Tennessee's Youth in Juvenile Justice Facilities: Mental Health and Substance Abuse Issues

Louise Barnes, Deborah Bennett, Charlotte Bryson, Sita Diehl, Trish Hayes, Craig Anne Heflinger, Liz Ledbetter, Pam McCain, Linda O'Neal, Patti Orten, Nancy Reed, Adriane Sheffield, Debrah Stafford, and Pat Wade

Tennessee Juvenile Justice/Mental Health Work Group

Abstract

In order to assess the prevalence of mental health and substance abuse among youth in one state's juvenile justice facilities, a survey was conducted of 40 Tennessee facilities. A total of 1215 youth were being held on the "one day census" that was taken as part of the survey. The survey documented many mental health and substance abuse issues: 1) 53 percent of the youth in juvenile justice facilities were experiencing mental health problems; 2) 15 percent were taking some type of psychiatric medicine while in the juvenile justice facility; 3) 42 percent were known to have substance abuse problems; and 4) 30 percent had co-occurring mental health and substance use problems. Policy and program recommendations based on these findings are discussed.

Keywords: juvenile justice, mental health, substance abuse, Tennessee

Introduction

Increasing attention is being paid across the country to mental health, substance abuse, and other special needs of youth involved in the juvenile justice system (Coalition for Juvenile Justice, 2000; National Council on Disability, 2003; U.S. Department of Health and Human Services., 2001). Although exact numbers are unclear, the prevalence of mental health disorders in the juvenile justice population is estimated to be significantly higher than the general population (Atkins, Pumariega, & Rogers, 1999; Stewart & Trupin, 2003), with a conservative estimate that half have some type of mental health problems with one out of every five youth in the juvenile justice system with serious mental health problems (MacKinnon-Lewis, Kauffman, & Frabutt, 2002; Edens & Otto, 1997).

In addition to mental health problems, many youth in the juvenile justice system present with substance abuse problems (MacKinnon-Lewis et al., 2002). Often, these substance abuse problems co-occur with some other mental health problem (Cocozza & Skowyra, 1999; Dembo & Schmeidler, 2003). While concerns have been raised about the incidence and prevalence of certain conditions within the juvenile justice system, advocates are apprehensive as to whether the system is adequately prepared to address the needs of the young people being served by the juvenile justice system.

A recent study of juvenile offenders (status or delinquent) referred to any of the 98 courts in Tennessee (Breda, 2001) found that about seven percent are referred either to mental health or substance abuse services by the court. This rate of treatment referral is substantially lower than even conservative estimates of service need (Otto, Greenstein, Johnson, & Friedman, 1992). This suggests that the juvenile court system, among other child-serving systems, is missing an opportunity to identify and respond to the service needs of youth before they become even more intractable.

The purpose of this study was to estimate the prevalence of mental health and substance abuse issues of youth held within secure facilities across the state of Tennessee. These data were

intended to inform policy and program planning. The Juvenile Justice/Mental Health Work Group was formed by the Criminal Justice/Mental Health (CJMH) Committee of the Statewide Planning Council of the Tennessee Department of Mental Health and Developmental Disabilities (TDMH) in order to examine these issues and formulate recommendations for policy planning (Tennessee Juvenile Justice/ Mental Health Work Group, 2004). The CJMH Committee had recently undertaken a survey of adult jails and mental health issues (see TDMH, 2001, 2003), and similar information was needed to improve services for youth. A list of participating Work Group members and their affiliations is included in Appendix 1.

Methods

This study was based on a survey administered at juvenile justice facilities across the state of Tennessee.

Participating Juvenile Justice Facilities

First, a comprehensive list of facilities across the state and their contacts was developed. Next, a letter was sent to each facility from Commissioner Virginia Trotter Betts of the Tennessee Department of Mental Health and Developmental Disabilities explaining the survey and asking for their participation. Finally, following training on standardized survey administration, committee members and their agency staff contacted each of the facility administrators and arranged a specific date from October to December 2003 to conduct the survey.

Several types of facilities used in Tennessee to serve youth involved with the juvenile justice system were included in this survey. Juvenile Detention Centers (JDCs) are operated by county governments, and while all except one are affiliated with a single county, some also contract with smaller counties to house their youth. Temporary Holding Resources (THRs) are usually county facilities that agree to serve youth on an as-needed basis in counties where there is no JDC and the need for youth detention is not regular. The Youth Correctional Facilities (YCFs) are operated by governmental agencies to serve and treat youth who have been adjudicated and are serving a sentence. This includes one adult prison that has a unit specifically for youth under 21 years of age. Similarly, governmental agencies also contract with other public and private agencies (Others) to house youth who are not suitable for the YCFs but need a secure placement. The final type of facility included is not a formal juvenile justice facility but one involved in the juvenile justice system by housing youth as they conduct mental health assessments ordered by the juvenile courts-usually at the Regional Mental Health Institutes (RMHI) operated by the state Department of Mental Health and Developmental Disabilities and its contractors. All of these facilities are secure and serve youth with juvenile justice involvement, either pre- or post-adjudication.

