U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Volume VII • Number 1

JUVENILE JUSTICE

Youth With Mental Health Disorders: Issues and Emerging Responses

Also

- Wraparound Milwaukee Program
- Suicide Prevention in Juvenile Facilities

OJJDP

Journal of the
Office of Juvenile Justice and Delinquency Prevention

From the Administrator

If we are to succeed in preventing and reducing juvenile delinquency, we must address not only the offenses that bring certain youth to the attention of the juvenile justice system but the underlying problems they face, including the mental health problems that affect so many youth in the juvenile justice system.

The increased attention recently accorded the mental health needs of youth in the juvenile justice system, noted by **Joseph Cocozza** and **Kathleen Skowyra,** is as welcome as it is overdue. We need to learn much more about "Youth With Mental Health Disorders" who are involved with the juvenile justice system so that we may enhance the quality of the services provided them.

Solving these problems requires designing and implementing effective treatment models. "Wraparound Milwaukee," as **Bruce Kamradt** reports, has successfully integrated a broad array of services to better serve youth with mental health needs who have been adjudicated delinquent. I am sure you will find this program and its results of interest.

The mental health needs of juveniles in custody is another area of concern to juvenile justice practitioners that needs to be addressed. Suicide is a particularly disturbing manifestation of unmet mental health needs, especially when it occurs during confinement. **Lindsay Hayes** offers constructive recommendations for "Suicide Prevention in Juvenile Facilities" and for providing mental health services to the youth confined in those facilities.

As the above articles illustrate, youth challenged with interrelated mental health disorders and delinquent behaviors need our help to get their lives back on track. OJJDP has included a number of initiatives and programs to this end in its *Comprehensive Plan for Fiscal Year 2000,* which are described in the journal's In Brief section.

It is my hope that the knowledge and insights offered by this issue will enlighten our efforts to assist youth with mental health disorders in the juvenile justice system.

John J. Wilson
Acting Administrator
Office of Juvenile Justice
and Delinquency Prevention

JUVENILE JUSTICE

Volume VII • Number 1 April 2000

FEATURES

IN BRIEF

OJJDP

810 Seventh Street NW.
Washington, DC 20531
(202) 307–5911

John J. Wilson,
Acting Administrator

Juvenile Justice (ISSN 1524–6647) is published by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to advance its mandate to disseminate information regarding juvenile delinquency and prevention programs (42 U.S.C. 5652).

The Office of Juvenile Justice and Delinquency Prevention is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance, the Bureau of Justice Statistics, the National Institute of Justice, and the Office for Victims of Crime.

Youth With Mental Health Disorders: Issues and Emerging Responses

by Joseph J. Cocozza and Kathleen R. Skowyra

Tragic mass homicides by juveniles, documented cases of neglect and inadequate services, and Federal policy initiatives focusing on providing systems of care for at-risk juveniles have propelled mental health issues among juvenile offenders into the headlines.

As the former Administrator of the Office of Juvenile Justice and Delinquency Prevention (OJJDP) has observed (Bilchik, 1998):

> It is crucial that we deal not only with the specific behavior or circumstances that bring them [youth] to our attention, but also with their underlying, often long-term mental health and substance abuse problems.

Recognition of the Mental Health Needs of Youth

The mental health needs of youth in the juvenile justice system have received more attention at the Federal level in the past 2 years than in the past three decades combined. During the past 2 years:

- The Civil Rights Division of the U.S. Department of Justice undertook a series of investigations that documented the consistent inadequacy of mental health care and services in juvenile correctional facilities in a number of States (Butterfield, 1998).
- The U.S. Department of Health and Human Services' Center for Mental Health Services initiated the first national survey of juvenile justice facilities to identify available mental health services (Center for Mental Health Services, 1998).
- Congress considered several bills and amendments that mandated comprehensive mental health and substance abuse screening and treatment programs for youth in the juvenile justice system (Manisses Communications Group, Inc., 1999).

Joseph J. Cocozza, Ph.D., is Vice President of Policy Research Associates (PRA) and Director of the National GAINS Center for People with Co-Occurring Disorders in the Justice System. Kathleen R. Skowyra is an Area Manager (Violence and Criminal Justice) for PRA. PRA offers comprehensive services for the application of social science research methods to crucial policy issues at the Federal, State, and local levels.

The importance of the mental health issue is also recognized at the State level, for example, in the response given recently by the Secretary of the Florida State Department of Juvenile Justice when asked about the most challenging issue facing juvenile corrections at the beginning of this century. His answer was not funding, sufficient beds, or security. Rather, the most challenging issue he identified was "providing specialized services such as mental health and substance abuse services within the juvenile correctional continuum" (Bankhead, 1999).

Our jails have once again become surrogate mental hospitals.

The current level of concern about the mental health needs of youth in the juvenile justice system stands in stark contrast to past neglect (Knitzer, 1982). A comprehensive review of the last several decades of research (Cocozza, 1992) concluded:

> We still know very little about the mental health needs of youth who are involved in the juvenile justice system. There are no good national studies on the number of such youth who come in contact with the juvenile justice system. Systematic information on how services are organized and delivered across the country, or on how the mental health and juvenile justice systems coordinate their efforts, does not exist. Moreover, we have no adequate information on what services are provided, their quality and whether or not they make a difference.

What has led to this dramatic change? A number of different factors are involved, including the following:

◆ **Growing recognition of the mental health needs of youth in general.** As noted by a number of authors, children's and adolescents' mental health needs have historically been addressed inadequately in policy, practice, and research (Hartman, 1997; Burns, 1999). Only recently have the number of youth with mental illness and their level of unmet need been recognized (Burns, 1999). Recent estimates place the rate of serious emotional disturbance among youth in the general population at 9 to 13 percent (Friedman et al., 1996), much higher than the 0.5- to 5-percent range previously used by State policymakers (Business Publishers, Inc., 1996).

◆ **Increasing reliance on the justice system to care for individuals with mental illness.** This trend has been clearly documented for the adult population. A report to Congress (Center for Mental Health Services, 1995:iii) found: "As jail and prison populations increased, and the number of persons with mental illness living at the fringe of their communities rose, the absolute number of persons with mental illness in jails and prisons also increased." The survey-based study *Criminalizing the Seriously Mentally Ill* (Torrey et al., 1992:iv) also concluded: "Our jails have once again become surrogate mental hospitals." Various other studies have confirmed that large proportions of individuals in the Nation's jails and prisons are seriously mentally ill. For example, Teplin (1990) reported prevalence rates of 6.4 percent for male jail inmates and 15 percent for female jail inmates. The most recent study released by the U.S. Department of Justice reported that 16 percent of State prisoners were identified as mentally ill (Ditton, 1999). Such findings buttress the view that "[j]ails and prisons have become the nation's new mental hospitals" (Butterfield, 1998a). As suggested

above, policymakers, practitioners, and advocates now recognize that the same trends and issues exist in the juvenile justice system.

◆ **Recent changes in the juvenile justice system.** The juvenile justice system has largely shifted away from treatment and rehabilitation and toward retribution and punishment as the "get tough" movement swept the Nation during the 1990's. The decade has seen more youth transferred to criminal court, longer sentences, and lower minimum ages at which juveniles can be prosecuted in the criminal justice system as if they were adults—all part of the "adultification" of juvenile justice (Altschuler, 1999). This trend toward criminalizing the juvenile justice system has raised questions about its role (Schwartz, 1999). The trend has also forced courts and the juvenile corrections system to address mental health-related issues for youth that had been previously restricted primarily to adults, such as the constitutional right to mental health treatment (Woolard et al., 1992), the applicability of the "not guilty by reason of insanity" defense (Heilbrun, Hawk, and Tate, 1996), and mental competency guidelines (Woolard, Reppucci, and Redding, 1996).

Prevalence of Mental Health Disorders Among Youth

Despite the growing concern, there is a paucity of adequate research on the prevalence and types of mental health disorders among youth in the juvenile justice system. A comprehensive review of the research literature (Otto et al., 1992) found the research to be scarce and methodologically flawed. Other reviews have reached similar conclusions (Wierson, Forehand, and Frame, 1992). Methodological problems include inconsistent definitions and measurements of mental illness; use of biased, nonrandom samples; reliance on retrospective case report data; and use of nonstandardized measurement instruments.

Despite these problems, some general conclusions can be drawn:

◆ **Youth in the juvenile justice system experience substantially higher rates of mental health disorders than youth in the general population.** This is a major conclusion drawn from a review of 34 studies (Otto et al., 1992) and is also consistent with the finding that mental illness prevalence rates in adult corrections populations are two to four times higher than the rates in the general adult population (Teplin, 1990).

There is a paucity of adequate research on mental health disorders among youth in the juvenile justice system.

◆ **A high percentage of youth in the juvenile justice system have a diagnosable mental health disorder.** One difficulty in addressing mental health issues in the juvenile justice system centers around the varying uses and definitions of the terms "mental health disorder" and "mental illness." One critical distinction is between youth with a diagnosable mental health disorder and youth with a serious mental health disorder or serious emotional disturbance (SED). Youth with a diagnosable mental health disorder are those that meet the formal criteria for any of the disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition, DSM–IV* (American Psychiatric Association, 1994) such as psychotic, learning, conduct, and substance abuse disorders. The terms "serious mental health disorder"

and "SED"—defined and measured in a number of different ways—are used to identify youth experiencing more severe conditions that substantially interfere with their functioning. The term "serious mental health disorder" often refers to specific diagnostic categories such as schizophrenia, major depression, and bipolar disorder. "SED," a term used for youth, includes those youth with a diagnosable disorder for whom the disorder has resulted in functional impairment affecting family, school, or community activities. With regard to diagnosable mental health disorders in general, research has found that most youth in the juvenile justice system qualify for at least one diagnosis. It is not uncommon for 80 percent or more of the juvenile justice population to be diagnosed with conduct disorder (Otto et al., 1992; Wierson, Forehand, and Frame, 1992; Virginia Policy Design Team, 1994). Given the broad definitional criteria for conduct disorder, Melton and Pagliocca (1992) point out that such a finding is not surprising, although many of these youth qualify for more than one diagnosis (Virginia Policy Design Team, 1994).

◆ **It is safe to estimate that at least one out of every five youth in the juvenile justice system has serious mental health problems.** Estimates of the prevalence of serious mental health disorders among these youth are particularly unreliable because of the problems with research and, as mentioned above, the varying definitions and measures of serious mental illness. If the prevalence rate of SED for youth in the general population is estimated at 9–13 percent (Friedman et al., 1996) and the prevalence rate of disorders for youth in the juvenile justice system is consistently found to be at least twice as high (Otto et al., 1992), one can reasonably expect the prevalence rate of serious mental health disorders for youth in contact with the juvenile justice system to be at least 20 percent. This estimate is consistent with the findings other researchers have reported (Schultz and Mitchell-Timmons, 1995). A more accurate estimate will require further research. It is clear, however, that while most youth in the juvenile justice system have a diagnosable mental illness and could benefit from some services, there is a sizable group of youth who critically need access to mental health services because they are experiencing serious problems that interfere with their functioning.

