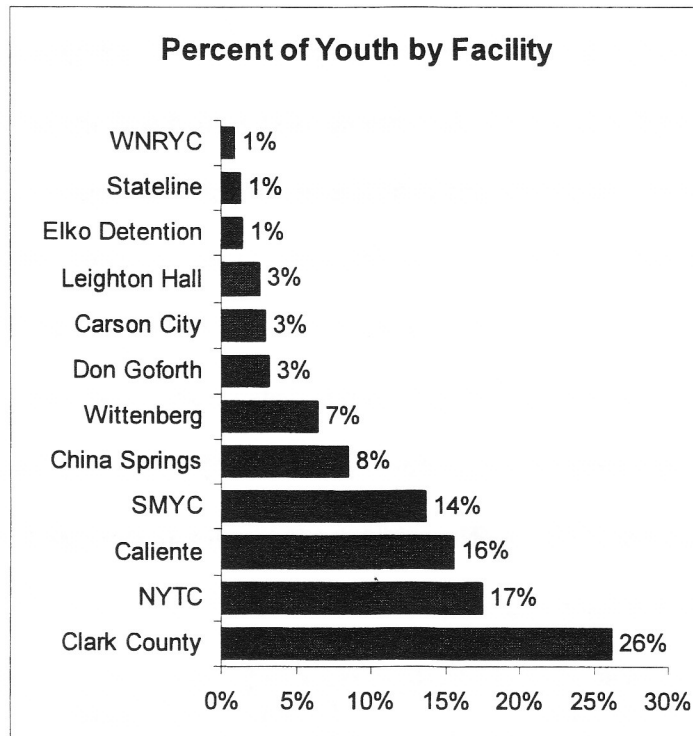
The data were collected once, from each of the 12 public juvenile detention centers in Nevada (See Table 1). The privately run facility in Douglas County, Rite of Passage, was not included in the sample.

Table 1. Juvenile Facilities in the State of Nevada (13*)

Nevada Youth Training Center <i>Elko County</i> <i>DCFS**</i>	Caliente Youth Center <i>Lincoln County</i> <i>DCFS</i>
China Spring Youth Camp <i>Douglas County</i> <i>DCFS</i>	Spring Mountain Youth Camp <i>Clark County</i> <i>DJJS***</i>
Clark County Juvenile Center <i>Clark County</i> <i>DJJS</i>	Elko County Detention <i>Elko County</i> <i>County Probation</i>
Leighton Hall <i>Humboldt, Lander, Pershing</i> <i>County Probation</i>	Wittenburg Hall <i>Washoe County</i> <i>County Probation</i>
Stateline Juvenile Detention <i>Douglas County</i> <i>County Probation</i>	Don Goforth Detention <i>Mineral County</i> <i>County Probation</i>
Murphy Bernardini Juvenile Detention <i>Carson City</i> <i>County Probation</i>	Western Nevada Regional Youth Center <i>Lyon County</i> <i>5 county co-op****</i>

*There were 14 facilities prior to 2002 – Summit View Youth Correctional Center in Clark County (privately run) closed on January 30, 2002
 **State Department of Child & Family Services
 *** Clark County Dept. of Juvenile Justice Services, formerly the Dept. of Family & Youth Services
 **** Counties include: Lyon, Douglas, Storey, Churchill, Carson City

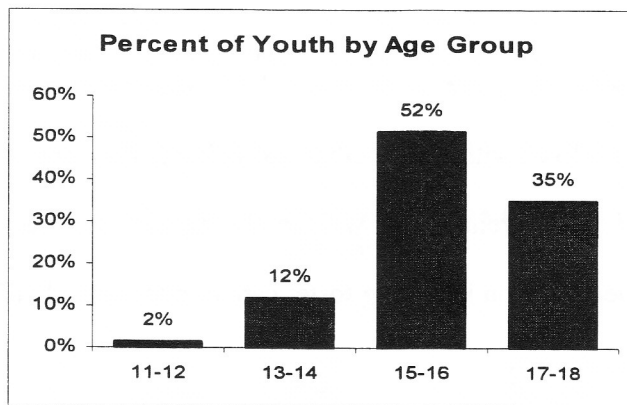
Clark County Juvenile Center in Southern Nevada and the Nevada Youth Training Center (NYTC) in Elko were the largest participating sites. The smallest facilities were the Western Nevada Regional Youth Center (WNRVC), Stateline Juvenile Detention, and Elko County Juvenile Detention.



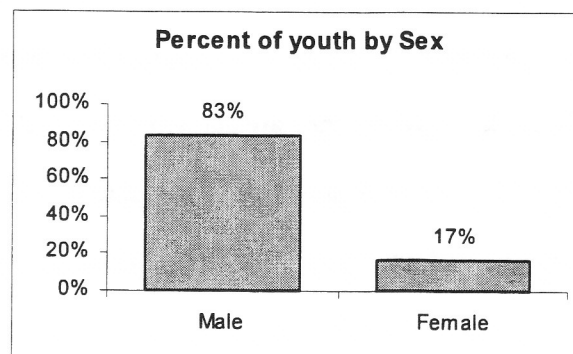
There were three sites determined to be urban: Wittenburg Hall in Washoe County, Clark County Juvenile Center, and the Spring Mountain Youth Camp (SMYC) which is administered by Clark County. The youth at these sites comprised 46% of the population. The other nine sites were deemed rural due to smaller sizes and more isolated locations. The youth at the rural sites comprised 54% of the population. Further,

there are three detention centers run by the State Department of Child & Family Services: Caliente Youth Center, Nevada Youth Training Center, and China Springs Youth Camp. The youth at the state facilities comprised 42% of the population. The remaining nine are administered by county probation departments. The youth at the county facilities comprised 58% of the population.

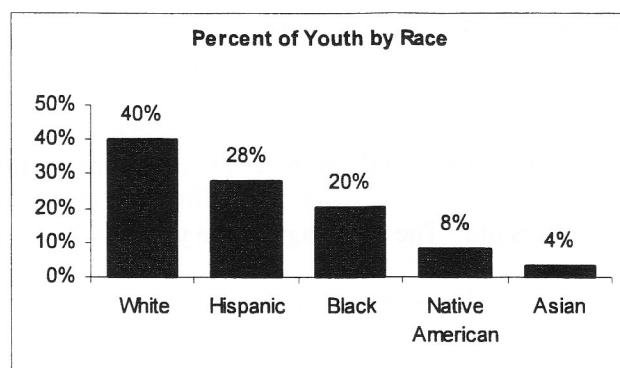
Youth Population – The 660 youth include both males and females who range in age from 11 years old to 18 years old. The mean age of the youth is 15.85 with most being 16 years old.



Males outnumber females by about four to one with males representing 83% of the youth and females representing 17% of the youth.



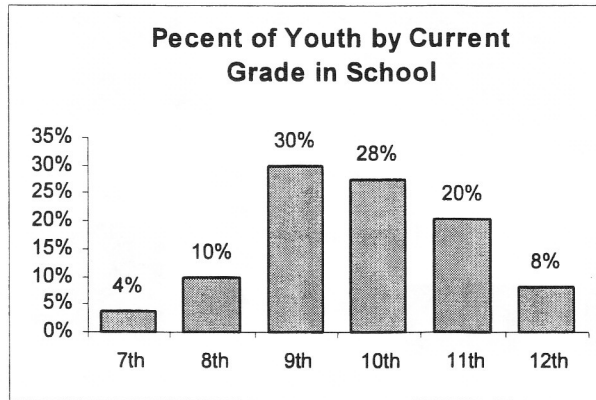
When asked to identify their race/ethnicity, 40% indicated White, 28% indicated Hispanic, 20% indicated Black, 8% indicated Native American, and 4% indicated Asian. Some of these percentages include youth who identified more than one category (i.e., mixed race).



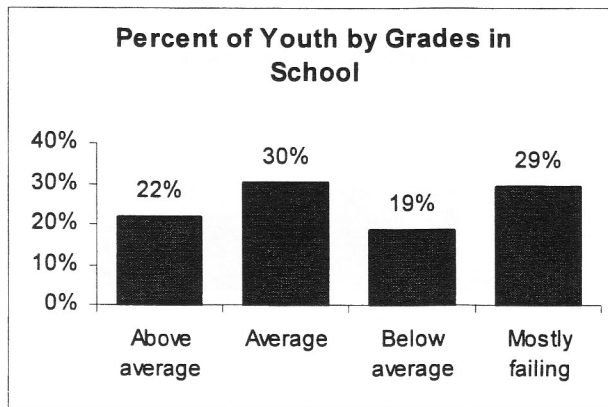
For almost half of the youth in the study (45%), their mother was their primary caretaker. Other youth lived with their mother and father (27%), one natural parent (usually mother) and a stepparent (11%), with another relative such as a grandparent (8%), or in some other situation including foster care or state custody (7%). Only 2% of youth lived with their fathers.

The youth were asked if their parents keep track of them and if they know, and approve of their friends. Most mothers (80%) tracked how well their child was doing in school. Although 60% of youth said their mothers knew most of their friends, only 40% reported that their mothers approve of their friends. Slightly less than half (49%) said their mothers almost always know where they are and what they are doing. Fathers were reported as somewhat less likely to track how they were doing in school (64%), to almost always know where they were and what they were doing (39%), to know who their friends are (51%), or to approve of their friends (33%).

The majority of the youth were in school prior to being detained. Most were in either the 9th or 10th grade as appropriate to their age.

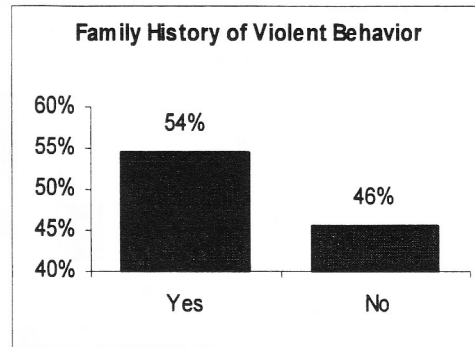
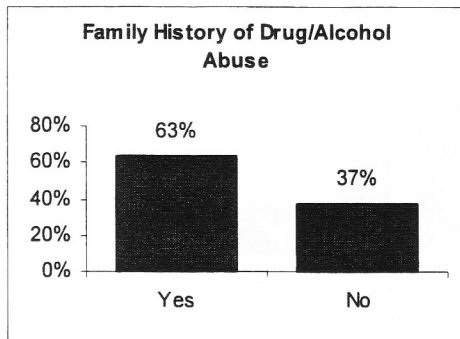


When asked about their grades before entering detention, slightly more than half indicated they had average or above average grades. Almost a third (29%), indicated they had mostly failing grades.