It should be noted that other facilities also serve juveniles with criminal justice involvement, and several jails hold youth awaiting trial on adult charges. These facilities were not included in this survey. Tennessee's jails for adults were the focus of a previous, comprehensive study of those facilities, again with a focus on individuals with mental health and substance abuse problems (TDMH, 2003).

Table 1 shows the types of juvenile justice facilities and the numbers of those who participated in the survey. Overall, 44 facilities were identified and contacted about participating in this voluntary survey and 40 (including all the JDCs and YCFs) participated. Figure 1 shows the locations of these facilities across the state of Tennessee by county.

Table 1
Number and Types of Tennessee Juvenile Justice Facilities

Type of Facility	Number Across the State	Number Participation
JDC	18	18
THR	9	8
YCF	6	6
RMHI	5	4
Others	6	4
Total	44	40

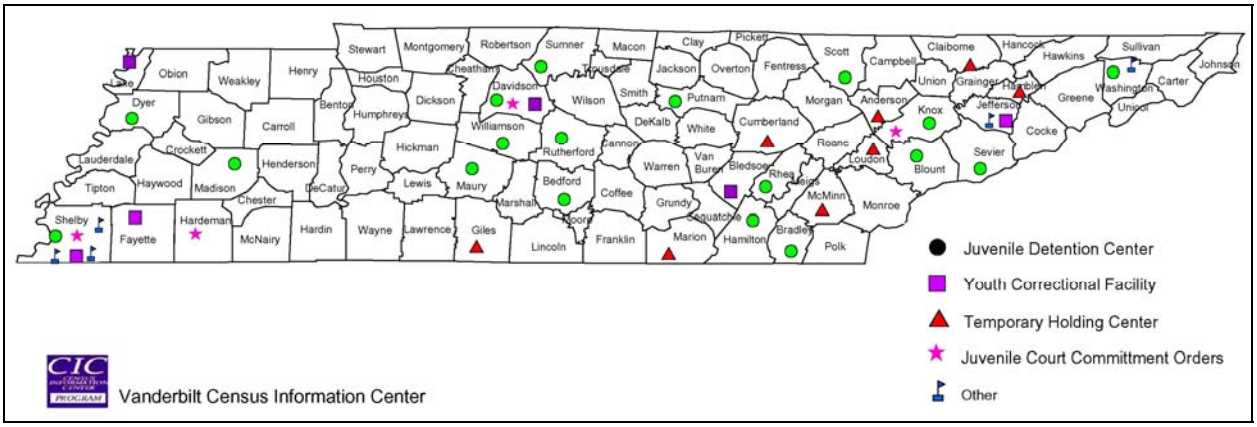

Figure 1
Juvenile Justice Facilities Participating in Survey by County

Tennessee's major metropolitan areas (Shelby, Davidson, Hamilton, Knox Counties) are those with the most concentrated number of facilities. While JDCs are located throughout the state, the smallest and least populated counties have either a THR (mostly in the eastern part of the state), or no facility contracting with other counties to provide this service when needed. The YCFs, JCCO/RMHIs, and Other contractors typically serve youth from their region and across the state, not just the youth in the county where they are located.

Survey

Tennessee does not have a standardized method for identifying or providing services for youth with mental health, substance abuse, or developmental disabilities in juvenile justice facilities. Some larger urban facilities had a more comprehensive assessment at intake that could identify problems and had resources, either within the facility or in the community, to work with these youth. However, many facilities lacked the ability to identify or serve youth with mental health or substance abuse problems. Our survey took a "one day census" approach to gather information about youth in 40 Tennessee juvenile justice facilities. Each facility identified a recent typical or high census day (in the case of those with few youth on a regular basis) and for all youth in their facility on that specific day, provided the requested information.

In order to standardize the data collection process, members of the JJMH Work Group and

other volunteers from affiliated agencies participated in a standardized training, either in person or through a conference call. Records were pulled for each youth that was in the facility on the "census" day, and the following information was collected: the demographic characteristics of the youths (e.g., age, race, or gender), data about their offense, whether this stay was pre- or post-adjudication, and the number of days since the youth had been admitted. Facility staff were requested to identify whether there were any mental health or substance abuse issues, and the following four specific questions were asked: 1) Was the youth put on suicide watch at any time during the stay? 2) Were there any mental health or substance abuse services provided to the youth at the facility? 3) Was mental health medication dispensed? and 4) Was there a mental health or substance abuse diagnosis recorded in the file? All facilities chose a day between mid-October and mid-December 2003 to complete their facility census.

Youth Sample

All youth less than 18 years of age who were incarcerated on the "census" day were included. As can be seen in Table 2, a total of 1,215 youth were being held in juvenile justice facilities across the state of Tennessee on the designated "census" day.