◆ **Many of the youth in the juvenile justice system with mental illness also have a co-occurring substance abuse disorder.** Over the past several years, there has been greater recognition and documentation of the high level of co-occurring substance abuse disorders among individuals with mental health disorders. Kessler et al. (1996) found that 50.9 percent of the general adult population with serious mental health disorders have a co-occurring substance abuse disorder, while Teplin, Abram, and McClelland (1991) found that 73 percent of adult jail detainees with serious mental health disorders had a co-occurring substance abuse disorder. Although research has just begun to focus on youth, Greenbaum, Foster-Johnson, and Petrila (1996:58) found that "approximately half of all adolescents

receiving mental health services" in the general population are reported as having a dual diagnosis. Among the juvenile justice system population, the rates may be even higher (Otto et al., 1992; Milin et al., 1991).

Emerging Strategies and Models

Given these findings, it is not surprising that juvenile justice officials regard the care of youth with serious mental health problems—and the multiple and complex issues surrounding the treatment of these youth—as among their greatest challenges. Efforts to address these problems confront numerous barriers, including the following:

- The confusion across multiservice delivery and juvenile justice systems, at both the policy and practice levels, as to who is responsible for providing service to these youth.
- Inadequate screening and assessment.
- The lack of training, staffing, and programs necessary to deliver mental health services within the juvenile justice system.
- The lack of funding and clear funding streams to support services.
- The dearth of research that adequately addresses the level and nature of mental health disorders experienced by these youth and the effectiveness of treatment models and services.

If one considers other complicating trends, such as managed care, the privatization of services, and the diagnostic and treatment issues surrounding particular populations such as youth of color (Issacs, 1992) and girls (Prescott, 1997), one quickly gets a sense of how great a challenge any change will be.

At the same time, a clear set of comprehensive strategies that appear to be critical to any progress is emerging. These strategies are consistent with many of the actions recommended by leading national experts (Whitbeck, 1992), State officials (Virginia Policy Design Team, 1994; Ohio Department of Rehabilitation and Correction, Youth Services, Mental Health, and Alcohol and Drug Addiction Services, 1995), and advocates (National Mental Health Association, 1999). They are being implemented—often in a less than ideal manner—for a limited number of youth and in only a few locations. Described below are some of these strategies and examples of supporting policies, programs, and services that are developing across the Nation as systems and communities begin to better address the needs of the growing number of youth with mental health disorders entering the juvenile justice system.

A clear set of comprehensive strategies is emerging.

Collaborating Across Systems

Cross-system collaboration must form the basis for all solutions. The field is beginning to understand that the needs and issues surrounding individuals with mental health disorders cannot be placed at the doorstep of any single agency or system (Steadman, McCarthy, and Morrissey, 1989). Systematic efforts to examine and improve the response to these youth, whether at the national (Whitbeck, 1992) or State level (Virginia Policy Design Team, 1994), reach the same conclusions. Although an individual system can help to improve the care and treatment of youth with mental illness in the juvenile justice system, effective solutions require that multiple relevant agencies coordinate and integrate strategies and services.

Collaborative efforts can include coordinated strategic planning, multiagency budget submissions, implementation of comprehensive screening and assessment centers, cross-training of staff, and team approaches to assessment and case management. Further, such efforts can be employed at varying points in the juvenile justice process—from intake through adjudication, disposition, and aftercare.

Whenever possible, youth with serious mental health disorders should be diverted from the juvenile justice system.

At the Federal level, the systems of care concept developed by the Center for Mental Health Services (CMHS) has encouraged the coordination of services for youth with SED in a number of communities across the Nation (Center for Mental Health Services, 1996). Most sites have not focused heavily on the juvenile justice population, but those that have, such as the Wraparound Milwaukee program, have observed positive results. Wraparound Milwaukee is a collaborative county-operated health maintenance organization that provides comprehensive care to youth referred from both the child welfare and juvenile justice systems and their families. The program is designed to provide community-based alternatives to residential treatment and psychiatric hospitalization (Wraparound Milwaukee, 1998; see Bruce Kamradt's article on Wraparound Milwaukee on pages 14–23). In addition, OJJDP and CMHS have collaborated for the past 2 years to increase juvenile justice system involvement in systems of care. Under this interagency agreement, OJJDP has provided funds to the CMHS technical assistance grantee to promote inclusion of youth with mental health needs involved in the juvenile justice system in other systems of care.

At the State level, there also have been attempts to foster more coordinated approaches. In Ohio, four State agencies—the Ohio Departments of Alcohol and Drug Addiction Services, Mental Health, Rehabilitation and Correction, and Youth Services—allocated funds for the Linkages Project. This project supports local efforts to improve the coordination of the criminal and juvenile justice, mental health, and substance abuse service systems to reduce incarceration and improve offender access to mental health services. One funded county, Lorain, used the funds to create the Project for Adolescent Intervention and Rehabilitation (PAIR), which targets youth placed on probation for the first time for any offense. Youth are screened and assessed for mental health and substance abuse disorders, and individual treatment plans are developed. Youth are then supervised by probation officers/case managers in conjunction with treatment providers. An evaluation of the PAIR program found that it provides an important service and coordinating function for youth, the courts, and the service systems involved (Cocozza and Stainbrook, 1998).

Diverting Youth From the Juvenile Justice System

Whenever possible, youth with serious mental health disorders should be diverted from the juvenile justice system. Given community concerns about safety, there are youth who, regardless of their mental health needs, will need to be placed in the juvenile justice system because of their serious and violent offenses. For other youth, however, their penetration into the juvenile justice system and placement into juvenile detention and correctional facilities will serve to further increase the number of mentally ill youth in the Nation's juvenile facilities who are receiving inadequate mental

health services. At the adult level, efforts to stem this tide have begun to focus on developing collaborative programs to divert individuals with serious mental illness into community-based services (Steadman, Morris, and Dennis, 1995).

Diverting appropriate youth from the juvenile justice process—whether at first contact with law enforcement officials, at intake, or at some other point prior to formal adjudication—can reduce the growing number of these youth entering the juvenile justice system and reduce the likelihood that their disorders will go untreated. Diversion to services, however, requires a multidisciplinary partnership involving the justice and treatment systems and a comprehensive range of services to which youth can be diverted.

The Persons in Need of Supervision (PINS) Diversion Program in New York is an example of how to implement such a diversion initiative. In 1985, the New York State PINS Adjustment Services Act was enacted on behalf of persons alleged to be in need of supervision in order to prevent inappropriate or unnecessary court intervention. Counties participating in the PINS Diversion Program must submit a plan containing interagency strategies for diverting youth from court and providing youth with community-based services. Upon State approval of the plan, the county is authorized to deny access to family court and to divert potential PINS and their families to assessment and adjustment services. Participating counties are required to create a multiagency Designated Assessment Service (DAS) to provide comprehensive assessments of the service needs of PINS youth and their families and to develop treatment plans based on assessment results. An interagency planning process encourages collaboration among the local and State agencies whose programs and resources target this population.

Mental Health Screening

One of the major obstacles in recognizing and treating youth with mental health disorders in the juvenile justice system is the lack of screening and assessment. All youth in contact with the juvenile justice system should be screened and, when necessary, assessed for mental health and substance abuse disorders. The screening should be brief, easily administered, and used to identify those youth who require a more comprehensive assessment to further define the type and nature of the disorder. The screening also should occur at the youth's earliest point of contact with the juvenile justice system and should be available at all stages of juvenile justice processing.

A major obstacle has been the absence of reliable, valid, and easy-to-use screening tools to help the juvenile justice system identify signs of mental illness. Grisso and Barnum (1998), however, recently developed a new tool, the Massachusetts Youth Screening Instrument (MAYSI). It is a short, easily administered inventory of questions that has been normed and tested on a number of juvenile justice populations and appears to provide a promising, standardized screen for use in juvenile justice settings (i.e., probation intake, detention, correctional facilities).

Community-Based Alternatives

Effective community-based alternatives should be used whenever possible. Over the past decade, a number of community-based approaches have been developed as alternatives to institutional care for children with serious mental health disorders, which is often more costly. These approaches are designed to keep youth in their homes, schools, and communities while providing a comprehensive set of services that respond to their mental health needs and related problems.

Standards should provide the field with meaningful guidance in providing effective mental health services.

A number of communities have implemented the systems of care initiatives noted previously and related efforts such as Wraparound services (Clark and Clarke, 1996). One approach that has demonstrated positive outcomes is Multisystemic Therapy (MST) (Henggeler, 1997; Henggeler and Borduin, 1990). Developed by Scott Henggeler and his colleagues, MST is a family- and community-based treatment model that provides services in the home and community settings and addresses a range of family, peer, school, and community factors. Research, most of which has been conducted on youth with serious antisocial behavior, has found that MST is a successful and cost-effective clinical alternative to out-of-home placements. The use of this therapy has resulted in positive outcomes in a number of dimensions, including the prevalence of recidivism, psychiatric symptomatology, and drug use (Henggeler, 1999).

Appropriate Treatment

It is critical that youth with mental health disorders who are placed in juvenile correctional facilities receive appropriate treatment. Even with greater emphasis on diversion and increased reliance on community-based alternatives, many such youth will be placed in juvenile correctional facilities because of the nature and severity of their acts. Clearly, for youth assessed as being seriously disordered, it is reasonable to expect that a mental health treatment plan will be developed and implemented by qualified, trained staff. Investigations by the U.S. Department of Justice's Civil Rights Division, as has been noted, indicate that this is not always the case.

With funding from OJJDP, the Council of Juvenile Correctional Administrators (1998) is developing and testing new performance-based standards for these youth that include treatment guidelines promulgated by a group of mental health and substance abuse experts. These standards should provide the field with meaningful guidance in providing effective mental health services.

Part of the difficulty in providing mental health services to incarcerated youth centers around larger issues concerning the relative responsibilities of the juvenile justice and treatment systems for these youth. Some jurisdictions have responded to the increasing number of youth with mental health disorders by making more secure beds available within the mental health system and transferring the more seriously disturbed youth back and forth between the two systems. Other jurisdictions have created a continuum of mental health services within the juvenile corrections system itself to address the needs of these youth (Underwood, Mullan, and Walter, 1997).

Although empirical data on the relative success of different approaches is lacking, a collaborative approach that involves both systems in planning, cross-training, and the delivery of services appears to be preferable. Such an approach builds on the strengths of each system and helps to establish connections that are critical to aftercare and community reintegration following release. In New York, for example, Mobile Mental Health Treatment Teams, supported by State juvenile justice and mental health agencies, serve youth with identified mental health needs in juvenile correctional facilities. Six regional teams provide onsite assessments, training, counseling, and other clinical services to youth in these facilities.