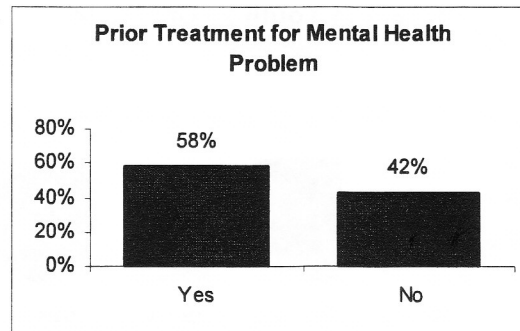


When asked about finish school and future plans, 88% thought they had a good chance of graduating High School and 74% indicated they thought about going on to some type of vocational training or college. One in five (20%), indicated they would probably end up dropping out of school. About a third (33%) indicated they had a chance of getting into trouble with the law again.

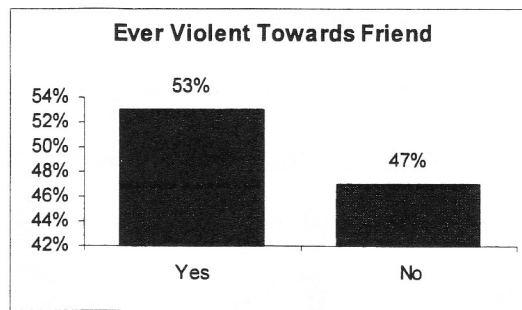
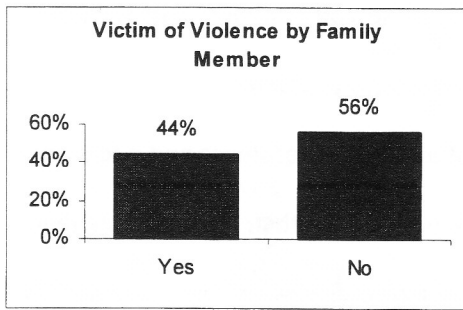
The youth were asked several questions about their own and their family's mental health. Many of the youth indicated that there was a family history of drug and/or alcohol abuse (63%), violent behavior (54%), and mental disorders (30%).



More than half of the youth (58%) had had some prior treatment for emotional or behavioral problems.



More than half (53%) reported they had been violent towards someone they cared about and 44% had themselves been a victim of violence by someone they cared about.



Almost one in five youth (18%) had attempted suicide. Almost half (40%) had a close friend or family member attempt suicide and almost one-fourth (24%) had a close friend or family member who died as a result of suicide.

Mental Health Assessment

The youth were administered two mental health assessment tools, the Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2) and the Manifestation of Symptomatology Scale (MOSS). Each of the instruments asks similar questions but provides different perspectives on the state of the youth’s mental health. In combination they offer the means of assessing potential risk for serious emotional disorders. Each set of scores was analyzed independently and the results of each are presented separately.

MAYSI-2 Results

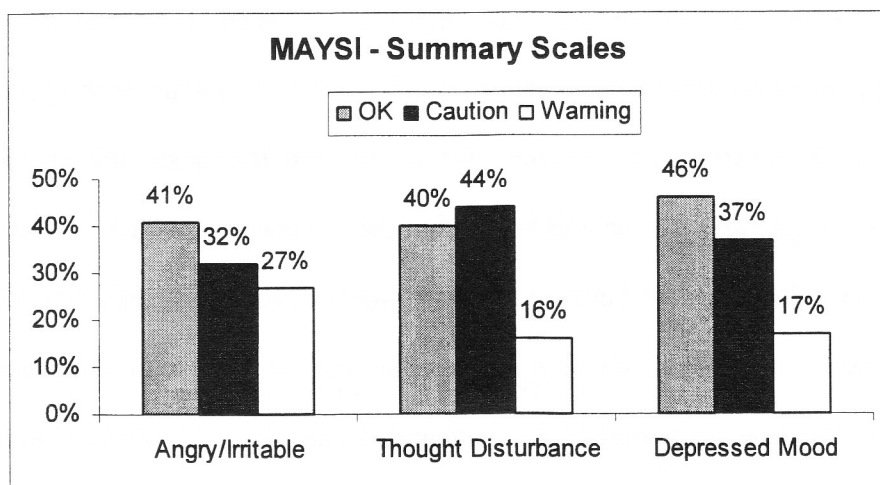
The MAYSI-2 includes six summary scales and an indicator of the level of psychological trauma an individual has experienced. Three scales measure emotion and thought disturbance – Angry/Irritable, Thought Disturbance, and the Depressed/Anxious scale. One average, 60% of the study population showed an elevated risk for emotional

and psychological problems on these three scales. Of these youth, almost half were at very high risk with scores indicating the possibility of severe problems.

The Angry/Irritable scale assesses feelings of anger, vengefulness and a tendency toward related irritability, frustration and tension. Scores higher than four indicate that anger may be expressed impulsively through physical aggression when the individual is experiencing annoyance or frustration. The average score for all youth in this study was 5.101 with 59% of youth scoring five or higher. Almost one-third (27%) were at very high risk with a score of eight or higher.

The Thought Disturbance scale indicates the possibility of serious mental disorder involving problems with reality orientation. This score has been normed only for boys. Girls were not included in either the scoring or the analysis. A score of one or higher may indicate abnormal perception and consciousness and a score of three or higher may indicate a psychotic illness or major depression with psychotic features. The average score for boys in this study was 1.135 with 60% reporting a score of one or higher. A score of three or higher was reported by 16% of boys.

The Depressed/Anxious scale indicates symptoms of depression and anxiety. Lower scores (3, 4, or 5) may indicate an emotional reaction to immediate events such as detention. Higher scores (6 or higher) may indicate an enduring problem. The average score for the study population was 3.089 with 54% reporting a score of three or higher. Scores higher than five were reported by 17% of the youth.



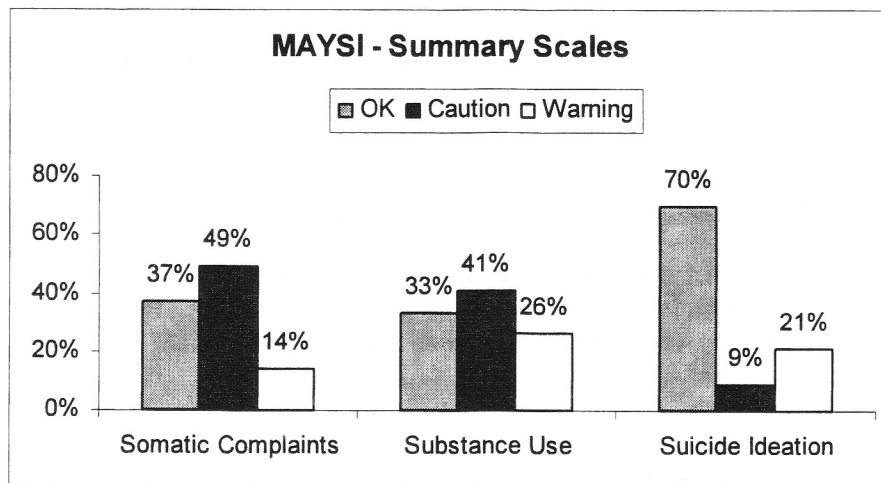
Three other MAYSI-2 scales – the Somatic Complaints, Alcohol/Drug Use, and Suicide Ideation scales – measure physical and behavioral manifestations of the individual’s emotional state. On average, two-thirds (63%), of the study population scored high on the *Somatic Complaints* and *Alcohol/Drug Use* scales. About a third of youth (30%), scored high on the *Suicide Ideation* scale.

The Somatic Complaints scale measures bodily expressions of anxiety including shortness of breath, upset stomach, and shakiness. Elevated scales not found in association with other elevated scales may be an indicator of physical illness. When found in combination with other elevated scales, a high score (3 or higher) may reflect significant emotional problems. The average score for the study population was 3.148 with 63% of youth scoring three or higher. Half of the youth (49%) had scores of three, four, or five. Scores of six or higher were reported by 14% of youth.

The Alcohol/Drug Use scale identifies youth for whom alcohol or drug use is a significant problem and who may be at risk for dependence and/or abuse. High scores (4 or higher) indicate an individual has or is developing significant substance abuse

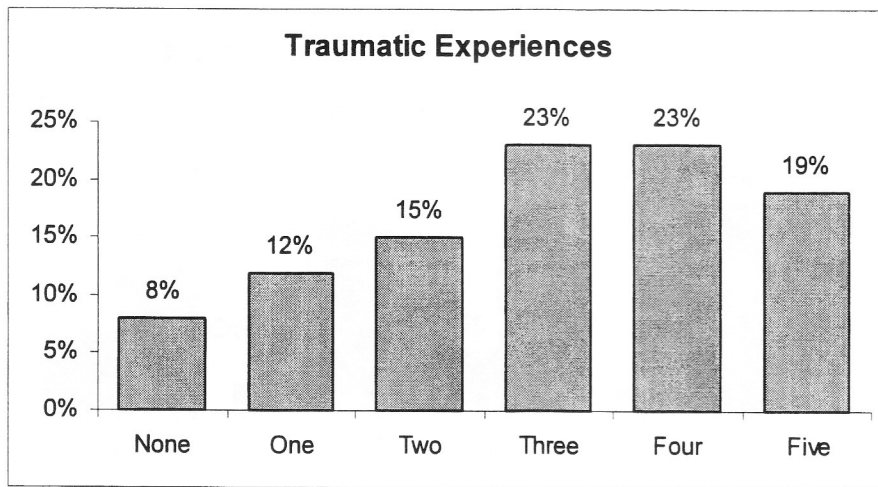
problems. Juvenile offenders usually score higher than other adolescents on this scale. The average score for the study population is 4.454 with 67% of youth scoring four or higher. One in four youth (26%) scored seven or higher indicating significant problems.