Table 2
Gender, Age, and Ethnicity of Youth by Type of Facility (Percent)

	JDC	THR	YCF	RMHI	Other	Total
Total Number of Youth	372	24	687	27	105	1215
Male (Ave.)	82	71	97	93	44	87
Average Age (Years)	15.6	16.3	16.6	15	15.5	16.2
African-American (Ave.)	54	13	57	44	79	57
White (Ave.)	42	87	40	52	20	40
Hispanic (Ave.)	2	0	2	0	0	2
Asian American (Ave.)	1	0	1	0	0	1
Other (Ave.)	1	0	1	4	1	1

Demographic Characteristics of the Sample

These youth were primarily male (87 percent) and averaged 16.2 years of age (range 10 to 17 years). It should be noted that while the JDCs, THRs, and RMHIs serve youth of both genders, many of the YCFs and other facilities are restricted to a single gender. Of all the youth, 40 percent were White and 60 percent were minorities. Overall, the youth in juvenile justice facilities were primarily African-American (57 percent) or White (40 percent), with very few Hispanic or Asian-American youths. These racial/ethnic proportions correspond with recent information reported by the Tennessee Council of Juvenile and Family Court Judges (TCJFCJ, 2002). Cases involving secure detention showed 33 percent White, 66 percent African-American, and one percent other minorities. Cases resulting in confinement in secure correctional facilities were 47 percent White, 51 percent African-American, and two percent other minorities.

Table 3
Proportion of Youth and Length of Stay (LOS) by Adjudication and Type by Facility

	JDC	THR	YCF	RMHI	Other	Total
Pre-Adjudicated Youth (Ave.)	77	67	0	100	0	27
Post-Adjudicated Youth (Ave.)	23	33	100	0	100	73
Ave. Youths per Facility	21	4	113	7	26	30
Facility Size (Range)	4-101	0-7	15-152	2-12	13-35	0-152
Pre-Adjudication LOS (Ave.)	11	1	-----	22	-----	12
Post-Adjudication LOS (Ave.)	14	17	172	-----	95	147
Overall Length of Stay – Average	12	9	172	95	95	111

Adjudication status and length of stay.
Approximately one quarter (27 percent) of these youth were being held prior to court decision (pre-adjudication) and the rest (73 percent) were post-adjudication (Table 3). On average, these youth had been held in a juvenile justice facility for over three months. This varied significantly by type of facility, and their status as pre- or post-adjudicated (see Table 4). Pre-adjudicated youth in the JDCs and THRs had been held in the facility, on average, for less than two weeks. Pre-adjudicated youth in the JCCOs had been held for an average of three weeks. The time allowed for a JCCO evaluation is up to 30 days. The post-adjudication youth in the YCFs and Other placements had been held in the facility several months.

Findings

Mental Health Problems

When juvenile justice facility staff were asked to identify youth who had mental health problems, they reported 23 percent of the youth (Table 4). Often, to answer this question the facility staff went to the intake paperwork, yet few of the facilities routinely asked about mental health problems during screening/intake. The RMHIs reported the highest proportion of identified mental health problems in each of the categories, but the youth were at those facilities due to suspected mental health problems. The THRs reported that none of their youth had any mental health problems. It should be noted that in a review of intake paperwork at the facilities, the THRs did not include any type of mental health issues.

Approximately one in five youth (21 percent) had some type of formal mental health diagnosis recorded in their facility records, with the facilities showing the highest proportion being those post-adjudication facilities with formal mental health assessments (YCFs and Others). Overall, 15 percent of the youth were taking some type of psychiatric medication while in the facility, ranging from none in the THRs to approximately one third of the youth in the RMHIs. The YCFs and RMHIs were providing some type of mental health services to over half their youth. High levels of suicide watch were reported by the RMHIs (48 percent), but it should be noted that this was the facility to which youth from any of the juvenile justice facilities were transferred if serious mental health problems were displayed. If any of these mental health problems were identified in the record (reported MH, diagnosis, medication, suicide watch), the study team designated a youth as having "probable mental health" problems. As mentioned earlier, the THRs had no information about mental health issues in their records. However, the RMHIs, YCFs, and Others showed similar levels of "probable mental health" for two-thirds of their youth. Overall, over half of the youth (53 percent) had some type of mental health problem specified (Table 4).