Conclusion

These are just some of the topics and issues that are relevant to a discussion on how to improve the field's understanding of and response to the mental health needs of youth in the juvenile justice system. There are many more that merit examination. For example, given what the field is learning about the high prevalence of co-occurring mental health and substance abuse disorders, emerging directions and strategies should emphasize approaches that rely on more integrated mental health and substance abuse treatment approaches. Although this review has dealt with youth in the juvenile justice system as a whole, research on variations in prevalence, needs, and types of treatment services must also consider issues surrounding particular populations such as minority youth and females in the juvenile justice system.

Nonetheless, several critical points emerge from the preceding review. First, a large number of youth who come in contact with the juvenile justice system require mental health treatment. Second, there is growing recognition of these needs and of the inadequacies of current assessments and services. Third, a set of clear strategies and useful models and tools are emerging. Much more is needed—funding, social and political will, and further research—but the foundation of a recognition of the problem and the development of promising practices appears to be in place as we enter the new millennium.

References

Altschuler, D.M. 1999. Trends and issues in the adultification of juvenile justice. In *Research to Results: Effective Community Corrections*, edited by P. Harris. Lanham, MD: American Correctional Association.

American Psychiatric Association. 1994. *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition, DSM–IV*. Washington, DC: American Psychiatric Association.

Bankhead, B. 1999. Q & A: Florida's Bill Bankhead. *Mobilizing Leadership in Juvenile Justice: Council of Juvenile Correctional Administrators* (Newsletter) July(19):6–7.

Bilchik, S. 1998. *Mental Health Disorders and Substance Abuse Problems Among Juveniles*. Fact Sheet #82. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Burns, B.J. 1999. A call for a mental health services research agenda for youth with serious emotional disturbance. *Mental Health Services Research* 1(1):5–20.

Business Publishers, Inc. 1996. CMHS set to release new SED prevalence estimates. *Mental Health Report* (Newsletter) (September 18):169.

Butterfield, F. 1998. Prisons replace hospitals for the nation's mentally ill. *New York Times* (March 5):A1.

Center for Mental Health Services. 1995. *Double Jeopardy: Persons with Mental Illness in the Criminal Justice System*. Rockville, MD: U.S. Department of Health and Human Services.

Center for Mental Health Services. 1996. *Systems of Care Fact Sheet*. Rockville, MD: U.S. Department of Health and Human Services.

Center for Mental Health Services. *1998. 1998 Inventory of Mental Health Services in Juvenile Justice Facilities, Halfway Houses and Group Homes.* Survey. Rockville, MD: U.S. Department of Health and Human Services.

Clark, H.B., and Clarke, R.T. 1996. Research on the wraparound process and individualized services for children with multi-system needs. *Journal of Child and Family Studies* 5(1):1–5.

Cocozza, J.J. 1992. Introduction. In *Responding to the Mental Health Needs of Youth in the Juvenile Justice System,* edited by J.J. Cocozza. Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice System, pp. 1–6.

Cocozza, J.J., and Stainbrook, K. 1998. *The Ohio Linkages Project: Final Evaluation Report.* Delmar, NY: Policy Research Associates, Inc.

Council of Juvenile Correctional Administrators. 1998. CJCA's performance-based standards project update: Implementation visits start in July. *Mobilizing Leadership in Juvenile Justice: Council of Juvenile Correctional Administrators* (July)15:8.

Ditton, P.M. 1999. *Mental Health and Treatment of Inmates and Probationers.* Special Report. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Friedman, R.M., Katz-Leavy, J.W., Manderscheid, R.W., and Sandheimer, D.L. 1996. Prevalence of serious emotional disturbances in children and adolescents. In *Mental Health, United States,* edited by R.W. Manderscheid and M.A. Sonnerschein. Washington, DC: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, pp. 71–89.

Greenbaum, P.E., Foster-Johnson, L., and Petrila, J. 1996. Co-occurring addictive and mental disorders among adolescents: Prevalence research and future directions. *American Journal of Orthopsychiatry* 66(1):52–60.

Grisso, T., and Barnum, R. 1998. *Massachusetts Youth Screening Instrument: Preliminary Manual and Technical Report.* Report. Worcester, MA: University of Massachusetts Medical School.

Hartman, L. 1997. Children are left out. *Psychiatric Services* 48(7):953–954.

Heilbrun, K., Hawk, G., and Tate, D.C. 1996. Juvenile competence to stand trial: Research issues in practice. *Law and Human Behavior* 20(5):573–578.

Henggeler, S.W. 1997. *Treating Serious Anti-Social Behavior in Youth: The MST (Multisystemic Therapy) Approach.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Henggeler, S.W. 1999. Multisystemic therapy: An overview of clinical procedures, outcomes, and policy implications. *Child Psychology & Psychiatry Review* 4(1):2–10.

Henggeler, S.W., and Borduin, C.M. 1990. *Family Therapy and Beyond: A Multisystemic Approach to Treating the Behavior Problems of Children and Adolescents.* Pacific Grove, CA: Brooks/Cole.

Isaacs, N.R. 1992. Assessing the mental health needs of children and adolescents of color in the juvenile justice system: Overcoming institutionalized perceptions and barriers. In *Responding to the Mental Health Needs of Youth in the Juvenile Justice System,* edited by J.J. Cocozza. Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice System, pp. 141–163.

Kessler, R.C., Nelson, C.B., McGonagle, K.A., Edlund, M.J., Frank, R.G., and Leaf, P.J. 1996. The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry* 66(1):17–25.

Knitzer, J. 1982. *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services.* Washington, DC: Children's Defense Fund.

Manisses Communications Group, Inc. 1999. Advocates win MH amendments to Senate juvenile crime bill. *Children's Services Report* (Newsletter) 3(10):1–2.

Melton, G.B., and Pagliocca, P.M. 1992. Treatment in the juvenile justice system: Directions for policy and practice. In *Responding to the Mental Health Needs of Youth in the Juvenile Justice System,* edited by J.J. Cocozza. Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice System, pp. 107–129.

Milin, R., Halinkas, J.A., Miller, J.E., and Morse, C. 1991. Psychopathology among substance abusing juvenile offenders. *Journal of the American Academy of Child and Adolescent Psychiatry* 30:569–574.

National Mental Health Association. 1999. *Juvenile Justice Initiative: Status Report and Call to Action.* Alexandria, VA: National Mental Health Association.

Ohio Department of Rehabilitation and Correction, Youth Services, Mental Health, and Alcohol and Drug Addiction Services. 1995. Managing mentally ill and substance abusing offenders in the community, demonstration project: A request for concept papers. State agency correspondence.

Otto, R.K., Greenstein, J.J., Johnson, M.K., and Friedman, R.M. 1992. Prevalence of mental disorders among youth in the juvenile justice system. In *Responding to the Mental Health Needs of Youth in the Juvenile Justice System,* edited by J.J. Cocozza. Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice System, pp. 7–48.

Prescott, L. 1997. *Adolescent Girls with Co-occurring Disorders in the Juvenile Justice System*. Delmar, NY: The National GAINS Center for People with Co-Occurring Disorders in the Justice System.

Schultz, C.S., and Mitchell-Timmons, J. 1995. *Prevalence of Mental Disorder in a Juvenile Justice Population*. Cleveland, OH: Case Western Reserve University School of Medicine, Department of Psychiatry.

Schwartz, I.M., ed. 1999. *The Annals of the American Academy of Political and Social Science: Will the Juvenile Court System Survive?* Thousand Oaks, CA: Sage Publications, Inc.

Steadman, H.J., McCarthy, D.W., and Morrissey, J.P. 1989. *The Mentally Ill in Jail: Planning for Essential Services*. New York, NY: The Guilford Press.

Steadman, H.J., Morris, S.M., and Dennis, D.L. 1995. The diversion of mentally ill persons from jail to community-based services: A profile of programs. *American Journal of Public Health* 85(12):1630–1635.

Teplin, L.A. 1990. The prevalence of severe mental disorder among male urban jail detainees: Comparison with the epidemiological catchment area program. *American Journal of Public Health* 80(6):663–669.

Teplin, L.A., Abram, K.M., and McClelland, G.M. 1991. *Psychiatric and Substance Abuse Disorders Among Juveniles in Detention: An Empirical Assessment*. Chicago, IL: Northwestern University Medical School.

Torrey, E.F., Stieber, J., Ezekiel, J., Wolfe, S.M., Sharfstein, J., Noble, J.H., and Flyn, L.M. 1992. *Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals*. Report to the National Alliance for the Mentally Ill and Public Citizen's Health Research Group.

Underwood, L.A., Mullan, W.C., and Walter, C.L. 1997. We built them and they came: New insights for managing Ohio's aggressive juvenile offenders with mental illness. *Corrections Management Quarterly* 1(4):19–27.

Virginia Policy Design Team. 1994. *Mental Health Needs of Youth in Virginia's Juvenile Detention Center*. Richmond, VA: Virginia Policy Design Team.

Whitbeck, J. 1992. The national work session: Issues and recommended actions. In *Responding to the Mental Health Needs of Youth in the Juvenile Justice System*, edited by J.J. Cocozza. Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice System, pp. 165–180.

Wierson, M., Forehand, R.L., and Frame, C.L. 1992. Epidemiology and the treatment of mental health problems in juvenile delinquents. *Advances in Behavior Residential Theory* 14:93–120.

Woolard, J.L., Gross, S.L., Mulvey, E.P., and Reppucci, N.D. 1992. Legal issues affecting mentally disordered youth in the juvenile justice system. In *Responding to the Mental Health Needs of Youth in the Juvenile Justice System*, edited by J.J. Cocozza. Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice System, pp. 91–95.

Woolard, J.L., Reppucci, N.D., and Redding, R.E. 1996. Theoretical and methodological issues in studying children's capacities in legal contexts. *Law and Human Behavior* 20(3):219–228.

Wraparound Milwaukee. 1998. *Annual Report*. Milwaukee, WI: Milwaukee County Mental Health Division, Child and Adolescent Services Branch.

Wraparound Milwaukee: Aiding Youth With Mental Health Needs

by Bruce Kamradt

The estimated percentage of youth with mental health disorders in the juvenile justice system varies from study to study. Estimates of diagnosable mental health disorders among the general population run about 20 percent. While there are no reliable national studies of the prevalence of mental health disorders among juvenile offenders, estimates from existing studies indicate that the rate for mental health disorders among juvenile offenders may be as high as 60 percent, of which an estimated 20 percent have severe mental health disorders (Cocozza, 1992).

Finding effective treatment models for youth in the juvenile justice system with serious emotional, mental health, and behavioral needs can be difficult. Systems tend to use more traditional residential and day treatment programs to serve these youth. The traditional categorical approach that the juvenile justice, child welfare, and mental health systems often use places youth in a "one-size-fits-all" program, regardless of the youth's needs.