The Suicide Ideation scale addresses thought and intentions about self-harm. These scores reflect recent and current subjective states. The developers of the MAYSI-2 note that there is currently no research to determine whether youth with high Suicide Ideation scores are actually more likely to attempt suicide. Elevated scores (2 or higher), however, are likely to reflect potential suicidal intent and very high scores (3 or higher) may reflect a high risk for a suicide attempt. The average score for the study population is 1.159 with 30% of youth reporting a score of two or higher. Of these youth, 70% had a score of three or higher indicated a high level of suicide ideation.



The final score on the MAYSI-2 assessment is the Traumatic Experiences scale. This scale reflects whether an individual has had greater lifetime exposure to traumatic events compared to other youth. Although the specific questions are different for boys and for girls the scores are comparable. High scores reflect exposure to specific

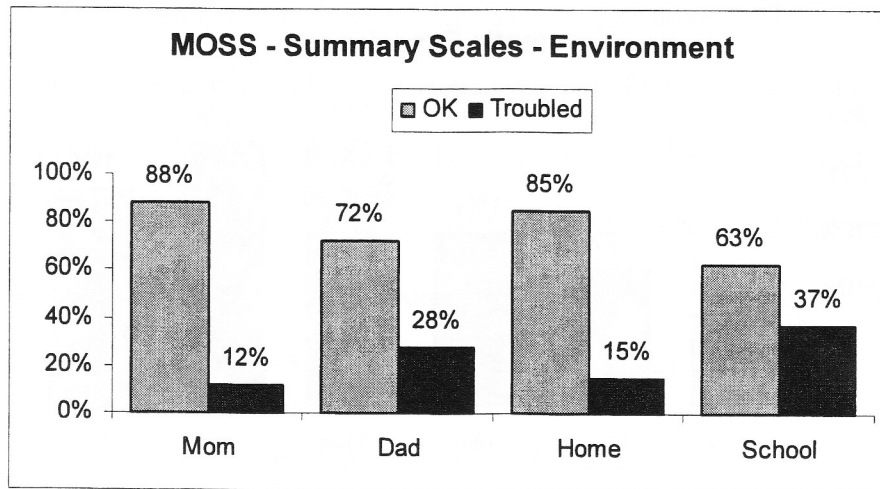
traumatic events such as rape or beatings and also the possible presence of Post Traumatic Stress Disorder. There should be individual follow-up with youth who respond positively to any of the questions however this was not possible within the scope of this study. The average score for the study population was 2.986 on a scale of 0 to 5 with 65% of youth scoring three or higher.



MOSS Results

The MOSS includes 13 content scales and three summary indexes which are constructed from combinations of certain content scales. Four of the MOSS content scales assess the individual's environment – the Mother scale, the Father scale, the Home Environment scale, and the School scale. The Mother and Father scales measure the quality of an individual's relationship with their mother and their father. A score of 65 or higher indicates a troubled relationship. In this study population, the average score for the Mother scale was 49.498 with only 12% scoring higher than 65. The average score for the Father scale was higher at 53.859 with 28% of youth scoring 65 or above. The Home Environment scale and the School scale assess aspects of the individuals home and

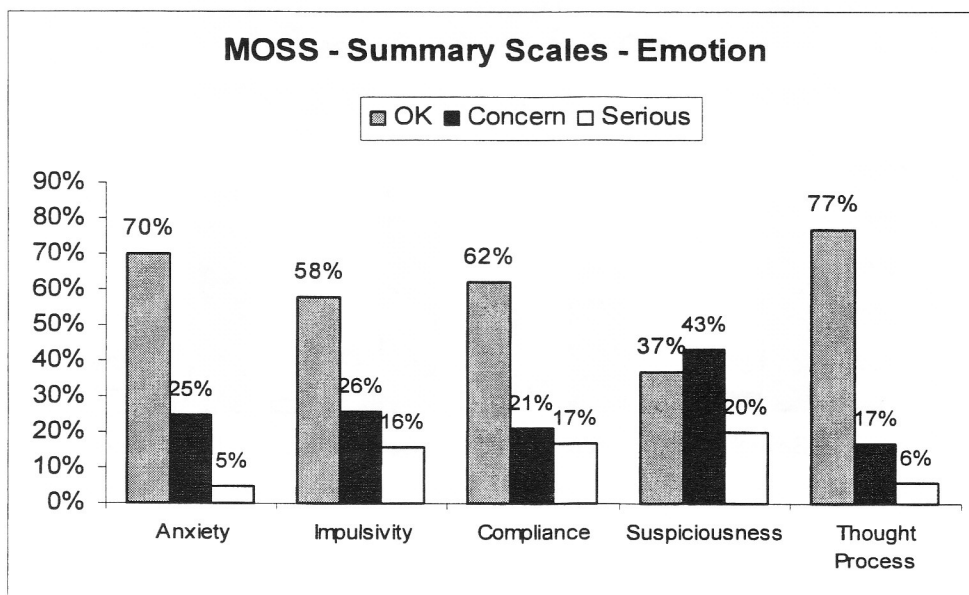
school environment. A score of 70 or higher indicates an unsupportive and uncomfortable home environment and school-related problems. The average Home Environment score for the study population was 56.398 with 15% of youth scoring 70 or above. The average School score was 55.745 with 14% scoring above 70 but with an additional 23% scoring between 60 and 70, an indicator of potential problems.



There are seven emotion scales included in the MOSS assessment. They include an Anxiety scale, an Impulsivity scale, a Compliance scale, a Suspiciousness scale, a Thought Process scale, a Depression scale, and a Self-Esteem scale. For each of these scales, a score of 60 or higher is indicative of problems. The Suspiciousness scale also includes scores of 55 and higher as indicative of problems.

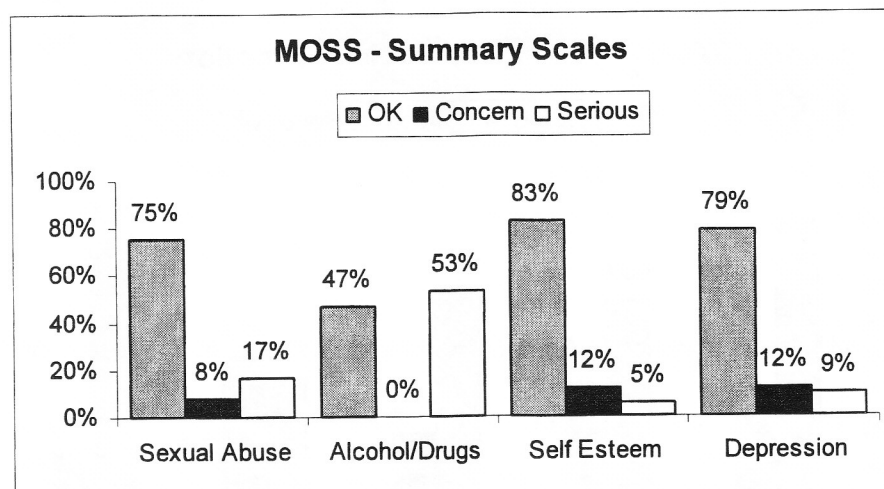
The Anxiety scale reflects an individual's level of tension, stress and worry. The average score for the study population was 52.073 with 30% of youth scoring 60 or above. The Impulsivity scale assesses the ability to control anger and hostile behavior. The average score for the study population was 56.506. Scores higher than 60 were indicated for 42% of the youth. Of these, 26% scored 70 or higher. High scores on the

Compliance scale indicates an individual disregards rules and has a propensity for getting into trouble. The average for the study population was 58.578 with 38% of youth scoring 60 or higher. The Suspiciousness scale focuses on how youth experience other people. Individuals with high scores are more likely to feel alienated, disliked, and distrustful. The average score for the study population was 57.235. Two-thirds of the study population (63%) scored 55 or above with 37% scoring 60 and above. The Thought Process scale serves as a screen for severe psychopathology and a measure of the respondent's cognitive processes. The average score for the study population was 51.705. Almost one-fourth (23%) of the study population scored a 60 or above.



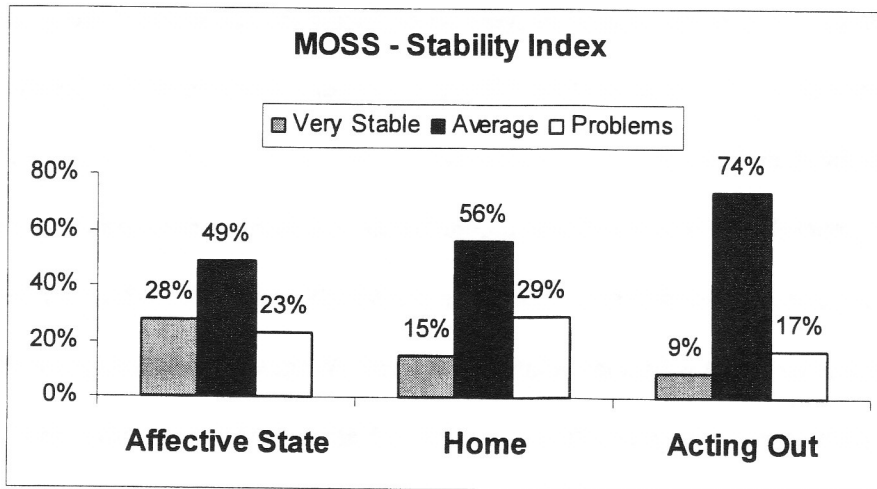
A score of 60 or higher on the Sexual Abuse scale indicates the possibility of sexual abuse or a traumatic sexual experience. One fourth of the study population scored 60 or higher with 17% scoring 70 or higher. This indicates the possibility that one in four youth have been sexually abused. The Alcohol and Drugs scale reflects behaviors

typically associated with the abuse of alcohol and/or drugs. More than half of the study population (53%) scored high enough to indicate serious problems with alcohol or drugs. The Self-Esteem scale assess how an individual may feel about how they look or about how they function. The average score for the study population was 50.561 with only 17% of youth scoring 60 or higher. The Depression scale assesses thoughts and feelings associated with depression, hopelessness, and suicide. The average Depression score for the study population was 53.063. One in five youth in the study population (21%) scored 60 or above with almost 10% scoring 70 or above.



