Committee on Education and Labor
Subcommittee on Healthy Families and Communities

Testimony of Andrea Weisman
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Thank you for this opportunity to speak to the members of the Subcommittee on Healthy Families and Communities. I am a doctor of clinical psychology and the Director of Health Services at the District of Columbia Department of Youth Rehabilitation Services. Prior to my current position, I was Director of Behavioral Health Services at the Maryland Department of Juvenile Services.

As you consider passage of Representative Kennedy's Juvenile Crime Reduction Act and the reauthorization of the Juvenile Justice and Delinquency Prevention Act, practitioners, public officials and advocates in both mental health and juvenile justice welcome your concern about the very serious issue of the prevalence of mental health disorders among youth who come into contact with the juvenile justice system.

While juvenile arrest rates have generally since declined since 1997, there are still over two million youth who are arrested and come into contact with the nation's state and local juvenile justice systems each year.[1] The now widely-accepted prevalence data indicate that as many as 70% of youth who come into contact with the juvenile justice system suffer one or more diagnosable mental health disorders, and that 25% suffer serious disorders causing impaired functioning in one or more life domains.[2] That means that as many 1,400,000 of these youth have at least one diagnosed mental health disorder and that as many as 500,000 have disorders of significant severity to cause dysfunction. By comparison, it is estimated that 10% of children and adolescents in the general population suffer from mental illness severe enough to cause some level of impairment. When we consider the frequently co-occurring substance abuse disorders, the numbers are astronomically high.

But these data alone fall short in really understanding the complexity of the issues our youth and our systems face in addressing these problems. There are other statistics we need to consider to really put this into context. For example, children of color are disproportionately represented in juvenile justice systems across the country.[3] The data clearly show that youth of color are more likely to be arrested, locked up before trial, sent to state facilities after adjudication and spend more time incarcerated that white youth, even when they are charged with the same categories of offense.

Another piece of the puzzle is this, and I'll use the District to exemplify: According to Annie E. Casey's Kids Count (2007) statistics, the District surpasses national averages on issues such as low birth weight of babies born, infant mortality, child deaths, teen deaths, teen births rates, teen high school drop out rates, teens not in school and not working, children living in poverty and children living in single parent households.

When I worked for the District's Department of Mental Health 5 years ago, their penetration rate – that is, the number of children and adolescents to whom services were being provided was just under 1% of all youth. This is an example, but children throughout the country are underserved by mental health systems. And I don't think it's too big a leap to claim that judging from disproportionate number of children of color who wind up in the juvenile justice system with diagnosed mental health disorders – which public mental health systems are especially under serving this youth population.

There's one more context setting parameter. There is growing evidence documenting the nearly pervasive experience of trauma among incarcerated youth PRIOR TO THEIR INCARCERATION. Some studies report prevalence rates as high as 93.2% for boys and 84% for girls.[4] Trauma refers to the experience or exposure to violence, physical, sexual or emotional abuse or neglect. Trauma for these youth comes in the form of family violence and close contact with violence among friends and in their communities, in addition to being the being the victim of physical, sexual, or emotional abuse or neglect. Internalizing trauma responses include: emotional numbing, depression, decline in functioning, confusion, nightmares and flashbacks. Externalizing trauma responses are evidenced in interpersonal conflicts, aggressive and risky behaviors, substance abuse and school avoidance or refusal.[5] These are entirely characteristic of incarcerated youth and likely account for the resulting diagnoses of oppositional defiant disorder and conduct disorder and other hyperkinetic disorders that make up [the ills] a majority of the 70% of youth diagnosed as having a mental health disorder. The trauma our youth have experienced is pervasive and it is multi-generational. If we don't treat the whole family system we will be less successful in responding to the needs of our youth.

Juvenile justice systems have struggled to develop the range of behavioral health services that satisfactorily address the needs of children and families. For example, the partnership between the John D. and Catherine T. McArthur Foundation and the National Center on Mental Health and Juvenile Justice through the foundation's Models for Change initiative has led to some significant improvements in the collaboration strategies between state level mental health and juvenile justice agencies.

In addition, SAMHSA's Center for Mental Health Services' System of Care work in numerous states has provided both the philosophy and the strategies for interagency collaboration among child serving agencies, including mental health, child welfare, education, and juvenile justice. Children and adolescents cross multiple agencies, and programs and services must come from the combined efforts and collaboration among them all - from the identification of a youth with mental health needs to their treatment in programs and services that all agencies have a collective interest in developing.