Wraparound Milwaukee, now in its fifth year of operation, takes a quite different approach to serving youth with mental health needs. The program serves more than 650 youth, 400 of whom are adjudicated delinquent. Created under a Center for Mental Health Services grant, Wraparound Milwaukee sustains itself by pooling dollars with its systems partners and taking an integrated, multiservice approach to meeting the needs of youth and their families. This approach, which is based on the Wraparound philosophy and the managed care model, offers care that is tailored to each youth. Data indicate that the program is achieving positive outcomes.

Process and Approach

The Wraparound philosophy began with John Brown, a Canadian service provider who developed the idea of placing youth in small group homes with individualized care, flexible programming, and a "never

Bruce Kamradt, MSW, is Director of the Children's Mental Health Services Division for Milwaukee County, the largest public provider and purchaser of children's mental health services in Milwaukee, WI. Over the past 5 years, the division has focused on a system of care to integrate mental health, child welfare, juvenile justice, and education services for complex-needs children and their families.

give up" philosophy (Behar, 1985). Karl Dennis' Kaleidoscope program in Chicago, IL, and John Van Den Berg's Alaska Youth Initiative adapted these concepts. The Kaleidoscope program—the oldest Wraparound initiative in the United States—used unconditional care and flexible, integrated services to meet youth and family needs (Burns and Goldman, 1998). The Alaska Youth Initiative used cross-system collaboration and funding and individualized planning to bring youth back to the community from out-of-State residential treatment placements (Burchard et al., 1993). Dr. Ira Laurie, National Director of the U.S. Department of Health and Human Services' Child and Adolescent Services System Program (CASSP), further conceptualized the process. His descriptions of the values of CASSP in treating children with serious emotional problems, including the development of individualized, child-centered, family-focused, community-based, and culturally competent services, have been adopted by Wraparound (Laurie and Katy-Leavy, 1987).

The evolution of Wraparound in systems design was further enhanced by the implementation and growth of system of care models, developed under demonstration grants from the U.S. Department of Health and Human Services' Center for Mental Health Services. This grant program incorporated the values, philosophy, and approaches of Wraparound to promote integrated service systems for youth with serious emotional problems operating across the mental health, juvenile justice, child welfare, and education systems.

Although there are many components to Wraparound, the following elements have been of particular importance in working with children in the juvenile justice and child welfare systems:

Demographics of the Delinquent Population in Wraparound Milwaukee

- Eighty percent are male.
- The average age is 14.7.
- Sixty-five percent are African American, 28 percent are Caucasian, and 7 percent are Hispanic.
- Sixty-five percent are from mother-maintained households.
- Fifty-three percent of the population's families are at or below the poverty level.

◆ **Strength-based approach to children and families.** Mental health and juvenile justice systems have focused largely on identifying a child's deficits or a family's problems. This is not the most effective way to engage a child or family in the treatment process. Focusing on a family's strengths, learning about the family's culture, and building on the natural supports that exist within the family, neighborhood, or community is a much more effective approach. Examples of such supports include peer groups, recreational basketball leagues, parenting classes, and positive relationships a child may have with grandparents, uncles, aunts, peers, and others.

◆ **Family involvement in the treatment process.** Families are the most important resource in any youth's life. Juvenile justice, child welfare, and mental health practitioners often have been too quick to identify families as the source of the youth's problems. The tendency is to remove youth from the home and institutionalize them in order to "fix" them. Youth, however, usually prefer to live with their families. Whenever possible, service providers should engage families in the treatment process. Accordingly, it is important that providers view families as capable and knowledgeable about their children's needs and enhance families' abilities to parent their troubled children.

Treatment plans that are tailored to address the unique needs of each child work best.

◆ **Needs-based service planning and delivery.** If families are to be involved as active partners, it is essential to listen to their assessment of their needs. Juvenile justice, child welfare, and mental health practitioners tend to assume that as "experts" they are best equipped to decide the programs and services youth need. If, for example, a youth and family have identified a need for respite care, a tutor, or a mentor to serve as a positive role model, why do some practitioners insist on providing outpatient therapy, day treatment, or residential care? The failure to listen to what a child and family identify as their needs, and to address those needs, can cause programs and services to fail.

◆ **Individualized service plans.** Treatment plans that are tailored to address the unique needs of each child and family work best. Individualized plans for youth, particularly those involved in the juvenile justice system, must address the typical needs of persons of like age, gender, or culture. These can involve living situations; legal status; and medical, health, and psychological needs.

◆ **Outcome-focused approach.** The Wraparound process does not rely on subjective assessments of what does or does not work. Clear goals for the youth and family—established by the youth and family in partnership with the professionals—are continually measured and evaluated. The key to this approach is to manage the process to ensure desired outcomes.

Implementation

Wraparound Milwaukee adapted the Wraparound process to its system of care in some very unique ways. In Milwaukee, the multiple needs of youth who cross juvenile justice, child welfare, and mental health system lines are coordinated through a public managed care organization. Youth and families are offered enrollment in a type of social/medical health maintenance organization (HMO) with a comprehensive benefit plan that offers more than 60 services. These services are individualized for each youth and family, based on their identified needs.

History

Wraparound Milwaukee is part of the Milwaukee County Human Services Department, Milwaukee County Mental Health Division, which provides juvenile probation and child welfare services. In 1994, Milwaukee County received a 5-year Federal grant from the Center for Mental Health Services to initiate system reform in the community. Although Wraparound Milwaukee experienced initial success in providing services to youth and families in the mental health system, it was not until it targeted youth in the child welfare and juvenile justice systems that it demonstrated the effectiveness of the

Wraparound approach with youth who have multiple needs.

In May 1996, Wraparound Milwaukee initiated a pilot project, The 25 Kid Project, to use Wraparound philosophy with both delinquent and nondelinquent youth placed in residential treatment centers. Prior to this project, child welfare and juvenile justice placements had reached record proportions—more than 360 youth were in placement on an average day at a cost of more than $18 million per year. Wraparound Milwaukee targeted 25 youth in residential treatment centers, identified by child welfare and juvenile justice professionals, who had no immediate discharge plans. The goal was to demonstrate that by using a Wraparound model most of these youth could be returned home or to community-based foster or kinship care, that they could be maintained safely in those settings, and that it would cost less than a residential placement. Within 90 days, Wraparound Milwaukee returned 17 of the youth to the community. Eventually, 24 of the 25 youth were placed in the community. Seven youth entered foster homes; the remaining 17 successfully returned to their families.

Key Components

The structural and design aspects of Wraparound incorporate components of care that are integrated to meet the specific needs of each child and family. The following components are essential to the success of the project:

- **Care coordination.** Care coordinators are the cornerstone of the system. They perform strength-based assessments, assemble the Child and Family Team, conduct plan-of-care meetings, help determine needs and resources with the youth and family, assist the team in identifying services to meet those needs, arrange for community agencies to provide specific services, and monitor the implementation of the case plan. Care coordinators in the Wraparound Milwaukee Project typically work with small caseloads (a ratio of one worker to eight families), which provides more time for the personal contact needed to work with youth with complex needs.

- **The Child and Family Team.** Wraparound plans are family driven. The care coordinator asks the family to identify all those who are providing support to the family. With this information, the care

Mental Health Issues of the Population in Wraparound Milwaukee

- **Predominant diagnoses when using the *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition, DSM–IV*** (American Psychiatric Association, 1994). Ninety-seven percent conduct disorder/oppositional defiant, 58 percent depression, 44 percent attention deficit, and 42 percent serious alcohol and substance abuse problems.
- **Primary identified concerns at intake for youth.** Fifty-two percent school/community, 40 percent acting out, 37 percent alcohol and substance abuse, and 33 percent severe aggressiveness.
- **Attempted suicide.** One in eight youth.
- **Primary family concerns at intake.** Fifty percent of parents have significant abuse issues, 33 percent of parents have a history of domestic abuse, 24 percent of parents have been incarcerated, and 22 percent of families have documented mental illness.

coordinator assembles the family members; the family's natural supports such as relatives, church members, and friends; and systems people, including probation or child welfare workers. These individuals form the core of the support system for the child and family.

◆ **A mobile crisis team.** To meet the needs of youth and families when a care coordinator might not be available, 24-hour crisis intervention services are available through the Mobile Urgent Treatment Team. The team consists of psychologists and social workers trained in intervening in family crisis situations that might otherwise result in the removal of youth from their home, school, or community. Youth participating in Wraparound are automatically enrolled in this crisis service, and their care plans include a crisis safety plan that the team can immediately access. The Mobile Urgent Treatment Team reviews all requests for inpatient psychiatric hospital admissions and operates two 8-bed group homes that provide short-term (up to 14 days) crisis stabilization. The crisis team and care coordinator work with the family to return the child to the community. Because of the crisis team's availability, Wraparound Milwaukee has nearly eliminated the use of inpatient psychiatric care for most youth in the project.

◆ **A provider network.** Wraparound Milwaukee has an array of services and resources to respond to the multiple needs identified by families. This enables the program to move beyond the few categorical services historically prescribed for youth and families. As a result, Wraparound has expanded its portfolio of services from 20 to 60. Practitioners provide services on a fee-for-service basis, with Wraparound setting the price of each category of service. Rather than creating fixed-price contracts, vendors apply to provide one or more of the services as part of a provider network. The provider network now includes more than 170 agencies, a number that allows for a diverse list of providers and increases the choices families have when selecting agencies in the network from which to receive services.

Managed Care and Blended Funding

Because Wraparound Milwaukee blends system funds, it can provide a flexible and comprehensive array of services to delinquent youth and their families. Wraparound Milwaukee pools funds through case rates paid by the child welfare and juvenile justice systems, receives a monthly capitation payment for each Medicaid child enrolled, and coordinates other insurance and Supplemental Security Income payments to form a type of insurance pool. In 1999, Wraparound Milwaukee received more than $26 million in pooled funds. The child welfare and juvenile justice systems fund Wraparound at $3,300 per month per child. Prior to Wraparound, these funds were used entirely for residential treatment care for which the systems paid $5,000 or more per month per child. The $1,542 per month per child capitation payment from Medicaid covers the projected cost for all mental health and substance abuse services and is based on pre-Wraparound actuarial costs for services for these youth.

After all funds are pooled and decategorized, Wraparound Milwaukee can use them to cover any services that families need. Wraparound offers the same range of services to all enrolled families and covers any costs that exceed the pooled funds. Table 1 lists a number of the services offered in the Wraparound Milwaukee benefit plan.