Three index scales provide a composite measure of an individual's emotional stability. The Affective State Index is based on the Depression, Anxiety and Self-Esteem content scales. About one-fourth of the study population (23%) scored above 60, indicating they may have a high degree of emotional instability. The Home Index is based on the Mother, Father, and Home Environment content scales and provides a broad measure of how the child feels about their parents and home life. Only about a third

(30%) of the study population had Home Index scores indicative of being at an elevated risk for problems. The Acting Out Index is based on the Impulsivity, School, and Compliance content scores. Less than one-fifth of the study population (17%) scored above 70 indicating a high likelihood of recurring behavior problems.



Comparative Findings

The analysis also included an examination of differences in assessment scores between males and females, ethnic groups, and a comparison between youth charged with violent or non-violent offenses as well as one between youth charged with drug or non-drug offenses. The charge categories were created from the researchers' interpretation of self-reported charges in response to a "Why are you here" question in the demographic portion of the questionnaire.

In general, youth charged with alcohol or drug-related crimes and those charged with violent crimes tended to score higher on the MOSS and MAYSI-2 scales than those whose crimes were not substance-related or violent. Whites scored the highest in all MAYSI-2 categories except substance use, while Native American youth scored the highest of any racial group for half of the MOSS scales. Girls scored higher than boys did on all scales except for the MOSS Father scale, and they scored significantly higher on the depression, traumatic experiences and suicide ideation scales.

Statistical Significance

Statistical significance is a unique concept used when interpreting results of statistical analysis. It is important to understand the meaning of "statistical significance" when reading these results. In non-statistical terms, "significant" means "important". In Statistics, "significant" means "probably true" or "not due to chance".

Significance is generally talked about in terms of the "Significance Level". The significance level refers to how likely it is that the result you get is due to random chance. The standard is .05, which means that the result has a 95% probability of actually

occurring in the population, or a 5% probability that the findings are due to random chance. Any result smaller than the standard (.05) means that the results are more likely to show an actual difference in the population and are less likely to occur due to random chance. Therefore, a .01 level is a 99% probability of actually occurring, and a .001 is a 99.9% probability of actually occurring. When you have the smaller p-values, you can be more confident that your results are demonstrating true differences in the population.

A key point is the difference in “statistically significant” and “important” or “interesting”. Just because a result is statistically significant, does not mean that it is an important result, and conversely, just because a result is NOT statistically significant, does not mean it is not important. A further caveat is that when a result is statistically significant, it may not translate into a large difference between populations. The difference may in fact be small, but the result is nonetheless statistically significant.

Males & Females

On all the scores on both the MOSS and the MAYSI-2 except for one, females scored higher than the mean score for that scale. Higher scores mean more problems with the issue being measured. However, despite the fact that almost all the female scores were higher, not all the differences were statistically significant.

For the seven MAYSI-2 scales, girls showed significantly higher scores than males on five of the scales. The substance abuse scale ($p=.278$) was a notable exception to the rule. The fact that the mean scores for boys and girls showed no statistical significance means that both boys and girls suffer about equally with substance abuse problems. This result was mirrored by the MOSS Alcohol & Drug scale, though the

MOSS result was closer to statistical significance ($p=.086$). In addition, the Angry-Irritable scale did not give significant results, but the results were marginally significant ($p=.063$). Perhaps with a larger sample of females, the significance of the difference could be determined.

For the remaining four of the MAYSI-2 scales, the results were extremely significant. Girls showed more somatic complaints than boys ($p<.001$), more suicidal ideation ($p<.001$), a significantly higher number of traumatic experiences ($p<.001$), and more problems with depression ($p<.001$).

The MOSS scales allowed researchers to examine several different issues not covered by the MAYSI-2 scales. For example, girls showed significantly higher mean scores on the sexual abuse scale ($p<.001$), more problems with suspiciousness, which often leads to higher levels of social isolation ($p<.001$), more problems with their mothers ($p<.001$), more problems with their home environments ($p<.001$), and more compliance problems than boys ($p<.001$). These results were extremely significant.

At the next levels of analysis, the girls showed more problems with depression ($p<.01$), which mirrors the results of the MAYSI-2 test. They also demonstrated more problems with self esteem than boys ($p<.05$), and more problems in school ($p<.05$)

There was one scale showing females both lower than the mean and lower than the male score, and that was the father scale on the MOSS. This means that the girls showed less troubled relationships with their fathers than the males. However, the differences between males and females on this scale were not statistically significant. In addition, the scores on the thought process scale ($p=.196$), the anxiety scale ($p=.278$), and the impulsivity scale ($p=.618$) were not significantly different either.

Ethnic Groups - Descriptives

White respondents score higher than the mean on both substance abuse scales, both depression scales, and boys demonstrate higher scores on the MAYSI-2 thought disturbance scale. Further, white respondents tend to show more problems with home environments, suicide ideation, more traumatic experiences, and high anxiety.

Black respondents demonstrated high scores on the sex abuse scale, the suspiciousness and the impulsivity scales, more problems with their fathers and their home environments, and high scores on the Angry/Irritable scale.

Hispanic youth scored higher than the mean on both substance abuse scales and both thought disturbance scales. They also showed an increased level of suspiciousness and problems in school.

The Native American participants scored above the mean for suicide ideation, depression, and sexual abuse. They also demonstrated problems with self-esteem, problems with their fathers and their home environments, and problems in school. There were also scores above the mean for impulsivity and compliance.

Asian youth scored above the mean for substance abuse problems on both scales, demonstrated higher levels of depression and thought disturbance (Boys), problems with their mother, and higher scores on the Angry/Irritable scale.

Comparisons across Ethnic Categories

For both suicide ideation and self-esteem, high scores on each of these scales demonstrates more problems with the issue being measured. The differences among the

groups for the Self Esteem scale are significant between ethnic categories ($p < .001$). Asian and Black youth demonstrate significantly lower scores on the MOSS self-esteem scale, showing fewer problems with self esteem. Native American youth have the highest score (most problems) followed by the White youth. Hispanic youth and those youth in the "Other" category have approximately equal scores, falling in the middle of the six categories.

With regard to suicide, the results were barely statistically significant ($p = .054$). Perhaps with a larger sample, these differences would have indeed been significant. While the results were not significant, they are discussed here because they were so close to statistical significance and they may bring insight to further program planning. White and Native American youth had the highest scores, with black and Asian youth scoring the lowest. As with self-esteem, the Hispanic and Other youth fell approximately in the middle.

Scores on the suicide ideation scale and on the self-esteem scale were correlated, and found to be statistically significant ($p < .001$) in a positive direction. This means that if a youth has a high score on one scale they are more likely to have a high score on the second scale. These results strongly suggests that when a youth has problems with self-esteem (a high score on the self-esteem scale), the youth's tendency toward suicide ideation (a high score on the suicide scale) is increased.

Further, Native American, black and white respondents scored the highest on the sexual abuse scale, though the results were not statistically significant. While white, Hispanic and black youth scored the highest on the traumatic experiences scale, these results were also not statistically significant. It should be noted that while these results

are not statistically significant, it does not mean that they are not important, and should assist facility staff in identifying juveniles at-risk for sexual abuse and traumatic experiences.

Scores on the anxiety and depression scales were also statistically significant between the ethnic groups ($p < .01$). Native American youth scored the highest on the depression scale, closely followed by white youth. The lowest scores on the depression scale came from the black youth, and then the Asian youth. White youth scored the highest on the anxiety scale, followed by Hispanic and Native American juveniles. Again, the lowest anxiety scores came from the black youth, and then the Asian youth, whose means were almost identical. Like suicide ideation and self-esteem, scores on the anxiety scale and the depression scale are significantly correlated in the positive direction ($p < .001$).

For the scale measuring problems at home, the Native American and the white respondents scored the highest ($p = .001$). The highest scores for the scale measuring problems in school were found with Native Americans, whites, and Hispanic youth ($p < .05$).

White, Asian, and Hispanic boys scored the highest on the Thought Disturbance scale (only administered to boys) on the MAYSI-2 ($p < .001$). On the MOSS scale measuring Thought Process, white, Hispanic and Native American youth scored the highest (this scale included the girls), though the results were not significant. Somatic complaints were identified the most in white and Asian youth ($p < .01$). Further, Native American, black and Hispanic offenders scored the highest on the Suspiciousness scale, though these results were also not statistically significant.

With regard to the Substance abuse scales, white and Asian offenders scored the highest on both scales. Hispanic youth scored third on the MAYSI-2 scale. With the MAYSI-2 depression scale, again Asian and white youth scored the highest. Native American youth scored the highest on the MOSS depression scale, followed by white youth. White, Hispanic and Native American youth scored the highest on the Anxiety scale, Native Americans and black youth scored the highest on the impulsivity scale, and the white and Native American offenders scored the highest on the compliance scale. It is interesting to note that substance abuse is not significant compared between boys and girls, but is significant ($p < .01$) on both MAYSI-2 and MOSS scales when compared between ethnic categories.

White & Non-White Respondents

The six-category ethnicity variable was recoded into a dichotomous White-Non-White variable for further statistical analysis. Despite a majority of Nevada's population being white, only 35% of respondents were white, while the remaining 65% were non-white. A comparison was made between these groups to identify any interesting trends. Using the MAYSI-2 scales, the majority of the scales were significantly different between the white and non-white participants. Suicidal ideation was significant ($p < .05$), with white offenders having a higher score. Substance use was more significant ($p < .01$), with white offenders again having a higher average score. Further, somatic (physical) complaints were very significant ($p < .001$), with white offenders again scoring higher than their non-white counterparts. The Angry-Irritable scale was barely significant ($p = .079$). The most interesting finding was the Traumatic Experiences scale and the

Depressed Mood scale. Neither of these scales was significantly different between white and non-white offenders. This suggests that depression crosses all cultures and environments, and that traumatic experiences are common across cultures as well. This finding should help program developers to have an understanding of the experiences that the offenders in their care have endured. Further, using the MOSS scales, White youth scored significantly higher on the Self-esteem scale ($p < .001$), the Depression scale ($p < .001$), the Anxiety scale ($p < .05$), the Home Environment scale ($p < .01$), and the Mom scale ($p < .01$) than their non-white counterparts.