Table 4
Proportion of Youth with Mental Health Problems by Type of Facility (by percent)

	JDC	THR	YCF	RMHI	Other	Total
Reported Mental Health Problem	13	---	28	52	26	23
Any Mental Health Diagnosis	4	---	23	60	64	21
Taking Mental Health Medication	7	---	19	30	19	15
Receiving Mental Health Service	17	---	59	56	13	41
Suicide Watch	2	---	7	48	5	6
Probable Mental Health Problem	26	---	66	63	71	53

Mental Health Diagnose

Approximately one in five (21 percent) of the youth in juvenile justice facilities were reported as having a formal mental health diagnosis (see Table 5). Attention Deficit Disorder included those with ADHD and impulse control disorders. Conduct disorders included those listed with Oppositional Defiant Disorder, Disruptive Behavior Disorder and Intermittent Explosive Disorder. Depression/Mood Disorders included Anxiety and other unspecified Mood Disorders. Major Mental Illness included youth diagnosed with Bipolar Disorder, Schizophrenia, and unspecified Psychosis. Other disorders included Post Traumatic Stress Disorder and Antisocial Personality Disorder. The highest proportion of youth with reported mental health diagnoses were those placed in the Other juvenile justice facilities, all with post-adjudicated youth, and the most frequent diagnoses reported were conduct disorder and depression. The most frequent psychiatric diagnoses reported for youth in juvenile justice facilities were conduct disorder and depression.

Table 5
Proportion of Youth with Psychiatric Diagnoses Reported by Type of Facility (by percent)

	JDC	THR	YCF	RMHI	Other	Total
Attention Deficit Disorder	2	---	4	26	5	4
Conduct Disorder	<1	---	8	26	39	9
Depression/Mood Disorders	1	---	9	---	19	7
Major Mental Illness	1	---	2	11	4	2
Other	---	---	2	---	2	1
Any Diagnosis	4	---	23	56	64	21

The RMHI youth were the next most likely to have a formal mental health diagnosis, with 56 percent having a diagnosis reported on the day of the "one day census." Note that youth who were sent to the RMHI facilities were usually pre-adjudication and had been referred by juvenile court judges who suspected serious mental health problems. The THRs did not report any mental health diagnoses for any of their youth.

Psychiatric Medication

Approximately one of every seven youth (15 percent) in the juvenile justice facilities was taking some type of psychiatric medicine (see Table 6). The primary type of psychiatric medication was antidepressants (11 percent of the youth). Youth in RMHIs were the most likely to be taking a psychiatric medication while at the facility.

Table 6
Proportion of Youth on Psychiatric Medication by Type of Facility (by percent)

	JDC	THR	YCF	RMHI	Other	Total
Stimulants	2	---	4	4	1	3
Anti-Depressants	4	---	13	19	16	11
Anti-Psychotics	3	---	7	7	4	5
Any Psychiatric Medication	7	---	19	30	19	15

Substance abuse problems

To determine if a youth had drug or alcohol abuse problems, several questions were asked: 1) Does the youth have a substance problem? Almost every facility specifically asked about substance abuse issues on their intake form so this information was readily available. Thirty-seven percent of the youth were identified by staff as having substance abuse problems. 2) Does the youth have a substance use diagnosis? Only a few (three percent) of the youth had a formal diagnosis of substance abuse documented. 3) Has the youth received a substance abuse service at the facility? Approximately one quarter of the youth (26 percent) were reported as having received such services. Based on having at least one of these endorsements, two of every five youth (42 percent) in juvenile justice facilities were experiencing known substance abuse problems.

Co-occurring mental health and substance abuse problems

If a youth had both probable mental health and substance use issues, he/she was identified as having a co-occurring problem (see Figure 2). Over one quarter (30 percent) of all youth in juvenile justice facilities had co-occurring mental health and substance use problems. The actual proportions of mental health and substance abuse difficulties are likely higher since some facilities did not systematically screen, especially for mental health issues. High proportions have also been found among Tennessee's delinquent youth in the annual Children's Program Outcome Review Team study conducted by the Tennessee Commission on Children and Youth (TCCY, 2003).

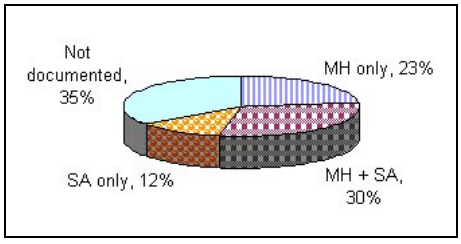

Figure 2
Proportion of Youth in Juvenile Justice Facilities with Known Mental Health and/or Substance Abuse Problems

Limitations

This report is based on information from 40 of 44 juvenile justice facilities across the state of Tennessee. While this represents 90 percent of the facilities, it does not include information from those who did not participate. One THR, one RMHI, and two Other facilities did not submit data for the study. The data above were presented by type of facility as well as the total in order to give the most accurate information. In addition, there are other secure facilities where youth under 21 years of age are held for criminal offenses, including adult jails across the state. These facilities were not included in this survey, but should be the focus of future work.

The one-day census approach, while providing a "snapshot" of the youth in facilities on one day, is not the ideal method for collecting data about populations in confinement. One limitation of this approach is that a youth might be counted more than once if he/she were transferred between facilities during the study time period. A more comprehensive approach would be to gather information on all youth held in a facility for a one month, or one year time-period. There is, however, no central database that has all of the information on youth in these different types of facilities across Tennessee.