Informal Services

While Wraparound Milwaukee offers an array of formal services to youth and

their families, informal services that the care coordinator and Child and Family Team identify through strengths assessment are often even more effective. The Wraparound care plan, therefore, should use a mix of formal and informal services. One family may identify a friend or relative whose positive relationship with the youth indicates suitability as a mentor. Another family may identify a relative to provide respite care to the parent. These supports will remain with the family beyond their enrollment in Wraparound Milwaukee. Other examples of informal supports are a neighbor who provides transportation, a local church with a peer support group, or a YMCA program that offers recreation and summer camp programs. These services often can be mobilized at little cost and offer the advantage of always being there for the youth and family in their own community.

Outcomes

Outcomes for youth participating in Wraparound Milwaukee have been encouraging. The use of residential treatment has decreased 60 percent since Wraparound Milwaukee was initiated (from an average daily census of 364 youth in placement to fewer than 140 youth). Inpatient psychiatric hospitalization has dropped by 80 percent; in 1998, only 322 days of care were provided. As mentioned above, the average overall cost of care per child has

Services in the Wraparound Milwaukee Benefit Plan

- Care Coordination
- In-Home Therapy
- Medication Management
- Outpatient—Individual Family Therapy
- Alcohol/Substance Abuse Counseling
- Psychiatric Assessment
- Psychological Evaluation
- Housing Assistance
- Mental Health Assessment/ Evaluation
- Mentoring
- Parent Aide
- Group Home Care
- Respite Care
- Child Care for Parent
- Tutor
- Specialized Camps
- Emergency Food Pantry
- Crisis Home Care
- Treatment Foster Care
- Residential Treatment
- Foster Care
- Day Treatment/Alternative School
- Nursing Assessment/Management
- Job Development/Placement
- Kinship Care
- Transportation Services
- Supervision/Observation in Home
- Afterschool Programming
- Recreation/Child-Oriented Activities
- Discretionary Funds/Flexible Funds
- Housekeeping/Chore Services
- Independent Living Support
- Psychiatric Inpatient Hospital

dropped from more than $5,000 per month to less than $3,300 per month. Because the savings have been reinvested into serving more youth, the project now serves 650 youth with the same fixed child welfare/juvenile justice monies that previously served 360 youth placed in residential treatment centers.

Clinical outcomes, as measured by the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 1994), have improved significantly for delinquent youth. CAFAS is used in all Children's Mental Health Services programs to measure changes in the youth's functioning at home, at school, and in the community. With CAFAS, a lower score indicates the youth is functioning more adequately. For a group of 300 delinquent youth enrolled in Wraparound Milwaukee, the average score at the time of enrollment was 74, which is considered in the high range of impairment. By 6 months after enrollment, the average score decreased to 56, in the moderate range of impairment. One year after enrollment, the average score was 48, again a moderate level of impairment.

The reduction in recidivism rates for a variety of offenses for delinquent youth enrolled in Wraparound Milwaukee has been even more encouraging. Data were collected for a period of 1 year prior to enrollment in the project and 1 year following enrollment by the county's Child and Adolescent Treatment Center. The center reviewed court records for 134 delinquent youth enrolled in Wraparound. Table 2 shows the breakdown of the proportion of children committing each type of offense.

The reduction in these reoffense patterns is statistically significant. Although more focused studies on recidivism are needed, the results to date are promising. Continued studies of these youth 2 years following enrollment are planned so the long-range effects of Wraparound can be measured.

Table 1: Recidivism Rates of Delinquent Youth Enrolled in Wraparound Milwaukee (*n*=134)

Offense	1 Year Prior to Enrollment*	1 Year Post Enrollment**
Sex offenses	11%	1%
Assaults	14	7
Weapons offenses	15	4
Property offenses	34	17
Drug offenses	6	3
Other offenses†	31	15

* Seybold, E. Child and Adolescent Treatment Center. Child and Adolescent Functional Assessment Scale and Child Behavior Checklist (Achenbach and Edelbrock, 1980) data collected and analyzed through July 1999.

** Seybold, E. Child and Adolescent Treatment Center. Data collected and analyzed as of September 1999.

† Primarily disorderly conduct not involving use of a weapon.

Wraparound Milwaukee Case Studies

Michael, a 15-year-old Hispanic, was referred to Wraparound Milwaukee as the result of delinquency charges of party to a crime and attempted arson of a school building. As a result of the charges, Michael was expelled from a Milwaukee public school, and the Probation Department was ready to recommend residential treatment.

Michael is cognitively delayed and has received special education services. At one point, he had a substance abuse problem and was diagnosed with depression.

Michael's Child and Family Team included his mother, grandmother, a mentor, a teacher, a probation worker, and an alcoholism treatment counselor. The team worked on Michael's identified academic needs. They learned that he had poor vision, which contributed to his school problems. Michael enrolled in a specialized learning center to develop his academic skills. Initial testing by the learning center revealed that Michael tested at only a first- and second-grade level in English, mathematics, and reading. After 4 months, he improved his academic performance by two grades.

Michael's mentor introduced him to recreational and other activities and became a positive role model and father figure. Michael's grandmother provided respite care to Michael's mother once a week. Informal service providers included the Council for the Spanish Speaking, which provides substance abuse counseling, and Milwaukee Christian Center and Journey House, which offers neighborhood recreation activities.

After 1 year in Wraparound, Michael has been readmitted to his Milwaukee public school as a freshman and placed in a special education program. He now tests at a fifth- and sixth-grade level in English, mathematics, and reading—an extraordinary improvement. Michael has had no further delinquencies.

Anthony, a 15-year-old African American, originally was placed in Wraparound Milwaukee because of multiple counts of criminal damage to property. He was diagnosed with attention deficit disorder and major depression. Anthony's family strengths included his parents' desire to keep him at home, the number of aunts and uncles who were interested in being resources for him in times of family stress, and his family's motivation for change. Anthony's personal strengths included his outgoing nature, affection for his siblings, desire to find a job, and love for his parents.

His Child and Family Team included his mother, stepfather, aunt, a sibling, an in-home therapist, a probation worker, a volunteer mentor, and his care coordinator. Formal services he received through Wraparound included in-home treatment, day treatment, mentoring, and job coaching. Anthony's aunt provided informal services—Anthony would stay with her during some of his crisis periods.

Anthony has been in Wraparound for 2 years. He has had no further law violations and has been an honor student in the alternative school program. He is returning to a Milwaukee public high school. He is also working with an employment agency in the provider network to obtain a part-time job.

Challenges

Wraparound Milwaukee is proving to be an effective model that can be replicated in other communities. It is important, however, to note the challenges to system collaboration that care coordinators and case managers face. Table 3 outlines these challenges and the solutions that these professionals implement when working across systems.

Wraparound's Future

The future of Wraparound Milwaukee as an effective approach to meeting the needs of youth with serious emotional, behavioral, and health issues in the juvenile justice or child welfare systems remains positive.

Milwaukee's community has adopted the model designed for early intervention services for abused and neglected children in the child welfare system.

Table 2: Challenges to System Collaboration

Challenge	Solution
Operating with different terminology (juvenile court and mental health system).	◆ Cross train. ◆ Share each other's turf.
Defining roles (Who's in charge?).	◆ Conduct team development training. ◆ Conduct job shadowing sessions. ◆ Share myths and realities.
Sharing information.	◆ Set up a common database. ◆ Share organization charts and phone lists. ◆ Share paperwork. ◆ Promote flexibility in schedules to support attendance at meetings.
Addressing issues of community safety.	◆ Document safety plans. ◆ Develop protocol for high-risk youth. ◆ Demonstrate adherence to court orders. ◆ Communicate with district attorneys and public defenders.
Keeping the stakeholders informed.	◆ Track and report outcomes. ◆ Share literature. ◆ Conduct workshops.
Sharing the value base.	◆ Reinforce Wraparound values in all meetings. ◆ Conduct strength-based cross training. ◆ Include parents in joint meetings.

This model is being considered for youth coming out of State juvenile correctional facilities.

Nationally, several States and communities have incorporated aspects of the program into their own systems of care. The Center for Mental Health Services describes Wraparound Milwaukee as a most promising practice in children's mental health.

The initial results are encouraging. Wraparound Milwaukee offers an innovative and cost-effective approach and an alternative to punitive approaches to juvenile violence and delinquency.

References

Achenbach, T.M., and Edelbrock, C. 1980. *Child Behavior Checklist*. Burlington, VT: University of Vermont, Department of Psychiatry.

American Psychiatric Association. 1994. *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition, DSM–IV*. Washington, DC: American Psychiatric Association.

Behar, L. 1985. Changing patterns of State responsibility: A case study in North Carolina. *Journal of Clinical Psychology* 14:88–195.

Burchard, J., Burchard, S., Sewell, R., and Van Den Berg, J. 1993. *One Kid at a Time: Evaluative Case Studies and Description of the Alaska Youth Initiative Demonstration Project*. Washington, DC: Georgetown University Child Development Center.

Burns, B., and Goldman, S. 1998. *Promising Practices in Wraparound for Children With Serious Emotional Disturbance and Their Families*. Vol. 4. Rockville, MD: Child and Adolescent Services Branch, Center for Mental Health Services, p. 82.

Cocozza, J.J., ed. 1992. *Responding to the Mental Health Needs of Youth in the Juvenile Justice System*. Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice System.

Hodges, K. 1994. *Child and Adolescent Functional Assessment Scale*. Ypsilanti, MI: Eastern Michigan University, Department of Psychology.

Laurie, I., and Katy-Leavy, J. 1987. In *Chronically Mentally Ill Patient*, Vol. 2, edited by L. Menneger and G. Hannah. Washington, DC: American Psychological Press.

Suicide Prevention in Juvenile Facilities

by Lindsay M. Hayes

Nelson, a 16-year-old American Indian, was committed to the Valley Youth Correctional Facility in May 1996 as a disposition for a sexual assault.[1] At an early age he had been physically abused by family members and sexually abused by neighborhood youth. Although he had never attempted suicide, Nelson had an extensive history of suicidal thoughts and tendencies. Psychiatric evaluation led to a diagnosis of conduct disorder and attention deficit hyperactivity disorder. The facility's psychiatrist saw him regularly and prescribed psychotropic medication. In October 1996, Nelson was placed on suicide watch after he had scratched his arms following an altercation with another youth. Nelson told the counselor that he often got depressed and mutilated himself after getting into trouble. Suicide precautions were discontinued several days later.

In June 1997, Nelson was placed in a quiet room for several hours after he was judged a risk to himself because he had inflicted superficial scratches on his arms and a risk to others because he threatened his peers. He later told unit staff that placement in the quiet room diminished his need to abuse himself (sometimes he would punch the walls to relieve his tension and anger). In July 1997, Nelson was again housed in a quiet room and placed on suicide precautions after threatening suicide. In December 1997, cottage staff referred him to a counselor as they were concerned about his depression and his questioning whether "life was worth living anymore." He was reportedly upset by the likelihood of being transferred to another facility because of his noncompliance with the treatment program. The situation was exacerbated by his mother's decision to stop visiting him in order to encourage his participation in treatment. The counselor believed that suicide precautions were unnecessary, and Nelson agreed to notify staff should he feel suicidal again.