Comparative Discussion

It is interesting to note that substance abuse is not significant compared between boys and girls, but is significant ($p < .01$) on both MAYSI-2 and MOSS scales when compared between ethnic categories. This suggests that there are likely to be cultural factors playing a role in substance abuse, and therefore substance abuse treatment programs, as well as mental health programs, should have extra assurance that they are culturally competent in order to help kids the most.

In the White-Non-White variable, it was particularly interesting to find that 35% of respondents were white, while the remaining 65% were non-white, despite a majority of Nevada's population being white. This suggests that Nevada is joining the nation with a Disproportionate Minority Confinement problem. That is, however, an entirely different issue and will not be addressed in this paper.

Violent Offenders

Kids brought in for violent offenses showed greater problems with self esteem, depression and anxiety, demonstrated problems with their fathers and home environments, problems in school, as well as higher scores on the compliance and impulsivity scales. They also showed problems with thought disturbance (for the boys only), higher scores on the somatic complaints scale, as well as substance use problems, more suicide ideation, and more traumatic experiences. Kids brought in for non-violent offenses demonstrated high scores on the sexual abuse scale, both substance abuse scales, and the somatic complaints scale.

Drug Offenders

Kids convicted of drug crimes demonstrated higher scores on both of the thought process scales and depression scales. They also demonstrated higher levels of anxiety, suicide ideation, and somatic complaints. They showed more problems at home and at school, and higher scores on the compliance scale. Kids who were not brought in on drug charges showed higher levels of suspiciousness, more problems with their fathers, and higher impulsivity scores.

DISCUSSION

There are several key areas in which to focus the discussion of the results. The discussion will examine problems with substance abuse, suicide ideation, violence, and the unique needs of female offenders.

Substance Abuse

It appears that substance abuse is very common among juvenile detainees. Many juvenile offenders who reported drug charges and scored high on both substance abuse scales also scored high on the anxiety scale, both thought process scales, the affective index, and both depression scales. This clearly supports the premise that substance abuse problems are strongly correlated to other mental health problems. Further, the kids with drug charges reported higher levels of suicide ideation, more traumatic experiences, and problems at home. Almost two-thirds (63%) of youth indicated a family history of drug and/or alcohol abuse, a correlate of substance abuse in youth themselves. Clearly, substance abuse is a problem in this population. However, it may be more effective in seeking to treat the substance abuse problem to assist the offenders in seeking mental health treatment while at the detention facility or family counseling upon release. In those instances where there is a co-occurring mental health disorder and a substance abuse disorder, treating the underlying mental health problem will help to treat the substance abuse problem. The effects of appropriate mental health treatment will also trickle down into reducing suicide ideation and future criminal behavior.

In addition, there are several populations at particular risk for substance abuse problems. Female offenders show a higher score on substance abuse scales than males.

White, Asian and Hispanic youth also demonstrate higher levels of substance abuse. Creating culturally competent mental health programs for these populations may assist them in reducing their substance abuse problems.

Existing research suggests that at least one half of juveniles who have a mental health problem will have a co-occurring substance abuse problem. This means that, statistically speaking, juvenile offenders who suffer from a mental health problem are significantly more likely to have a co-occurring substance abuse problem than their counterparts who do not have a mental health problem. Our research shows that both males ($p < .001$) and females ($p < .001$) who suffer from anger and irritability problems are significantly more likely to have a co-occurring substance abuse problem. Males who demonstrate somatic complaints ($p < .001$) and have major thought disturbance problems ($p < .001$) are also significantly more likely to have a co-occurring substance abuse problem. Males who suffer from depression ($p < .001$) are also significantly more likely to have a substance abuse problem, while this relationship is not significant for females ($p = .097$).

Further, research suggests that juveniles who have a current drug problem are more likely to have seen a mental health professional before. We tested this theory by suggesting that youth who score in the Caution/Warning categories of the substance abuse scale are significantly more likely to report prior mental health treatment. Indeed, those youth who answered "Yes" to the question "Have you ever been treated for a psychological problem" were significantly more likely to have a high score on the substance abuse scale ($p < .001$). This supports the theory that many juveniles have co-occurring mental health and substance abuse problems.

Further, many juvenile drug users often report parental alcohol abuse. Our theory was that youth who score in the Caution/Warning categories of the substance abuse scale will be significantly more likely to report parental alcohol abuse. Our results firmly support this contention. Those youth who have high scores on the substance abuse scale are significantly more likely to report parental alcohol abuse ($p < .001$).

Juveniles with emotional problems (especially those who are socially isolated or lonely) are significantly more likely to report a substance abuse problem than those who are not isolated. We correlated the MOSS depression and anxiety scales with the substance abuse scale, and discovered that the depression is not significantly correlated with substance abuse ($p = .172$), but anxiety does show a significant correlation with substance use ($p < .05$). However, depression is significantly correlated with anxiety ($p < .001$). Further, the MOSS suspiciousness scale, which also measures social isolation, is significantly correlated with both the self esteem scale ($p < .001$) and the substance abuse scale ($p < .01$). This suggests that social isolation exacerbates self-esteem problems and substance abuse. Self-esteem itself is not significantly correlated with alcohol and drug use ($p < .258$), which suggests that the combination of social isolation and self-esteem are the catalyst for substance abuse problems. Both the depression and anxiety scales were significantly positively correlated with suspiciousness ($p < .001$) and self-esteem ($p < .001$), suggesting that social isolation exacerbates depression and anxiety as well as self-esteem

Research also suggests that youth who experience early physical or sexual abuse often report higher drug use. In our research, we tested this existing theory by examining those youth who have high scores on the MOSS sexual abuse scale and correlating those

scores with their scores on the substance abuse scale in order to find out whether they will be significantly more likely to have a substance abuse problem. The sexual abuse scale is positively correlated with alcohol and drug use ($p < .001$), which research has suggested may occur due to self-medication for trauma.

Suicide Ideation

In suicide research, it is a fairly well-accepted premise that a prior suicide attempt increases the risk of suicide completion, and is the best predictor of future suicidal behavior. In our research, we were able to identify youth who had a prior suicide attempt (18%). There were significant differences between males and females, showing that females were significantly more likely to have a prior suicide attempt. This supports previous suicide research as well. In order to examine the theory that juveniles with high scores on the suicide ideation scale will be significantly more likely to report a prior suicide attempt, we compared the population. As expected, juveniles who had high scores on the suicide ideation scale were significantly more likely to report a prior suicide attempt. This should be a red-flag for facility administrators, in that knowing whether or not a youth has a history of suicide attempts can assist in identifying future risk factors.

According to existing research, slightly less than 20% of drug users have experimented with suicide. Our research does not actually examine suicide attempts, but rather looks at suicide ideation. Using a crosstab and a chi-square test, the scales demonstrate that youth who score in the Caution/Warning categories of the substance abuse scale are significantly more likely to score highly on the suicide scale ($p < .001$). This shows that suicide ideation is linked to substance abuse, and assisting youth to resist

drugs and alcohol may reduce the incidence of suicide ideation and probably attempts as well in this population.

A substance abuse problem in combination with an affective disorder will increase the risk of suicide. This translates into the idea that youth who score in the Caution/Warning categories of the substance abuse scale and on the depression/anxiety scale will be significantly more likely to score highly on the suicide ideation scale. These were tested using crosstabs and chi-square tests and the MAYSI-2 scales. Both the substance abuse scale and the depressed mood scales showed statistically significant results with the suicide ideation scale ($p < .001$). This means that individually, depression and substance abuse affect suicide ideation. A layered crosstab showed that substance abuse and depression together significantly affect scores on the suicide ideation scale ($p < .001$).

Research in the suicide area is complex, and many theories are present. One of these is that many juveniles who experience suicide ideation also have a diagnosable mood disorder (depression or anxiety). Further, low self-esteem exacerbates the suicide-depression problem. We theorized that youth who score in the Caution/Warning categories of the MAYSI Depression/Anxiety scale and on the MOSS Self-Esteem scale will be significantly more likely to score highly on the suicide ideation scale. The research supports this theory, with a layered crosstab and chi-square test showing significant results. These results must be taken with a grain of salt, due to cell counts less than five in several cells, but they highlight an important trend.

According to existing research, impulsive aggression problems exacerbate suicide risk. This was tested by comparing both the MAYSI-2 Anger-Irritability Scale and the

MOSS Impulsivity scale to scores on the suicide ideation scale. Youth who score in the Caution/Warning categories of the anger and impulsivity scales should be significantly more likely to score highly on the suicide scale. Both scales showed similar results, in that those youth with high scores on the anger scales showed significantly higher scores on the suicide ideation scale. This suggests that facility staff may use a juvenile's anger problems as a marker for possible suicide problems and may keep the child under closer supervision or refer him or her for counseling with a trained mental health professional.

Youth who report parental mental health problems and parental substance abuse problems will be significantly more likely to score highly on the suicide scale. This theory is based on existing research stating that parental difficulties often translate into problems for their children. The theory was tested by comparing mean scores for those youth answering a series of Yes-No questions about their family history. Youth who answered "Yes" to the question asking if there was a family history of mental health problems were significantly more likely to have a high score on the suicide ideation scale ($p < .001$). Youth who answered "Yes" to the question asking if there was a family history of substance abuse were significantly more likely to have a high score on the suicide ideation scale ($p < .001$). In addition, there were almost twice as many youth answering "Yes" to this question, suggesting that parental substance abuse may be especially common in the families of these kids, and therefore parental substance abuse might be able to be considered as a risk factor or predictor of future delinquency for very young children.

Further, family discord has been shown to exacerbate suicide risk, suggesting that youth who have high scores on the MOSS Home Index scale (demonstrating more

problems at home) will be significantly more likely to score highly on the suicide scale. Our research supports this hypothesis, showing significant results ($p < .01$) when comparing these scales for both males and females. A mechanism for assessing problems at home might assist facility staff in determining suicide risk.