Also, the information in this report is a conservative estimate of the mental health, substance abuse, and developmental disability needs of youth in juvenile justice facilities. Information was obtained from facility staff and data in existing records. Not only have the deficiencies in standardized screening and records been discussed, but also one-day "snapshots" have been criticized for underestimating levels of mental health problems (Cox, Banks, & Stone, 2000). A more systematic clinical assessment would be needed to provide more accurate data.

Discussion and Implications

This study was the first attempt in Tennessee to assess the mental health and substance abuse status of youth in juvenile justice facilities. High levels of mental health, substance abuse, and co-occurring disorders correspond with previous studies in other states (Atkins et al., 1999; Biggs, Rosenblatt, & Rosenblatt, 2000; Edens & Otto, 1997; Rutherford, Bullis, Anderson, & Griller-Clark, 2002) and document the need to address these issues in Tennessee. Regarding THR's not reporting that any of their youth had mental health problems, McLearen and Ryba (2003) found that smaller jails are likely to report having fewer persons with mental illness. It may be possible that small THR's also have difficultly detecting juveniles with mental health problems. Alternatively, it is plausible that youths with serious problems are not placed in these types of facilities.

This study builds on two previous reports conducted about adults in Tennessee's jails (TDMH, 2001, 2003). Focus on incarcerated adults with mental health and substance abuse problems has recently led to the development of an interdisciplinary mental health/ criminal justice training program that provides an overview of mental illness. Curriculum is targeted to the specific roles of personnel in the criminal justice and the mental health systems. The training program provides curricula and comprehensive education and training across the spectrum of professionals and constituencies involved in both the mental health and criminal justice systems free of charge (TDMH, 2004).

In addition, TDMH established eight Criminal Justice/Mental Health (CJ/MH) Liaison pilot projects (TDMH, n.d.). At the time of this study, there were 16 CJ/MH liaisons providing services in 21 of the 95 counties across the state, with training activities statewide. The CJ/MH Liaison Project is a community project that examines the issues affecting adults with serious mental illness who are involved in

the criminal justice system. The purpose of the project is to facilitate communication and coordination between the community, the criminal justice and mental health systems to achieve common goals: to support the establishment of services that would promote diversion activities; and provide liaison activities for adults with serious mental illness who are incarcerated or at risk of incarceration. The success of the projects depends greatly on community support and the willingness of communities to work collaboratively to improve the functioning of the criminal justice and mental health service delivery systems.

The CJ/MH Liaison responsibilities include: 1) Examining the issues affecting adults with mental illness who are incarcerated or who are at risk of becoming incarcerated; 2) Facilitating communication and coordination between the criminal justice and mental health systems and the community; 3) To provide liaison and case management activities for adults with a mental illness and who are involved in the criminal justice system; and 4) Training activities that include training with Tennessee Correctional Institute staff and regional training on mental health crisis management for sheriff personnel and alternative transporting agents.

Policy and Program Recommendations

The purpose of this study was to document the level of mental health and substance abuse problems among youth incarcerated in Tennessee's juvenile justice facilities and to address their needs by supporting policy and program improvement. The findings of this survey suggest the following recommendations within five areas: coordination of planning and service delivery across sectors, improvement needed within the juvenile justice system, improvement targeted at the community service providers, funding, and further information needs.

1. Coordinated planning and service delivery. These youth and their needs are not solely the responsibility and jurisdiction of the juvenile justice system. These are youth who also need intervention from the mental health, substance abuse, developmental disabilities, educational, and child welfare systems. Joint planning and resources are needed to: Prevent youth problems from becoming so severe that the youth appear in the juvenile justice system, and serve youth within the juvenile justice system and upon their release to the community.

The Governor's Children's Cabinet, composed of the Commissioners of all child-serving state departments (Children's Services/ Child Welfare, Education, Health, Human Services, Mental Health and Developmental Disabilities), was asked to consider this issue in two ways. First, they were encouraged to include other involved state and community agencies in their deliberations and to request joint action to address these issues, such as the Bureau of TennCare, the Tennessee Administrative Office of the Courts, the Office of Criminal Justice Programs (Department of Finance and Administration), and the Tennessee Council of Juvenile and Family Court Judges. Tennessee Voices for Children can play a valuable role in representing the youth and their families in the discussion.

Second, it was recommended that the Governor's Children's Cabinet endorse a System of Care approach statewide as a public policy priority. There have been a growing number of demands to coordinate services for children and adolescents, not only across statewide substance abuse organizations, but among an array of community services and supports. The Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services has been promoting a System-of-Care approach that recognizes and incorporates *all* of the people and services needed to address the multiple problems of youth and their families (SAMHSA, 2004). Originally designed for children with serious

emotional disorders, there has been a growing recognition that this model is useful for conceptualizing a coordinated services system for all children, adolescents, and their families.