On January 12, 1998, at approximately 5:30 p.m., Nelson was placed in a quiet room as a discipline for flashing gang signs in the dining room and making sexual comments about female cottage staff. Cottage staff returned Nelson—who appeared quiet and lonely to his peers—to his housing cottage at approximately 6:50 p.m. At approximately 10:30 p.m., cottage staff found Nelson in his room hanging from a

Lindsay M. Hayes, M.S., is Assistant Director of the National Center on Institutions and Alternatives. He has conducted research, provided technical assistance and training, and served as an expert witness in the area of jail, prison, and juvenile suicide for the past 20 years.

[1] To ensure confidentiality, the names of the victim and facility have been changed.

ceiling vent by a sheet. Staff initiated cardiopulmonary resuscitation and called for an ambulance. Paramedics arrived shortly thereafter, continued lifesaving measures, and transported the youth to a local hospital where he died a few days later as a result of his injuries.

Prevalence

Nelson's death is one of an undetermined number of suicides that occur each year in public and private juvenile facilities throughout the Nation. According to the Centers for Disease Control and Prevention (CDC), the suicide rate of adolescents ages 15 to 19 has quadrupled from 2.7 suicides per 100,000 in 1950 to 11 suicides per 100,000 in 1994 (Centers for Disease Control and Prevention, 1995). CDC also reported that more teenagers died of suicide during 1994 than of cancer, heart disease, acquired immune deficiency syndrome, birth defects, stroke, pneumonia and influenza, and chronic lung disease combined.

Several national studies have examined the extent and nature of suicide in jail and prison facilities (Hayes, 1989, 1995), but there has been little comparable national research regarding juvenile suicide in secure detention or confinement. The only national survey of juvenile suicides in secure custody (Flaherty, 1980) reflected a problematic calculation of suicide rates. Reanalysis of suicide rates in that study found that youth suicide in juvenile detention and correctional facilities was more than four times greater than youth suicide in the general population (Memory, 1989). Accurate data on the total scope and rate of juvenile suicide in custody are still lacking.

The U.S. Bureau of the Census has been collecting data on the number of deaths of juveniles in custody since 1989. In the first year of the survey, juvenile officials self-reported 17 suicides in public detention centers, reception and diagnostic centers, and training schools during 1988 (Krisberg et al., 1991). Fourteen such suicides were reported during 1993 (Austin et al., 1995). Given the epidemiological data regarding adolescent suicide, coupled with the increased risk factors associated with detained and confined youth, the reported number of suicides in custody appears low. The National Center for Health Statistics, however, reported that 30,903 persons committed suicide in the United States in 1996. Of these, approximately 7 percent (2,119) were youth age 19 or younger. For youth younger than age 15, suicides increased 113 percent between 1980 and 1996 (Snyder and Sickmund, 1999). Because of statistics like these, many juvenile justice experts and practitioners believe that suicides are underreported. To date, no comprehensive study of deaths in custody has been undertaken.

Suicide in juvenile detention and correctional facilities was more than four times greater than youth suicide overall.

Risk Factors

Brent (1995) identified mental health disorder and substance abuse as the most important set of risk factors for adolescent suicide. Other risk factors include impulsive aggression, parental depression and substance abuse, family discord and abuse, and poor family support. Life stressors, specifically interpersonal conflict and loss and legal and disciplinary problems, were also associated with suicidal behavior in adolescents, particularly substance abusers. Many of these risk factors are prevalent in youth confined in juvenile facilities (Alessi et al., 1984; Rohde, Seeley, and Mace, 1997).

Although there are insufficient national data regarding the incidence of youth suicide in custody, information suggests a high prevalence of suicidal behavior in juvenile correctional facilities. According to a study funded by the Office of Juvenile Justice and Delinquency Prevention, more than 11,000 juveniles engage in more than 17,000 incidents of suicidal behavior in juvenile facilities each year (Parent et al., 1994). In addition, the limited research on juvenile suicide in custody suggests that confined youth may be more vulnerable to suicidal behavior based on current or prior suicidal ideation (i.e., thoughts and/or ideas of hurting or killing oneself). For example, one study found that incarcerated youth with either major affective disorders or borderline personality disorders had a higher degree of suicidal ideation and more suicide attempts than comparable adolescents in the general population (Alessi et al., 1984).

Policies to provide close observation of suicidal residents did not appear to significantly reduce suicidal behavior.

Other studies found that a high percentage of detained youth reported a history of suicide attempts (Dembo et al., 1990) and psychiatric hospitalization (Waite, 1992) and current and active suicidal behavior (Davis et al., 1991). Two recent studies of youth confined in a juvenile detention facility found that suicidal behavior in males was associated with depression and decreased social connection, while suicidal behavior in females was associated with impulsivity and instability (Mace, Rohde, and Gnau, 1997; Rhode, Seely, and Mace, 1997). Finally, other researchers found high rates of suicidal behavior (Duclos, LeBeau, and Elias, 1994) and psychiatric disorders (Duclos et al., 1998) among American Indian youth confined in juvenile facilities.

Conditions of Confinement

In August 1994, the Office of Juvenile Justice and Delinquency Prevention published *Conditions of Confinement: Juvenile Detention and Corrections Facilities* (Parent et al., 1994). The study described in that Report investigated several conditions of confinement within juvenile facilities, including suicide prevention practices. Using four specific assessment criteria to evaluate suicide prevention practices—written procedures, intake screening, staff training, and close observation—the study found the following:

- Only 25 percent of confined juveniles were in facilities that conformed to all four suicide prevention assessment criteria.
- Facilities that conducted suicide screening at admission and trained staff in suicide prevention had fewer incidents of suicidal behavior among their residents.
- Suicidal behavior increased for youth housed in isolation.
- Written policies to provide close observation of suicidal residents did not appear to significantly reduce the rate of suicidal behavior. Because these policies are typically implemented after the risk or attempt is recognized, however, they may reduce the number of suicides.

Critical Components of a Suicide Prevention Policy

The American Correctional Association (ACA), the National Commission on Correctional Health Care (NCCHC), the National Juvenile Detention Association

(NJDA), and other national organizations have long advocated comprehensive suicide prevention programming. ACA and NCCHC have promulgated national detention and corrections standards that are adaptable to individual juvenile facilities. While the ACA standards are more widely recognized, the NCCHC standards offer more comprehensive guidance regarding suicide prevention and identify the recommended ingredients for a suicide prevention plan: identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting, review, and critical incident debriefing (National Commission on Correctional Health Care, 1999). NJDA has developed a suicide prevention curriculum that is incorporated into its detention staff basic training course. Using a combination of ACA and NCCHC standards, the author has developed a comprehensive suicide prevention plan for juvenile facilities that addresses the following key components: staff training, intake screening and ongoing assessment, communication, housing, levels of supervision, intervention, reporting, and followup/mortality review. These components form a continuum of care intended to minimize suicidal behavior within secure juvenile detention and correctional facilities.

Staff Training

The essential component of a successful suicide prevention program is properly trained staff—the backbone of any juvenile facility. Mental health, medical, or other program staff prevent few suicides because juveniles usually attempt suicides in housing units during late evening hours or on weekends, when program staff are absent. Accordingly, suicide attempts must be thwarted by direct-care staff who have been trained in suicide prevention and have developed an intuitive sense about the youth under their care.

All direct-care, medical, and mental health personnel, in addition to any staff who have regular contact with youth, should receive 8 hours of initial suicide-prevention training, followed by 2 hours of refresher training each year. The initial training should address the reasons the environments of juvenile facilities are conducive to suicidal behavior, factors that may predispose youth to suicide, high-risk suicide periods, warning signs and symptoms, components of the facility's suicide prevention policy, and liability issues associated with juvenile suicide. The 2-hour refresher training should review the predisposing risk factors, warning signs and symptoms, and any changes to the facility's suicide prevention plan and discuss any recent suicides or suicide attempts in the facility.

Intake Screening and Ongoing Assessment

Intake screening and ongoing assessment of all confined youth are critical to a juvenile facility's suicide-prevention efforts. Although youth can become suicidal at any point during their confinement, the following periods are considered times of high risk (National Commission on Correctional Health Care, 1999):

- During initial admission.
- On return to the facility from court after adjudication.
- Following receipt of bad news or after suffering any type of humiliation or rejection.
- During confinement in isolation or segregation.
- Following a prolonged stay in the facility.

Suicide prevention begins at the point of arrest.

Intake screening for suicide risk may be included in the medical screening form or on a separate form. The screening process should obtain answers to the following questions:

- Was the youth considered a medical, mental health, or suicide risk during any previous contact or confinement within this facility?
- Does the arresting or transporting officer have any information (e.g., from observed behavior, documentation from the sending agency or facility, conversation with a family member or guardian) that indicates the youth should currently be considered a medical, mental health, or suicide risk?
- Has the youth ever attempted suicide?
- Has the youth ever considered suicide?
- Has the youth ever been or is the youth currently being treated for mental health or emotional problems?
- Has the youth recently experienced a significant loss (e.g., job, relationship, death of a family member or close friend)?
- Has a family member or close friend ever attempted or committed suicide?
- Does the youth express helplessness or hopelessness and feel there is nothing to look forward to in the immediate future?
- Is the youth thinking of hurting or killing himself or herself?

To make a thorough and complete assessment, the intake process should also include procedures for referring youth to mental health or medical personnel. Following the intake process, a procedure should be in place that requires staff to take immediate action in case of an emergency. If staff hear a youth verbalize a desire or intent to commit suicide, observe a youth engaging in self-harm, or otherwise believe a youth is at risk for suicide, they should constantly observe the youth until appropriate medical, mental health, or supervisory assistance can be obtained.

Communication

Certain behavioral signs exhibited by youth may indicate suicidal behavior. Detection and communication of these signs to others can reduce the likelihood of suicide. Direct-care staff who establish trust and rapport with youth, gather pertinent information, and take action can prevent many juvenile suicides (Roush, 1996). There are three paths of communication in preventing juvenile suicides: between the arresting or transporting officer and direct-care staff; between and among facility staff (including direct care, medical, and mental health personnel); and between facility staff and the suicidal youth.

In many ways, suicide prevention begins at the point of arrest. Close observation of what youth say and how they behave during arrest, transport to the facility, and intake are crucial in detecting suicidal behavior. The scene of arrest is often the most volatile and emotional time, so arresting officers should pay

particular attention to youth during this time: The anxiety or hopelessness of the situation can provoke suicidal behavior, and onlookers such as family members, guardians, and friends can provide information on any previous suicidal behavior. The arresting or transporting officer should communicate any pertinent information regarding the well-being of the youth to direct-care staff. It is also critical for direct-care staff to maintain open lines of communication with parents or guardians, who often have pertinent information regarding the mental health status of residents.