Slightly less than 20% of youth in the survey population have attempted suicide. Thirty percent of the youth scored above the Caution mark on the MAYSI-2's suicide ideation scale. Of those youth who scored above the Caution level, 70% indicated a extremely high level of suicide ideation. Knowing that 20% of respondents have actually attempted suicide before, and that a previous attempt is the strongest predictor of another suicide attempt (Rohde, Mace, & Seeley, 1997), facility staff need to pay careful attention to scores on this scale and ensure that these kids receive proper treatment. Even more attention should be paid when a high suicide ideation score corresponds to a high score on the depression scale or substance abuse scale. Co-occurring mental health problems and substance abuse problems place that juvenile at very high risk for suicide. If the MOSS scale is implemented as a screening tool as well, then facility staff may also examine the scores on the impulsivity scale, the compliance scale, and the self-esteem scale. Since family discord and abuse are also risk factors for suicide, the Home scale may also provide administrators with information about the juvenile's risk. If community and family factor information is collected, those juveniles with a parent who has a substance abuse problem or depression may be given special attention with regard to suicide risk.

Violence

Violence is clearly more prevalent in the juvenile offender population. More than half (54%) of the juveniles indicated a family history of violence. Close to half (44%) had been the victim of violence by a family member, and another 53% had been violent themselves. Since victimization can cause such long-term detriments to the health of these teenagers and is correlated to an increased level of substance abuse, depression and other psychological problems (including PTSD) and delinquency, these youth should have special attention paid to their problems. Youth with violent charges showed higher anxiety levels, more problems with self-esteem, problems with impulsivity and compliance, as well as higher levels of depression, substance abuse and greater numbers of traumatic experiences. Further, youth brought into the detention centers score higher on the Home scale and demonstrated more problems with their fathers than those with non-violent charges. While it is not in the purview of the detention center to counsel families, perhaps an increase in referrals to community programs who can assist families with counseling and/or parenting classes would be beneficial to the youth's future development. Especially in the cases of youth who have high scores on the sexual abuse scale, their family functioning is less than those non-abused youth, and that family might benefit greatly from a counseling referral.

Female Offenders

In the last few years, with the increase in number of female adolescents entering the juvenile justice system, greater attention has been paid to the special needs of female offenders. This research project identifies special areas of attention for Nevada's

administrators. Since the girls surveyed scored higher than the boys on all scales except one, these incarcerated girls are clearly demonstrating special treatment needs.

Girls scored ten points higher than the boys did on the sex abuse scale, showing that these girls are definitely more likely to be victims of abuse. In addition, they reported a higher number of traumatic experiences, more suicide ideation, and more problems with self-esteem. They also demonstrated more problems with substance abuse and depression (on both the MOSS and the MAYSI-2 scales). Research has suggested that these girls are abusing substances as a method of self-medication to help them cope with stress, mental health problems, and exposure to trauma and abuse. Perhaps this could change the way that substance abuse problems in female offenders can be approached. Instead of viewing it through the lens of treating the substance abuse problem, the staff psychologist could examine the underlying issues with abuse, depression and trauma in the hope that improving coping mechanisms could reduce the substance abuse problem on its own. Further, implementing programs to assist girls in developing coping mechanisms and life skills could reduce the potential for substance abuse in the future by providing an alternative before the substance abuse begins.

Recommendations

Since it is clear that the juvenile offenders in Nevada suffer from a variety of mental health problems, it is best to implement a standardized screening process. As Grisso & Underwood (2003) stated, the screening process is a short "triage" process designed to identify a youth's needs and assist staff in referring for further treatment where needed. The screening should be undertaken at the youth's earliest contact with

the detention center, ideally at intake. In order to facilitate the implementation process, the MAYSI-2 is recommended as an excellent tool for screening. It is simple to administer, taking approximately 15-20 minutes for the youth to complete on his or her own, simple to score, and the results can be interpreted without specialized training, which means there is less burden on the facility staff. This tool is recommended for screening youth for mental health problems at intake.

Special attention should be paid to the youth's score on the substance abuse scale, and there should be a mechanism for getting those kids with higher scores into a treatment program. Further, since those kids who came in with drug-related charges seemed to have different mental health needs than those who had non-drug charges, further assessment should be undertaken for those youth. A second screening tool may be used for the substance abuse screening if the MAYSI-2 score is sufficiently high as to cause concern.

Further, a high score on the suicide ideation scale is one that should require immediate attention from test administrators. Special action plans can be developed that ensure that the juvenile with the high suicide ideation receives a more in-depth mental health assessment as well as taking some simple steps to prevent possible suicide while in detention. Previous research (Chino, M., Fullerton-Gleason, L., and Personius, J., 2002) has shown that a single-question suicide screening can identify kids at risk for suicide, which gives the facility a head start on prevention.

Further, facility administrators should implement a training program for facility staff about mental health problems. Facility staff who work with the juveniles on a day-to-day basis should be educated on the key indicators of certain mental illnesses. These

are the people in the best position to recognize a problem with the youth under their care. Comprehensive training programs should be implemented to ensure that staff members are able to recognize signs of mental illness and make appropriate referrals for assessments by mental health professionals within the facility.

Future Research

Future research can go two ways. More descriptive information about the incarcerated youth can be collected from facilities that implement a standardized screening process. Those completed screening forms can be entered into a research database, allowing researchers to further refine the overall picture of mental health in incarcerated youth. However, while descriptive data is useful, the most beneficial direction for future research would be to expand the data collection process and examine a larger number of factors relating to delinquency. There are a number of family and community factors that affect a juvenile's tendency for contact with the juvenile justice system. A research project that begins to assess those factors, especially those that occur early in life, will make a huge contribution to the field of prevention. Interventions will be developed that can find ways of diverting juveniles from the system, reducing the burden on the juvenile justice system and creating happier and healthier kids in the community, which cannot help but benefit society as a whole.

PART TWO

An Assessment of the Juvenile Detention

Facilities in Nevada

INTRODUCTION

The second component of the project includes a facility assessment designed to establish a baseline for mental health services currently being provided to inmates. Since Nevada's thirteen juvenile detention facilities in the state are operated by different entities rather than one overarching agency, there may be a lack of consistency between the facilities. This portion of the project was designed to determine the differences and focus on ways of providing a measure of consistency between the facilities.

The facility assessment includes an examination of current mental health services, a staff perspective of mental health services currently provided and services needed, and a review of each facility's policy and procedure with regard to mental health services. This portion of the project was conducted after the psychological assessment of the offenders is complete and preliminary data analysis has been done, in order that the facility's currently provided services can be compared to the identified needs of its population.

The current service assessment will focus on the kinds of services provided in-house to offenders. It will also look at the procedure for referring inmates to external services. The number of mental health service providers currently employed at each facility and their educational backgrounds (social work vs. psychology, for example) will be looked at. All of this information is easily gathered secondary data and will be gathered with the help of the facility manager.

The information collected in this phase of the project will allow researchers not only to compare the facility's services with the needs of the offender housed there, but it will also allow for a comparison between facilities with regard to services (Is each facility

providing a similar level of service to its offenders?), needs (Does each facility differ on the amount of mental health care needed by its population – Should every facility be providing the same level of care if different facilities have different mental health needs?).

METHODS

Participants

Participants included ten members of the juvenile justice system in Nevada. They included five Chief Juvenile Probation Officers, four Facility Administrators, and one mental health service provider.

Materials and Procedure

The facility survey was developed by staff at the Nevada Institute for Children addressing the issues identified above. There were 34 questions in five sections, asking about how mental health problems are identified, access to mental health care, training and development opportunities for staff, policy issues, and summary thoughts.

The survey was emailed in a Word document form to the participants. They were offered the opportunity to complete it electronically and return it by email or fax a printed copy back, as well as the option to complete it through a telephone interview. They had as much time to complete it as needed and were asked to return it by the end of December. Participation was completely voluntary. There were no penalties for not completing the survey.

No identifying information was collected. Responses that were emailed back were separated from the email address and those that were faxed were separated from the cover sheet. Names were not linked to responses in any way. No personal information was collected. The information sought was with regard to the facility only.

RESULTS

The first section of the questionnaire asked about identifying mental health problems among the offenders. Question one asked respondents to list the most common mental health problems they see. The most common answer was anxiety, with seven responses. Drug and alcohol problems and depression were next, with six responses, followed by low self-esteem, anger and irritability, and suicide ideation.

The next question asks participants to list the two most serious mental health problems encountered in the facility, followed by the most common problem. The most serious problems were depression, anger and suicide ideation, closely followed by substance abuse. Other responses included conduct disorder and behavior problems, as well as one or two specific psychotic disorders. The most common problems identified were behavior problems/conduct disorder, major depression, and substance abuse.

Next, participants share how mental health problems are identified in the kids, the person most likely to identify the problem, and to whom the problem is reported. The most common ways problems were identified in the kids were through psychologists and facility staff, as well as probation officers, family reports and simple observations. The most common identifiers are probation officers and facility staff. Mental health problems are most often reported directly to mental health staff and other staff such as court personnel and detention staff. The nurse also gets a report, as does the facility administrator. Social workers and probation officers are also usually notified.

These questions were followed by a question about how needed services are determined once a problem is reported, and how prescribed medications are distributed to the kids who need them. Overall, needed services are determined by a further evaluation

of the youth by mental health staff, often with referrals made to other providers. One comment included the phrase “availability of funding” which suggests that services are provided when the facility can afford them. Medications are distributed by the facility’s nurse or other detention staff.

The second section of the questionnaire delves into access to mental health care in the facility. These questions were asked with the intent of understanding the process of getting kids who have mental health problems the appropriate care. The first question asked about how facility staff get the youth their mental health care. Two-thirds of respondents said that a professional comes to the facility, while slightly less than half said that an office visit is scheduled for the youth in the community. Other responses included “multi-discipline team staffing”, and “hinges on insurance”, which again suggests that payment is a factor in the provision of mental health care. The second question asks about financing the mental health care. The majority of respondents said that the state or county covers the cost of the services, with half of the respondents listing the family as the funding source. In some cases the facility was listed, as well as the provider and in one case “some grants”.