2. Juvenile justice system improvements. Within the juvenile justice facilities, three primary issues to be addressed are screening for mental health and substance abuse issues, training for staff, and links with appropriate community agencies. Regarding screening, a valid and reliable screening tool that can be used by lay professionals in the juvenile justice system needs to be identified. Several recent reviews provide resources to pursue (e.g., Grisso & Underwood, 2004; Wasserman, Ko, & McReynolds, 2004). One method for implementing this screening recommendation is to make it a part of standards for certification and licensure for juvenile justice facilities.

In addition, juvenile justice facility staff need education and training on identification of and services for mental health, substance abuse and developmental disability problems (Boesky, 2001; Dembo et al., 1996). Tennessee's criminal justice training about adults with mental health problems (Diehl, 2004c) could be adapted for youth issues and provide orientation and ongoing training for juvenile justice facility staff and court youth services officers. Another training resource could be built upon the online tutorial for juvenile justice, mental health and substance abuse treatment professionals from the National GAINS Center for People with Co-occurring Disorders in the Justice System and the University of Washington (Trupin & Boesky, 2001).

Juvenile court judges should be briefed on these issues and included in planning comprehensive solutions. At the judges' annual conference in August, 2004, the findings of this report were shared with them. At the 2005 conference, they will be briefed on other progress to date, including the work by the Legislature's Select Committee. Furthermore, the juvenile justice system needs improved linkage with appropriate community treatment agencies.

3. Community improvements. Within communities, outreach to this population and linkage with the courts and juvenile justice facilities is needed at the time of first court appearance, referral, and follow-up. Community improvements and involvement should not be limited to the mental health and substance abuse agencies, but include all agencies that work with these youth, including developmental disability, health, education, and child welfare service systems.

Existing resources in communities should be better used by the juvenile justice system. For instance, approximately three-quarters of the adolescents who appear before the juvenile court have TennCare, the state's Medicaid managed care insurance plan (Children's Mental Health Services Research Center, 2004; Heflinger, Gaensbauer, & Simpkins, 1998). Behavioral health screens and diagnostic assessments through TennCare's EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Program (Center for Medicare and Medicaid Services, 2005) should be available for all TennCare youth. Encouragement of similar screens for all youth, regardless of insurance type, should be available to identify behavioral health risks before the problems come to the attention of the juvenile justice system.

Crisis intervention services need to be readily accessible to address the needs of youth in detention facilities who appear suicidal. In addition, psychiatric consultation regarding medication issues is needed. At discharge from juvenile justice facilities, youth and their families need a smooth transition back to the community and appropriate resources, including follow-up to ensure that the link has been made.

Training is also needed for community providers about interfacing with the juvenile

justice system. Current resources (e.g., Diehl, 2004b, 2004c) should be adapted, and a wide variety of community training events are available to implement this curriculum (e.g., the annual conference of the Tennessee Association of Mental Health Organizations).

In addition, community mental health court liaisons similar to those in the adult community mental health system (TDMH, n.d.) are needed for juvenile courts and juvenile justice facilities. Community agencies and the juvenile justice facilities must also develop supports for and partnerships with families of youth at risk of or already involved in the juvenile justice system. Families have sought juvenile court intervention specifically to obtain mental health services for their children when they have hit barriers to services access (Cusac, 2001; Olson, 2003). Family-friendly educational materials available nationally (National Mental Health Association, n.d.) and locally (Diehl, 2004a, b) could be adapted for Tennessee families of children and adolescents who come into contact with the juvenile justice system.

4. Funding. TennCare provides the most public behavioral health services across the state and its Medicaid counterpart is the nation's primary insurer of adolescents (Schneider, Fennel, & Long, 1998; Weil, 2003). TennCare services need to be easily accessible to prevent acceleration of problem behavior and to enhance the youth's transition to the community. Many of the youth who come before the juvenile court have TennCare/Medicaid. Juvenile court liaisons are needed to access services for TennCare eligible youth as they first encounter the juvenile justice system, as well as when they are transitioning back to the community. Juvenile court judges and staff should request information about TennCare youth and their most recent health care screening (through EPSDT) and, if not available or adequate, request a comprehensive screening. In addition, rules should be created by the Bureau of TennCare to suspend, not terminate, TennCare eligibility for youth who are incarcerated, with a simple and straightforward process for re-instating youth as they are discharged.

5. Need for further information. Finally, the Work Group recommends that more information is needed to inform policy and service delivery planning. Information is needed about youth in adult jails and lockups, since they were not included in this report nor the one on adult jails (TDMH, 2003). In addition, the following issues should also be explored regarding youth in the juvenile justice system in order to inform policy and service planning: 1) Relationship between prior use of mental health/substance abuse services and admission to a juvenile justice facility; 2) Use of community behavioral health services following discharge from juvenile justice facilities; 3) Recidivism in juvenile justice facilities among youth with mental health, substance abuse, developmental disabilities, and co-occurring disorders; and 4) The growing number of Hispanic and other immigrant youth in the juvenile justice system and an assessment of the resources in the system to serve these youth.