During intake and screening, effective management of suicidal youth is based on communication between direct-care personnel and other professional staff in the facility. Because youth can become suicidal at any point during confinement, direct-care staff should be alert, share information, and make appropriate referrals to mental health and medical staff. The facility's shift supervisor should ensure that direct-care staff are properly informed of the status of each youth designated for suicide precautions and should similarly brief the incoming shift supervisor. Interdisciplinary team meetings to discuss the status of youth designated for suicide precautions should occur on a regular basis and include direct-care, medical, and mental health personnel. Finally, the authorization for suicide precautions, any changes in these precautions, and the observations made of youth designated for precautions should be documented on specific forms and distributed to appropriate staff.

Housing

When determining the most appropriate housing location for a suicidal youth, juvenile facility officials often physically isolate and restrain the individual with the concurrence of medical or mental health staff. These responses may prove detrimental to the youth. Isolation increases the sense of alienation and further removes the individual from proper staff supervision (Parent et al., 1994). Housing assignments should maximize staff interaction with the youth and avoid heightening the depersonalizing aspects of confinement. Suicidal youth should be housed in the general population, mental health unit, or medical infirmary, where the youth is close to staff. Removing a youth's clothing (with the exception of belts and shoelaces) and using physical restraints should be done only as a last resort when the youth is physically engaging in self-destructive behavior.

Rooms designated to house suicidal youth should be suicide-resistant, free of significant protrusions, and provide full visibility (including room doors with clear panels large enough to provide staff with unobstructed interior views). Finally, each housing unit in the facility should contain emergency equipment, including a first-aid kit, pocket mask or face shield, Ambu-bag, and a rescue tool that cuts through fibrous material. Direct-care staff should ensure, on a daily basis, that such equipment is in working order.

Supervision

Promptness of response to suicide attempts in juvenile facilities is often driven by the level of supervision. Medical evidence suggests that brain damage from strangulation caused by a suicide attempt can occur within 4 minutes and death can occur within 5 to 6 minutes (American Heart Association, Emergency Cardiac Care Committee and Subcommittees, 1992). Two levels of supervision are recommended for suicidal youth: close observation and constant observation. Close observation is reserved for youth who are not actively suicidal but express suicidal thoughts (e.g., expressing a wish to die without a specific threat or plan) or have a recent history of self-destructive behavior. Staff should observe such youth at staggered intervals not to exceed 15 minutes. Constant observation is reserved for youth who are actively suicidal—either threatening or engaging in suicidal behavior. Staff should observe such youth on a continuous, uninterrupted basis. Some jurisdictions use an intermediate level of supervision with observation at staggered intervals that do not exceed 5 minutes. Other aids (e.g., closed-circuit television and roommates) can be used as a supplement to, but never as a substitute for, these observation levels. Finally, mental health staff should assess and interact with—not just observe—suicidal youth on a daily basis. A careful assessment should be made of the youth's underlying mental health needs, and a plan should be developed to address those needs.

Intervention

The manner and promptness of the staff's intervention after a suicide attempt often determine whether the victim will survive. Providing competent training and establishing an effective system of communication can facilitate this intervention process. First, all staff who come into contact with youth should be trained in first-aid procedures and cardiopulmonary resuscitation (CPR). Second, any staff member who discovers a youth engaging in self-harm should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel, if necessary, and begin first aid or CPR. Third, staff should never presume that the youth is dead; rather, they should initiate and continue appropriate life-saving measures until they are relieved by arriving medical personnel. In addition, medical personnel should ensure daily that equipment used in responding to an emergency within the facility is in working order. Finally, although not all suicide attempts require emergency medical intervention, mental health staff should intervene and assess all suicide attempts.

Reporting

In the event of a suicide attempt or suicide, appropriate officials should be notified through the appropriate chain of command. Following the incident, the victim's family and appropriate outside authorities should be notified immediately. Staff who came into contact with the victim before the incident should submit a statement that details their knowledge of the youth and the incident.

Followup

A juvenile suicide is extremely stressful for staff and residents. Staff may feel ostracized by fellow personnel and administration officials; the direct-care worker may display misplaced guilt, wondering "What if I had made my room check earlier?"; and residents are often traumatized by critical events occurring within a facility. When crises occur, staff and residents should be offered immediate assistance. One form of assistance is Critical Incident Stress Debriefing

(CISD). A CISD team, comprising professionals trained in crisis intervention and traumatic stress awareness (e.g., police officers, paramedics, firefighters, clergy, and mental health personnel), provides affected staff and residents an opportunity to process their feelings about the incident, develop an understanding of critical stress symptoms, and develop ways of dealing with them (Meehan, 1997; Mitchell and Everly, 1996). For maximum effectiveness, the CISD process or other appropriate support services should occur within 24 to 72 hours of the critical incident.

Every suicide and serious suicide attempt (i.e., attempts requiring medical treatment or hospitalization) should be examined through a mortality review process. If resources permit, clinical review of suicide through a psychological autopsy—a retrospective reconstruction of the victim's life—is also recommended (Sanchez, 1999). Ideally, the mortality review should be coordinated by an outside agency to ensure impartiality and should be separate from other formal investigations that may be required to determine the cause of death. The review should include a critical inquiry of the following aspects of the case:

- Circumstances surrounding the incident.
- Facility procedures relevant to the incident.
- All relevant training received by involved staff.
- Pertinent medical and mental health services and reports involving the victim.
- Recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures.

Conclusion

"For every two youth (ages 0–19) murdered in 1996, one youth committed suicide" (Snyder and Sickmund, 1999:24). Youth suicide is recognized as a serious public health problem, but suicide within juvenile facilities has not received comparable attention, and the extent and nature of these deaths remain unknown. Collaborative efforts among child-serving agencies and technical assistance training for juvenile facility staff are just two of the components that are essential for suicide prevention within secure juvenile detention and correctional facilities. Now is the time to focus additional attention and resources on preventing suicide within these facilities.

References

Alessi, N.E., McManus, M., Brickman, A., and Grapentine, L. 1984. Suicidal behavior among serious juvenile offenders. *American Journal of Psychiatry* 141(2):286–287.

American Heart Association, Emergency Cardiac Care Committee and Subcommittees. 1992. Guidelines for cardiopulmonary resuscitation and emergency cardiac care. *Journal of the American Medical Association* 268:2172–2183.

Austin, J., Krisberg, B., DeComo, R., Rydenstine, S., and Del Rosario, D. 1995. *Juveniles Taken Into Custody: Fiscal Year 1993*. Report. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Brent, D.A. 1995. Risk factors for adolescent suicide and suicidal behavior: Mental and substance abuse disorders, family environmental factors, and life stress. *Suicide and Life-Threatening Behavior* 25 (Supplement):52–63.

Centers for Disease Control and Prevention. 1995. Suicide among children, adolescents and young adults—United States, 1980–1992. *Morbidity and Mortality Weekly Review* 44:289–291.

Davis, D.L., Bean, G.L., Schumacher, J.E., and Stringer, T.L. 1991. Prevalence of emotional disorders in a juvenile justice institutional population. *American Journal of Forensic Psychology* 9:1–13.

Dembo, R., Williams, L., Wish, E.D., Berry, E., Getreu, A.M., Washburn, M., and Schmeidler, J. 1990. Examination of the relationships among drug use, emotional/psychological problems, and crime among youths entering a juvenile detention center. *The International Journal of the Addictions* 25:1301–1340.

Duclos, C.W., Beals, J., Novins, D.K., Martin, C., Jewett, C.S., and Manson, S.M. 1998. Prevalence of common psychiatric disorders among American Indian adolescent detainees. *Journal of the American Academy of Child and Adolescent Psychiatry* 37(8):866–873.

Duclos, C.W., LeBeau, W., and Elias, G. 1994. American Indian suicidal behavior in detention environments: Cause for continued basic and applied research. *Jail Suicide Update* 5(4):4–9.

Flaherty, M. 1980. *An Assessment of the National Incidence of Juvenile Suicides in Adult Jails, Lockups, and Juvenile Detention Centers*. Champaign, IL: Community Research Forum.

Hayes, L.M. 1989. National study of jail suicides: Seven years later. *Psychiatric Quarterly* 60(1):7–29.

Hayes, L.M. 1994. Juvenile suicide in confinement: An overview and summary of one system's approach. *Juvenile and Family Court Journal* 45(2):65–75.

Hayes, L.M. 1995. Prison suicide: An overview and a guide to prevention. *The Prison Journal* 75(4):431–455.

Krisberg, B., DeComo, R., Herrera, N.C., Steketee, M., and Roberts, S. 1991. *Juveniles Taken Into Custody: Fiscal Year 1990 Report*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Mace, D., Rohde, P., and Gnau, V. 1997. Psychological patterns of depression and suicidal behavior of adolescents in a juvenile detention facility. *Journal of Juvenile Justice and Detention Services* 12(1):18–23.

Meehan, B. 1997. Critical incident stress debriefing within the jail environment. *Jail Suicide/Mental Health Update* 7(1):1–5.

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

Mitchell, J.T., and Everly, G.S. 1996. *Critical Incident Stress Debriefing: An Operations Manual for the Prevention of Traumatic Stress Among Emergency Services and Disaster Workers*, 2d ed. Ellicott City, MD: Chevron Publishing.

National Commission on Correctional Health Care. 1999. *Standards for Health Services in Juvenile Detention and Confinement Facilities*. Chicago, IL: National Commission on Correctional Health Care.

Parent, D.G., Leiter, V., Kennedy, S., Livens, L., Wentworth, D., and Wilcox, S. 1994. *Conditions of Confinement: Juvenile Detention and Corrections Facilities*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Rohde, P., Seeley, J.R., and Mace, D.E. 1997. Correlates of suicidal behavior in a juvenile detention population. *Suicide and Life-Threatening Behavior* 27(2):164–175.

Roush, D.W. 1996. *Desktop Guide to Good Juvenile Detention Practice*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Sanchez, H.G. 1999. Inmate suicide and the psychological autopsy process. *Jail Suicide/Mental Health Update* 8(3):3–9.

Snyder, H.N., and Sickmund, M. 1999. *Juvenile Offenders and Victims: 1999 National Report*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Waite, D. 1992. Unpublished data. Richmond, VA: Virginia Department of Youth and Family Services.

OJJDP-Supported Mental Health Initiatives and Programs

The following OJJDP-supported initiatives and programs target youth with mental health disorders in the juvenile justice system.

Assessing Alcohol, Drug, and Mental Health Disorders Among Juvenile Detainees

This program, implemented by Northwestern University, supplements an ongoing National Institute of Mental Health longitudinal study assessing alcohol, drug, and mental health disorders among juveniles in detention in Cook County, IL. The program, which OJJDP began funding in FY 1998, has three goals:

- To determine how alcohol, drug, and mental disorders among juvenile detainees develop over time.
- To investigate whether juvenile detainees receive needed psychiatric services after their cases reach disposition and they are back in the community or serving sentences.
- To study how risk behaviors associated with violence, drug use, and HIV/AIDS develop over time, what the antecedents of these behaviors are, and how these behaviors are interrelated.