The next questions determine mental health staffing at the facility, asking whether there is a mental health professional in the facility, on call, and what educational level the professional is at. Approximately half of the respondents said there was no mental health professional at the facility, while three of them responded that they had a professional in the facility full time. One said they had a professional as needed, and another said they were in the hiring process. As far as mental health professionals on call, five facilities said they had one on call full-time, one had a professional on call part-time, and another

said that they weren't sure, because they use the State of Nevada MHDS facility. The majority use Licensed Clinical Social Workers (LCSWs) as their mental health professional. Others listed professionals with MSWs, MFTs, one RN, and one psychologist.

The next two questions ask about resources available to facility staff both in the facility and in the community. In general, the facilities provide individual and group counseling, screening and assessments, and two provide individual psychiatric attention. Services available in the community included individual and group counseling, individual psychiatric attention, screening and assessments, outpatient care. Two facilities listed inpatient care, and one facility said that they don't use community services. Other questions include the identification of challenges or barriers to the provision of optimal care for the kids, and what resources participants feel are missing. Many respondents replied that a lack of funding for mental health programs or staff was a major barrier to the provision of optimal care, followed by "Few treatment programs in the community". Other responses included lack of training [in mental health issues] for front-line staff and too few mental health staff at the facility. When asked about missing resources, responses were approximately evenly split among categories. Respondents wished for detailed uniform reports for each youth, risk factor analyses for each youth based on screening tools, full-time mental health professional on staff, and development of formal operating procedures. Other comments included: "wellness to families", "holistic prevention early on", "regular psychiatric needs assessments", and more "psychiatrists in the community who work with youth".

Participants were then asked to write about what happens to youth with identified mental health problems when they are released. Responses included: “family provided with referral information”, “Recommendations provided”, and “Probation officers facilitate attendance if on probation”. Only two facilities mentioned follow-up. Participants were also asked to rate to what extent they feel there is a continuity of care in post-release treatment for these kids. The continuity of care was rated on a five-point Likert scale, with options that included “Always”, “Often”, “Sometimes”, “Rarely”, and “Never”. Sixty percent of respondents felt that there was “Often” a continuation of mental health care post-release, and 30 percent said that there was “Sometimes” a continuity of care. No respondents marked “Always”, “Rarely” or “Often”.

Further, participants identify priority mental health needs of the facility, as well as specific changes that would help facility staff better address the mental health needs of the population. Priority needs were more mental health staff, more training for front-line staff, and more treatment programs. Specific changes mentioned included a mental health screening at intake, standard assessment and testing protocols, more mental health and substance abuse programs, and easier access to medication.

The third section of the questionnaire discusses mental health training for facility staff. Participants are asked whether staff is provided mental health training, what kind of training is available, whether it is mandatory or voluntary, if they would like to have additional training provided, and what kind of training they would like to have. Finally, they were asked to describe how training is accessed. First, responses fell overwhelmingly into the “Yes” category, indicating that training on mental health issues is provided for facility staff. Respondents indicated mandatory training on suicide,

substance abuse, dispensing medication, behavior management and crisis prevention. By far the most common was training on issues related to suicide. Voluntary topics included dual diagnosis [of mental health and substance abuse], trauma and addiction, and different kinds of therapy. One survey indicated that workshops in the community are also utilized, with some mandatory and others voluntary. All surveys indicated that they would like more training to be available. Requested training topics included: suicide signs and symptoms, signs and symptoms of other mental health problems, like depression, bipolar disorder, conduct disorder and other behavior problems, Fetal Alcohol Syndrome, personality disorders, anxiety disorders, post-traumatic stress disorder and ADHD. Further, respondents requested training on substance abuse issues, life skills, gender-specific issues, medications, sexual behavior issues, relapse prevention and discharge planning, mental health assessments, wrap-around services, and the de-escalation of hostile situations. Participants described access to training in a number of different ways. Some had a training coordinator or supervisor who organized trainings for the facility, others attend trainings organized by the division manager, one respondent said that they try to identify professionals who are willing to travel, others place requests to their own supervisors. One cautioned that even though requests are made, the “training funds are minimal”.

The fourth section addresses common policy issues. The questions determine whether the facility has written procedures about mental health, what directs the current policies and procedures, if the participants have any feedback about mental health policy and practice that could be used for a statewide plan, and if they feel there is additional information that they could use to better address mental health issues among incarcerated

youth. Almost all participants said that their facility has clear written policies regarding mental health problems, while two surveys said they did not. In an effort to understand what policies govern the procedures for mental health care in juvenile detention facilities, respondents were asked to describe whether it was state statutes, state regulations, county policies, department policies or facility policies that drive their provision of mental health care. The majority said that it was facility policy or department policy. Some cited county policies and others cited state regulations and statutes. One survey listed ACA (American Corrections Association) Guidelines. With regard to items to include in a statewide plan for mental health care to juvenile offenders, participants recommended uniform screening and assessment tools, improved communication between facilities and providers, technical assistance in the development of clear written policies about mental health care, standardized "Best-Practice" programs, and a solid link with classroom and mental health providers. Additional information requested to better inform practice included: research-based treatment options, prior treatment information, techniques for identification and surveillance, street-level counseling and after-school programs, and information about ways to include families in programming and development.

Finally participants were asked to write answers to two summary questions, "What works well about the current system" and "What are the limitations of the current system". Responses to the question about what is working included: available resources on call 24-hours, good communication between probation officers and facility staff, and staff interactions with regard to the understanding of different roles. Respondents to the question about limitations of the current system provided more comments, which included: limited access to mental health professionals, kids remaining in detention

longer than necessary due to problems getting them placed in community-based programs or inpatient care facilities, too few facility staff , difficulty in transporting youth when there are no on-site treatment facilities for a particular problem, too few programs in place at the facility and in the community, and a difficulty accessing services for youth with multiple diagnoses.

DISCUSSION

There are several issues that are of crucial importance that are highlighted in this survey. First, and perhaps most obvious, is a lack of funding available for mental health staff at each facility, for treatment programs, as well as training seminars. It is crucial that funding is found for staff and for training of existing staff. Having trained staff in the facility could streamline the provision of mental health care for the youth, which may help them to understand and cope with their problems. Further, having a mental health professional in the facility or at least on-call at all times is essential, because their specialized training is needed in many situations that involve a youth with a mental health problem. With more mental health professionals in the facility, not only will the facility be able to provide more mental health care and treatment programs, but they will be better able to conduct mental health screenings at intake, identify any mental health problems through observation or interaction with the kids, and provide referrals. Further, it seems that in some cases where funding is severely limited, it is affecting the facility's ability to provide necessary care to youth who need help. Insurance is always complicated, however it would be a good idea to ensure that each facility has enough funding at least to provide proper care to the youth who need it.

Second, there seems to be a lack of consistent policy with regard to mental health problems in the facilities. Existing policies appear to be mostly at a facility or department level, which means that the same child could receive different services at a different facility. There should be a concerted effort to design and implement a standard policy which applies to all the juvenile detention facilities across the state. Having a standard policy in place at the state level would provide assistance to staff with the

process of providing mental health care, including standardized screenings and assessments, step-by-step procedures for coping with mental health problems as well as mental health crises in identified cases, and would provide some plan for mental health training opportunities. The plan would likely be best served at a state level, however if counties implemented identical plans, the effect would be similar.

There also needs to be a focus on the development of new programs in the community that are accessible to the facility. A consistently identified need was for services in the community. While certainly programs exist and are being utilized, there is often a wait to get in or difficulty accommodating the need. Further funding for mental health programs in the facility may alleviate some the current need to reach out to the community programs.

In addition, training seems to be a clearly identified need. It appears that a regular training program covering requested topics about mental health would be well received and well attended. This would be a good area to focus on. A possibility would be to hire a trainer, one who is at least an LCSW, who can travel to different sites and present a program about a specific mental health issue per month for facility staff. This would be a very beneficial program to implement and would be much appreciated.

PART THREE

An Analysis of the Mental Health Policy Affecting Juvenile Offenders in Nevada

INTRODUCTION

There are generally three sources of law that are applicable in addressing the rights of incarcerated juveniles with respect to their mental health needs. These include the Constitution (particularly the 8th and 14th Amendments), the Americans with Disabilities Act, and the Individuals with Disabilities Education Act. Under these legal standards, juveniles are entitled to reasonable safety and adequate medical and mental health care. Furthermore, as noted by the United States Supreme Court in *In re Gault*, the purpose of the juvenile justice system is to determine “what is he, how has he become what he is, and what had best be done in his interest and in the interest of the state to save him from a downward career...the child was to be ‘treated’ and ‘rehabilitated’ and the procedures...were to be ‘clinical’ rather than punitive.” Courts across the country have been addressing the disparate treatment of incarcerated juveniles since the early 1970s. More recently, the federal government and some states have begun to address the need for adequate mental health services in juvenile detention facilities.

Overview of Federal Laws

Americans with Disabilities Act

The American with Disabilities Act (ADA) provides individuals with disabilities protections similar to those provided on the basis of race, color, sex, national origin, age and religion. The law guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, state and local government agencies, and telecommunications. The ADA defines an individual with a disability as someone who has a physical or mental impairment that substantially limits a major life

activity, someone who has a history or record of such an impairment, or someone who is perceived by others as having such an impairment. Title II of the ADA includes all activities of state and local governments regardless of the size of the government entity or whether or not it receives federal funding. Title II requires that state and local governments give people with disabilities an equal opportunity to benefit from all of their programs, services and activities, including public education.

Individuals with Disabilities Education Act

The Individuals with Disabilities Education Act (IDEA) established the right of children with disabilities to attend public schools, to receive services designed to meet their needs free of charge, and to learn in regular education classrooms alongside non-disabled children to the greatest extent possible. These core substantive rights at the heart of IDEA are also known as a free, appropriate, public education in the least restrictive environment. IDEA does not cover all children with disabilities. Rather, the law has a two-prong eligibility standard: children must have at least one of a list of specific impairments (including mental retardation and serious emotional disturbance), and they must need special education and related services by reason of such impairment(s).