In summary, these five areas of policy and program recommendations all point towards the need for an integrated and coordinated system of service delivery to all youth in Tennessee that would not only divert them from the juvenile justice system but also identify the needs of youth who end up in that system and direct them to needed resources. The System of Care approach, discussed under Recommendation 1, is designed to integrate and coordinate services for youth once they are identified or make their way into the service system. In addition, a health education or promotion approach is needed that would not only increase physical and mental health and well-being among the state's youth but also provide early identification and intervention as issues first emerge. Nationally, the President's New Freedom Commission

(2003) has recognized the disorganization of the service system for both mental health and substance abuse issues; and called for a coordinated system of care for prevention, early intervention, and treatment.

References

Atkins, D. L., Pumariega, A. J., & Rogers, K. (1999). Mental health and incarcerated youth I: Prevalence and nature of psychopathology. Journal of Child and Family Studies, 8, 193-204.

Biggs, E. E., Rosenblatt, A., & Rosenblatt, J. A. (2000). Criminal behavior and emotional disorder: Comparing youth served by the mental and juvenile systems. Journal of Behavioral Health Services & Research, 27, 227-237.

Boesky, L. M. (2001). Mental health training in juvenile justice: A necessity. Corrections Today, 63, 98-101.

Breda, C. S. (2001). The mental health orientation of juvenile courts. Journal of Behavioral Health Services & Research, 28, 1-8.

Center for Medicaid and Medicaid Services. (2005). Medicaid and EPSDT. Retrieved January 21, 2005, from http://cms.hhs.gov/medicaid/epsdt/default.asp.

Children's Mental Health Services Research Center. (2004). Behavioral and mental health profiles and services for children and families referred to juvenile courts in Tennessee. Knoxville, TN: University of Tennessee Children's Mental Health Services Research Center.

Coalition for Juvenile Justice. (2000). Handle with care: Serving the mental health needs of young offenders. Coalition for Juvenile Justice 2000 Annual Report. Washington, DC: Coalition for Juvenile Justice.

Cocozza, J. J., & Skowyra, K. R. (1999). Youth with mental health disorders: Issues and emerging responses. Juvenile Justice Bulletin, 7, 3-13.

Cox, J. F., Banks, S., & Stone, J. L. (2000). Counting the mentally ill in jails and prisons. Psychiatric Services, 51, 533.

Cusac, A. (2001). Arrest my kid: He needs mental health care. The Progressive, 65, 22-26.

Dembo, R., & Schmeidler, J. (2003). A classification of high-risk youths. Crime and Delinquency, 49, 201-230.

Dembo, R., Turner, G., Schmeidler, J., Sue, C. C., Borden, P., & Manning, D. (1996). Development and evaluation of a classification of high-risk youths entering a juvenile assessment center. Substance Use & Misuse, 31, 303-322.

Diehl, S. (2004a). What to do when you are in trouble with the law: A guide for mental health consumers in Tennessee. Retrieved May 15, 2005, from http://www.state.tn.us/mental/specialpops/cj/WhatToDoBklt.pdf.

Diehl, S. (2004b). You can help when someone with mental illness has been arrested: A guide for family members and advocates in Tennessee. Retrieved May 15, 2005, from http://www.state.tn.us/mental/specialpops/cj/YouCanHelpBklt.pdf.

Diehl, S. (2004c). Criminal justice response to people with mental illness arrested or incarcerated in Tennessee. Retrieved May 15, 2005, from http://www.state.tn.us/mental/specialpops/cj/responsecurriculum.pdf.

Edens, J. F., & Otto, R. K. (1997). Prevalence of mental disorders among youth in the juvenile justice system. Focal Point, 11, 1-6.

Grisso, T., & Underwood, L. A. (2004). Screening and assessing mental health and substance use disorders among youth in the juvenile justice system. Retrieved May 12, 2005, from http://www.ncjrs.org/pdffiles1/ojjdp/204956.pdf.

Heflinger, C. A., Gaensbauer, R., & Simpkins, C. G. (1998, July). Pre-custody Tenn-Care Services: Response to the EPSDT Consent Decree, Reports #1 – #3. Nashville, TN: Vanderbilt Institute for Public Policy Studies, Center for Mental Health Policy.

Mackinnon-Lewis, C., Kaufman, M. C., & Frabutt, J. M. (2002). Juvenile justice and mental health: Youth and families in the middle. Aggression and Violent Behavior, 7, 353-364.

McLearen, A. M., & Ryba, N. L. (2003). Identifying severely mentally ill inmates: Can small jails comply with detection standards? Journal of Offender Rehabilitation, 37, 25-40.

National Council on Disability. (2003). Addressing the needs of youth with disabilities in the juvenile justice system: The current status of evidence-based research. Retrieved May 15, 2005, from http://www.ncd.gov/newsroom/publications/2003/juvenile.htm

National Mental Health Association. (n.d.) When your child is behind bars: A family guide to surviving the juvenile justice system. Retrieved April 20, 2005, from http://www.nmha.org/children/justjuv/bars.pdf.