There are several core values and strategies in approaching this effort, some of which are already embodied in the Juvenile Justice and Delinquency Prevention Act:

1. ***Deinstitutionalization of Status Offenders***
   Status offenses are those that only a minor can be charged with such as truancy, running away and curfew violations. These are the very behaviors

we would expect from a youth being sexually abused or otherwise traumatized – many girls are running away from abusive adults in their families or neighborhoods. Locking girls up for what may be adaptive or survival behavior is wrong. Incarceration is not good for anybody, and for traumatized youth it recapitulates their original trauma experiences.

2. ***Early Identification of Youth with Mental Health or Substance Abuse Disorders***
A critically important development in recent years is the systematic identification of youth with mental health or substance abuse disorders with validated screening instruments (such as the MAYSI-2[6], GAIN-Q[7] and Trauma Severity Index[8]) upon their first contact with juvenile justice agencies. Screening must lead to culturally sensitive, evidenced-based treatments – whether within juvenile justice agencies or facilities or in the community.

3. ***Diversion TO COMMUNITY-BASED PROGRAMS***
Whenever public safety concerns allow, youth should be diverted from detention or incarceration to home- or community-based treatments with proven effectiveness.

4. ***Use of Evidenced-based Treatments and Services***
Quite a lot is now known about the kinds of services and supports that work most effectively with the juvenile justice population. These include Multi-systemic Therapy, Functional Family Therapy and Multi-Dimensional Treatment Foster Care.[9] These interventions bring therapeutic services into the home (or foster home) with varying intensity and for various durations to work with the youth and family in natural settings.

5. ***Adult Jail and Lockup Removal***
Youth locked up in adult jails suffer significantly higher negative outcomes than youth in juvenile facilities, from higher suicide rates to increased likelihood of being victims of assault and abuse.[10] Youth under the age of 18 should not be held in adult jails, whether they are charged in the juvenile justice system or the adult criminal justice system.

6. ***"Sight and Sound" Separation***
Youth held in adult jails [or prisons] even for brief periods of time, such as for screening or waiting for transport to juvenile facilities, should be kept completely separated from adult inmates to reduce the likelihood of their being abused or exploited.

7. ***Disproportionate Minority Contact (DMC)***
States and local jurisdictions must be held accountable to assess and address the racial and ethnic disparities affecting youth of color that exist throughout the juvenile justice system.

JJDPA's reauthorization with proposed amendments and Rep. Kennedy's new piece of legislation, taken together, would take us further than we have been previously in ensuring that youth in need of mental health treatment will receive effective services at home or in their communities.

Let me share with you now the singular efforts of the District in creating a model for change. DYRS has implemented Positive Youth Development as its signature focus. PYD incorporates a culturally competent, strength-based, family-focused agenda for those youth in the District who further penetrate and are committed to the District's juvenile justice system. DYRS has also adopted a public health model for its health services – both medical and behavioral health. With the recognition of trauma *as* the central issue with which most of our youth are faced and the multi-generational nature of this phenomenon, DYRS has adopted a set of strategies that incorporate families, schools, living unit staff and multiple agencies in the development of family recovery plans.

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[2] *Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System.* Skowyra, Kathleen and Cocozza, Joseph. The National Center for Mental Health and Juvenile Justice. January 2006.
[3] State Disproportionate Minority Confinement Data. W. Hayward Burns Institute at www.BurnsInstitue.org.
[4] Hennessey, M. et al. Trauma among girls in the juvenile justice system. Washington, DC: Juvenile Justice Working Group of the National Child Traumatic Stress Network, 2004.
[5] Hodes, Gordon R. *Responding to Childhood Trauma: The Promise and Practice of Trauma Informed Care.* National State Mental Health Program Directors. National Technical Assistance Center
[6] Grisso, T. and Bynum, R. Massachusetts Youth Screening Instrument Version 2, 2000.
[7] Titus, J.C. and Bennett, M. The GAIN-Q (GQ): The Development and Validation of a Substance Abuse and Mental Health Brief Assessment, 2003.
[8] Ford, J.D., Chapman, J.F. Hawke, J. and Albert, G. *Trauma Among Youth in the Juvenile Justice System.* Program Brief, National Center for Mental Health and Juvenile Justice, 2007.
[9] Burns, B., Hoagwood, K. and Mrazek. P. Effective Treatment for Mental Disorders in Children and Adolescents, *in Clinical Child and Family Psychology Review*, Vol. 2, No. 4. 1999:199-244.
[10] ACT 4 Youth Juvenile Justice: A Nationwide Initiative Addressing Reauthorization of the Juvenile Justice and Delinquency Prevention Act (JJDPA). Core Requirements at http://www.act4djj.org/about_reauirements.html.