U.S. Constitution

The 8th Amendment to the United States Constitution essentially establishes, in part, a ban on the infliction of “cruel or unusual punishment.” The 14th Amendment to the United States Constitution provides, in part, that “no state shall make or enforce any

law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.” The relevant portion of the law is commonly referred to as the “due process” clause and is applicable to state and local government entities.

Overview of Court Cases

State and federal courts have been addressing the inadequate treatment of incarcerated juveniles since the mid 1960s. Although juveniles do not carry with them all the rights that adults do, the courts have recognized that juveniles, even in a non-penal system, do have some basic fundamental rights. The landmark Supreme Court case addressing the rights of juveniles is *In re Gault* (387 U.S. 1 (1967)). In *Gault*, the Supreme Court held that juveniles, like adults, have rights under the Fourteenth Amendment and the Bill of Rights such as notice, right to counsel, right to confrontation, and the privilege against self-incrimination. While *Gault* primarily addressed due process rights prior to detention for juveniles, later cases have addressed the treatment of juveniles once they are in the custody of the state.

In 1982 the United States Supreme Court decided the case of *Youngberg v. Romeo* (457 U.S. 307). Although the case centered around the inadequate treatment of a mentally retarded adult in a state institution, the holding of the court set the standard for reviewing the rights of those under state confinement. In doing so, the court held that “respondent has constitutionally protected liberty interests under the Due Process Clause of the Fourteenth Amendment to reasonably safe conditions of confinement, freedom

from unreasonable bodily restraints, and such minimally adequate training as reasonably may be required by these interests.” (*Youngberg*, 307). Although the Supreme Court has not specifically held this standard to reviewing conditions at juvenile detention facilities, several lower courts have cited this holding as being equally appropriate when addressing the rights and disparate treatment of incarcerated juveniles.

For example, in *Gary v. Hegstrom*, the Ninth Circuit held “that the district court correctly concluded that the fourteenth amendment applie[d] to conditions of confinement at” the juvenile detention facility. (831 F.2d 1430, 1987) In so holding, the Ninth Circuit concluded that the district court had properly found that the inadequate mental health resources at the facility had violated the juveniles’ constitutional rights. Hence, states have a duty to provide adequate mental health services to detained juveniles in order to provide the constitutionally protected rights of reasonably safe conditions of confinement as well as freedom from unreasonable bodily restraint; not to mention appropriate rehabilitative treatment under the traditional theory of *parens patriae*.

Federal and State Efforts for Improvement

Federal Efforts

The federal government has made significant efforts to address the inadequacy of mental health services in state juvenile detention facilities. Most importantly, in 1980, the United States Congress enacted the Civil Rights of Institutionalized Persons Act (42 U.S.C.A. 1997), often referred to as CRIPA. The statute was enacted to protect the federal rights of juveniles in detention and correctional facilities, as well as others. Specifically, the Act gives authority to the Attorney General of the United States to

institute a civil action when investigations reveal that a “State is subjecting [defined] persons...to egregious or flagrant conditions which deprive such persons of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States...” The authority to enforce the Act was delegated to the Special Litigation Section of the Civil Rights Division under the U.S. Department of Justice. Since the inception of the law, the Special Litigation Section has investigated the conditions of confinement in over 100 juvenile detention facilities.

The Special Litigation Section has “made a priority of ensuring adequate access to mental health treatment.” (www.usdoj.gov/crt/split/juveniles.htm). In a speech at the National Juvenile Corrections and Detentions Forum in 1999, Steven Rosenbaum, Chief of the Special Litigation Section, noted that “60% of incarcerated juveniles have a diagnosable mental health disorder, while 20% have severe psychological disorders.” (www.usdoj.gov/crt/split/documents/juvspeech.htm) He also identified the five factors which signify an adequate mental health system in juvenile facilities:

1. Identification of mentally ill youth;
2. Provision of treatment to identified mentally ill youth;
3. Prevention of harm to mentally ill youth or others;
4. Protection of mentally ill youth from abuse; and
5. Appropriate accommodations to enable mentally ill youth to benefit from mental health programs offered at the facility.

Furthermore, Mr. Rosenbaum identified the need for individualized treatment by qualified professionals on a consistent basis.

Although the Special Litigation Section has often had to resort to litigation in resolving the deficiencies of investigated facilities, most have ended with specific settlement agreements with the states that seek to remedy the identified inadequacies of the facilities.

An additional attempt by Congress to secure adequate mental health services for youth in juvenile detention facilities was initiated by Representative George Miller (CA) in 2001. Rep. Miller sponsored the "Mental Health Juvenile Justice Act" with thirty-six co-sponsors in the 107th Session of Congress (H.R. 2198). As introduced, the Act sought to amend the Juvenile Justice and Delinquency Prevention Act of 1974 by providing grants to train juvenile justice personnel in appropriate methods to access mental health and substance abuse treatment services for juveniles. The Act would have also amended the Public Health Service Act to provide competitive grants for programs that offer mental health treatment and diversion services for juveniles. Most importantly, however, the Act would have required states to enact a system of mental health screening and treatment in order to be eligible for certain federal funds.

In his introductory statement, Rep. Miller stated that:

mental health treatment and services have been proven more effective than incarceration in preventing troubled young people from reoffending and are less expensive than prison. In the long run, they are even more cost-effective to us as a society, because they increase the odds that a young person will become a responsible, productive, taxpaying citizen rather than a permanent ward of the state.

The Act was referred to several committees including the Committee on Education and the Workforce, the Committees on Energy and Commerce, and the Judiciary. Despite efforts by the sponsor and co-sponsors to enact the legislation, the Act never made it to a vote. As of the date of this report, this legislation has not been re-introduced to Congress.

State Efforts

Few states have enacted legislation specifically addressing the mental health needs of youth in juvenile detention facilities. Although the states' are ultimately responsible for the juveniles in their care and custody, specific policies and procedures regarding providing mental health assessment and services to incarcerated juveniles is rarely present in state legislation. Below are a few examples of states that have made efforts to address the issue.

Washington (RCW 71.36.030)

The Washington state law requires regional support networks to initiate a local planning effort to develop a children's mental health delivery system. The plan must include a report identifying the number of children in need of mental health services, including those in juvenile detention facilities. The law further requires that the report provide a description of how those mental health needs will be met.

Florida (985.209)

Florida law requires the establishment of "juvenile assessment centers," which "shall provide collocated central intake and screening services for youth referred to the department [of Juvenile Justice]." The intake and screening services of the centers include, but are not limited to "needs assessment; substance abuse screening and assessments; [and] physical and mental health screening..."

Arizona (8-246)

In Arizona, the law requires that each juvenile who is referred to the juvenile court must be administered a common risk needs assessment. The assessment is then to be used by the juvenile court to “determine the appropriate disposition of the juvenile.” Additionally, the law requires that the needs assessment must be updated for the juvenile upon each subsequent referral to the juvenile court.

Minnesota (260.152)

The legislature of Minnesota enacted a law to establish pilot projects “to reduce the recidivism rates of juvenile offenders, by identifying and treating underlying mental health problems that contribute to delinquent behavior...” The law further provides that the projects “must include availability of screening for mental health problems of children who are alleged or found to be delinquent...[and] provide or ensure access to nonresidential mental health services identified as needed in the assessment.”

Colorado (16-8-203)

The state of Colorado enacted legislation to establish a pilot program to provide “intensive treatment management” for juveniles who are “charged with or adjudicated for an offense or who are found not guilty by reason of insanity.” The purpose of the pilot program is to “reduce recidivism and the need for out-of-home placement or hospitalization.” Among other requirements, the chosen programs must “provide psychiatric services, medication supervision, and crisis intervention.”

Policy Recommendations for Nevada

Title 5 of the Nevada Revised Statutes covers procedures in juvenile cases and juvenile courts. In developing the title, the Legislature provided that:

When a child is removed from the control of the parent or guardian of the child, the juvenile court shall secure for the child a level of care which is equivalent as nearly possible to the care that should have been given to the child by the parent or guardian.

This statement clearly exemplifies the recognition by the State of Nevada of the traditional theory of “*parens patriae*” whereby the state assumes the role of parent while a child is under their care and custody in the juvenile justice system. This theory has emphasized the need for care, treatment and rehabilitation by the state in dealing with juvenile offenders.

The screening tools administered during this study revealed that approximately 95% of male youth in Nevada juvenile detention facilities showed indications of a mental health disorder. Similarly, 91% of female youth screened also showed signs of mental health issues. More disturbing, however, is the finding that nearly 50% of the males and over 50% of the females were identified as needing immediate mental health services. Although further assessment is necessary to determine the extent and degree of mental illness and needed services, it is clear that the vast majority of youth in Nevada’s juvenile detention facilities are in need of mental health services in order to receive the care, treatment and rehabilitation necessary to effectuate the goals of the state’s juvenile justice system.

Nevada law does not specifically address the issue of provision of mental health services for incarcerated juveniles. A juvenile judge, at her discretion, may order a juvenile to be assessed if the juvenile is showing outward indications of mental illness.

Additionally, the law provides that the superintendent of a facility must designate staff to “determine which program of education, employment, training, treatment, care and custody is appropriate for the child” within 30 days of entrance into the facility. The law is ambiguous, however, as to what type of “treatment and/or care” is to be addressed.

The following are recommendations to improve state legislation in regard to providing the appropriate level of mental health services for youth who are in the care of custody of the state:

1. The state legislature should require the establishment of a statewide committee to address the mental health needs of incarcerated juveniles. Such committee should include, at a minimum, representatives from juvenile detention facilities, juvenile courts, mental health professionals, and mental health researchers. The primary purpose of the committee should be to examine, in depth, the specific types of mental health services that are needed to address the problems of incarcerated juveniles with the intent of rehabilitation and reduction of recidivism rates. The committee should also explore costs and means of financing an adequate system of mental health services in juvenile detention facilities.
2. The state should require mental health screenings for all juveniles who enter a juvenile detention facility, regardless of the existence of outward signs of mental health problems. Further, in depth, assessments should be provided as deemed necessary by the screenings.

3. The state should require juvenile detention facilities to provide intensive, appropriate mental health services by qualified mental health personnel. Although the state requires facilities to provide “treatment” to the juveniles, the law should specifically identify the need for quality, intensive mental health services.

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