Olson, J. (2003). Parents surrender children to gain mental health aid. The IRE Journal, 26, 18-19.

Otto, R. K., Greenstein, J. J., Johnson, M. K., & Friedman, R. M. (1992). Prevalence of mental disorders among youth in the juvenile justice system. In J. Cocozza (Ed.), Responding to the mental health needs of youth in the juvenile justice system (pp. 7-48). Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice System.

President's New Freedom Commission on Mental Health. (2003). Achieving the promise: Transforming mental health care in America. Retrieved April 20, 2005, from http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html.

Rutherford, R. B., Bullis, M., Anderson, C. W., & Griller-Clark, H. M. (2002). Youth with disabilities in the correctional system: Prevalence rates and identification issues. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

Schneider, A., Fennel, K., & Long, P. (1998). Medicaid eligibility for families and children. Retrieved April 20, 2005, from http://www.kff.org/content/archive/2106/eligibility.pdf

Stewart, D. G., & Trupin, E. W. (2003). Clinical utility and policy implication of a statewide mental health screening process for juvenile offenders. Psychiatric Services, 54, 377-382.

Substance Abuse and Mental Health Services Administration. (2004). Comprehensive community mental health services program for children and their families. Retrieved April 20, 2005, from: http://mentalhealth.samhsa.gov/publications/allpubs/CA-0013/default.asp

Tennessee Commission on Children and Youth. (2003). Program outcome review team, 2003 evaluation results. Retrieved April 20, 2005, from http://www.state.tn.us/tccy/cport03.html

Tennessee Department of Mental Health and Developmental Disabilities. (n.d.). Criminal justice and mental health in Tennessee: Criminal justice and mental health projects. Retrieved April 20, 2005, from http://www.state.tn.us/mental/cj/cj2.html

Tennessee Department of Mental Health and Developmental Disabilities, Criminal Justice/Mental Health Task Force. (2001). Criminal justice/mental health task force report. Retrieved April 20, 2005, from http://www.state.tn.us/mental/mhs/CJTFReportJan2001.pdf

Tennessee Department of Mental Health and Developmental Disabilities, Criminal Justice/Mental Health Task Force. (2003). A survey of county jails in Tennessee. Nashville, TN. Retrieved April 20, 2005, from http://www.state.tn.us/mental/publications/jailsurveyreport.pdf

Tennessee Juvenile Justice/Mental Health Work Group. (2004). Tennessee's youth in juvenile justice facilities: Mental health, substance abuse, and developmental disability issues. Retrieved April 20, 2004, from http://www.state.tn.us/mental/specialpops/cj/jjmhreport061104.pdf

Trupin, E., & Boesky, L. M. (2001). Working together for change: Co-occurring mental health and substance use disorders among youth involved in the juvenile justice system. Delmar, NY: National GAINS Center for People with Co-occurring Disorders in the Justice System.

U.S. Department of Health and Human Services. (2001). Youth violence: A report of the surgeon general. Retrieved April 20, 2005, from http://www.surgeongeneral.gov/library/youthviolence/youvioreport.htm

Wasserman, G. A., Ko, S. J., & McReynolds, L. S. (2004). Assessing the mental health status of youth in juvenile justice settings. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

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Author Information

Craig Anne Heflinger, Ph.D.*
Vanderbilt University
E-Mail: c.heflinger@vanderbilt.edu

*Corresponding author

Appendix A

Members of the Tennessee Juvenile Justice/Mental Health Work Group, Criminal Justice/Mental Health Committee TDMHDD Statewide Planning Council, in Alphabetical Order

Name	Affiliation at Time of Survey
Louise Barnes	Tennessee Department of Mental Health and Developmental Disabilities
Deborah Bennett	Juvenile Court of Memphis and Shelby County
Charlotte Bryson	Tennessee Voices for Children
Sita Diehl	Tennessee Department of Mental Health and Developmental Disabilities
Trish Hayes	Justice Integration Services
Craig Anne Heflinger	Vanderbilt University
Liz Ledbetter	Tennessee Department of Mental Health and Developmental Disabilities
Pam McCain	Tennessee Department of Children's Services
Linda O'Neal	Tennessee Commission on Children and Youth
Patti Orten	Tennessee Voices for Children
Nancy Reed	Tennessee Department of Mental Health and Developmental Disabilities
Adriane Sheffield	Vanderbilt University
Debrah Stafford	Tennessee Commission on Children and Youth
Pat Wade	Tennessee Commission on Children and Youth

The Tennessee Juvenile Justice/Mental Health (JJMH) Work Group was established as a subcommittee of the Criminal Justice/Mental Health Advisory Committee to assess the status of the State's juvenile justice and mental health systems. The JJMH Work Group is comprised of stakeholders from programs that work specifically with children and youth.