This project is unique because of its large sample size. It includes 1,833 youth from Chicago, IL, who were arrested and then interviewed between 1996 and 1998. The sample is stratified by gender, race (African American, non-Hispanic white, Hispanic), and age (10–13, 14–17). Investigators have completed initial interviews and have collected extensive archival data (e.g., arrest and incarceration history, health and/or mental health treatments) on each subject. They have been tracking the whereabouts of subjects and are beginning to reinterview these adolescents. The large sample size provides sufficient statistical power to study rare disorders, patterns of drug use, and risky, life-threatening behaviors.

Center for Students With Disabilities in the Juvenile Justice System

In FY 1999, OJJDP undertook a joint initiative with the U.S. Department of Education's Office of Special Education and Rehabilitative Services to establish the Center for Students With Disabilities in the Juvenile Justice System. The Attorney General and the Secretary of Education expect this project to significantly enhance juvenile justice system services for students with disabilities. Based on a combination of research, training, and technical assistance, these enhancements in prevention, educational services, and reintegration will improve results for children and youth with disabilities. The Center, implemented by the University of Maryland, provides guidance and assistance—based on research-validated practices—to States, schools, justice programs, families, and communities to design, implement, and evaluate comprehensive educational programs for students with disabilities who are within the juvenile justice system.

Circles of Care Program

In FY 1998, the Center for Mental Health Services (CMHS) initiated the Circles of Care Program to build the capacity of selected American Indian tribes to plan and develop a continuum of care for American Indian youth at risk of mental health, substance abuse, and delinquency problems. As part of multiyear joint efforts with CMHS, OJJDP entered into a 3-year interagency agreement to support the program, and in FY 1998 and FY 1999, OJJDP transferred funds to CMHS to support one of nine selected tribal sites.

Communities In Schools, Inc.—Federal Interagency Partnership

This program continues an ongoing national school dropout prevention model developed and implemented by Communities In Schools, Inc.

(CIS). CIS provides training and technical assistance in adapting and implementing the CIS model in States and local communities. The dropout prevention model brings social, employment, mental health, drug prevention, entrepreneurial, and other resources to high-risk youth and their families in the school setting. During the Federal Interagency Partnership, CIS State organizations assume primary responsibility for local program replication. The partnership is based on enhancing the following:

- CIS's training and technical assistance capabilities.
- CIS's capability to introduce selected initiatives for youth at the local level.
- CIS's information dissemination capability.
- CIS's capability to network with Federal agencies on behalf of State and local CIS programs.

With OJJDP's support, CIS focuses on family strengthening initiatives that benefit both youth and their families.

Comprehensive Children and Families Mental Health Training and Technical Assistance

Under an FY 1999 3-year interagency agreement, OJJDP transferred funds to the Center for Mental Health Services (CMHS) to support training and technical assistance for the CMHS-funded Comprehensive Mental Health sites. These funds will enhance the involvement of the juvenile justice system in the systems of care being developed in each of the CMHS-funded sites.

Multisite, Multimodal Treatment Study of Children With Attention Deficit/ Hyperactivity Disorder

In 1992, the National Institute of Mental Health (NIMH) began a study of the long-term efficacy of stimulant medication and intensive behavioral and educational treatment for children with attention

Juvenile Suicide in Confinement: A National Survey

The Office of Juvenile Justice and Delinquency Prevention recently awarded the National Center on Institutions and Alternatives (NCIA) a contract to conduct a national survey on the prevalence of juvenile suicide in confinement.

The project—initiated in August 1999 and supported by the National Juvenile Detention Association and Council of Juvenile Correctional Administrators—will for the first time determine the extent and distribution of suicides in approximately 3,400 public and private juvenile detention centers, training schools, reception/diagnostic centers, ranches, camps, and farms throughout the Nation.

Answers to the survey questions will allow NCIA staff to gather descriptive data on demographic characteristics of suicide victims, characteristics of the incidents, and characteristics of the facilities in which the suicides occurred. A report of the findings will be available as a resource tool for both juvenile justice practitioners in expanding their knowledge base and juvenile correctional administrators in creating and/or revising policies and training curriculums on suicide prevention.

All juvenile facilities in which a suicide occurred during the 5-year period of 1995–99 are strongly encouraged to participate in the study. Data provided will be coded and held in the strictest confidence. Results of the study will be presented in summary fashion; therefore, victim and facility names will not appear in any report.

For more information on the Juvenile Suicide in Confinement Project, contact:

Lindsay M. Hayes, Project Director
National Center on Institutions and Alternatives
40 Lantern Lane
Mansfield, MA 02048

508–337–8806
508–337–3083 (fax)
E-mail: lhayesta@aol.com

deficit/hyperactivity disorder (ADHD). Under an interagency agreement with NIMH, OJJDP has transferred funds to support this research, funded principally by NIMH. The study will continue through 2000, following the families with ADHD children identified in 1992 and a comparison group. OJJDP's participation, which began in FY 1998, allows investigators to study the subjects' delinquent behavior and any contact with the legal system, including arrests and court referrals.

Strengthening Services for Chemically Involved Children, Youth, and Families

This program, jointly supported by the U.S. Departments of Justice and Health and Human Services (HHS), provides services to children affected by parental substance use or abuse. OJJDP administers this training and technical assistance program, which began in FY 1998, with funds transferred to OJJDP by HHS's Substance Abuse and Mental Health Services Administration, through a cooperative agreement with the Child Welfare League of America (CWLA), a nonprofit organization. CWLA, which implements the program, has identified five residential child welfare sites, one in each of the CWLA's five regions, to demonstrate the effectiveness of integrating AOD prevention/treatment strategies into existing child welfare and juvenile justice programs and services. The goals of this integration of strategies are to educate staff and to improve outcomes for adolescents participating in the programs. CWLA also provides technical assistance to other member agencies replicating the various program models identified through their evaluations of the programs.

For Further Information

Additional sources of information on programs for children with disabilities and their parents are provided below:

Center for Effective Collaboration and Practice
American Institutes for Research
1000 Thomas Jefferson Street NW.
Suite 400
Washington, DC 20007
800–457–1551
202–944–5454 (fax)
E-mail: center@dc.air.org
Internet: www.air.org/cecp

Austin Child Guidance Center
810 West 45th Street
Austin, TX 78751
512–451–2242
512–454–9204 (fax)
E-mail:
staff@austinchildguidance.org
Internet:
www.austinchildguidance.org

Federation of Families for Children's Mental Health
1021 Prince Street
Alexandria, VA 22314
703–684–7710
703–836–1040 (fax)
E-mail: ffcmh@ffcmh.org
Internet: www.ffcmh.org

National Mental Health Association
Office of Prevention and Children's Mental Health Services
Juvenile Justice and Mental Health
1021 Prince Street
Alexandria, VA 22314–2971
800–969–6642
703–684–7722
703–684–5968 (fax)
E-mail: childinfo@nmha.org
Internet: www.nmha.org

Northwestern Human Services
620 Germantown Pike
Lafayette Hill, PA 19444
610–260–4600
Internet: www.nhsonline.org

Youth & Family Centered Services
1705 Capital of Texas Highway South
Suite 500
Austin, TX 78746
512–327–1119
512–327–4576 (fax)
E-mail: info.yfcs@yfcs.com
Internet: www.yfcs.com

IN BRIEF

Treating Serious Anti-Social Behavior in Youth: The MST Approach

Traditional mental health approaches for serious, violent, and chronic juvenile offenders have all too often failed to yield successful results. Adolescent drug and substance abuse is remarkably resistant to treatment.

The Multisystemic Therapy (MST) approach to the treatment of serious antisocial behavior in adolescents represents a significant departure from more traditional strategies. MST is a home-based services approach developed in response to the lack of scientifically proven, cost-effective treatment options for this population.

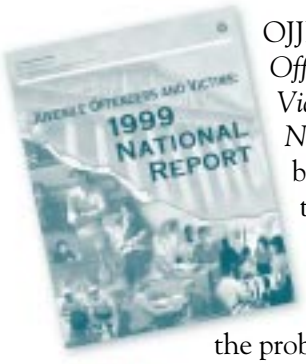
Treating Serious Anti-Social Behavior in Youth: The MST Approach, an OJJDP Bulletin released in May 1997, provides an overview of the MST approach and features evaluations of programs that have implemented it. The Bulletin is available online at www.ojjdp.ncjrs.org/pubs/delinq.html or can be ordered from OJJDP's Juvenile Justice Clearinghouse (see the order form).

Mental Health Disorders and Substance Abuse Problems Among Juveniles

An OJJDP Fact Sheet released in July 1998, *Mental Health Disorders and Substance Abuse Problems Among Juveniles,* describes steps that OJJDP is taking with government and private organizations to address specific behavior or circumstances that bring juveniles into the justice system and discusses the underlying, often long-term mental health and substance abuse problems of youth in the juvenile justice system.

The OJJDP steps described in this Fact Sheet include supporting research and data collection that provide a clearer picture of the incidence and prevalence of mental health and substance abuse disorders among juveniles, assessing juveniles when they first come in contact with the system, increasing the number of high-quality treatment programs in the community and in juvenile institutions, and focusing on juveniles who are at risk for delinquency rather than those already in the juvenile justice system. This Fact Sheet is available online at www.ojjdp.ncjrs.org/pubs/fact.html or can be ordered from OJJDP's Juvenile Justice Clearinghouse (see the order form).

Juvenile Offenders and Victims: 1999 National Report



OJJDP's *Juvenile Offenders and Victims: 1999 National Report* brings together the most recent statistics on a variety of topics related to the problems of juvenile crime, violence, and victimization. Readers will find extensive baseline information on juvenile population characteristics; patterns of offending and victimization; and the structure, procedures, and activities of the juvenile justice system. The information is presented in numerous tables, graphs, and maps, accompanied by analyses written in clear, nontechnical language.

The *National Report* covers several topics of particular interest to readers concerned with mental health issues:

- **Drug abuse:** juvenile arrests for drug abuse offenses, patterns of deviant behavior (including marijuana use) among youth ages 12–16, illicit drug use among high school seniors, and societal costs of juvenile drug abuse.
- **Child abuse and neglect:** incidence and characteristics, including data on psychological and emotional abuse.
- **Suicide:** long-range trends in youth suicide, and data by age group, race, and sex.
- **Violence:** extensive data on incidence and characteristics of juvenile arrests for violent crimes and patterns of violent behavior among youth.

This Report is available online at www.ojjdp.ncjrs.org/pubs/violvict.html or can be ordered in hard copy or CD–ROM format from OJJDP's Juvenile Justice Clearinghouse (see the order form).

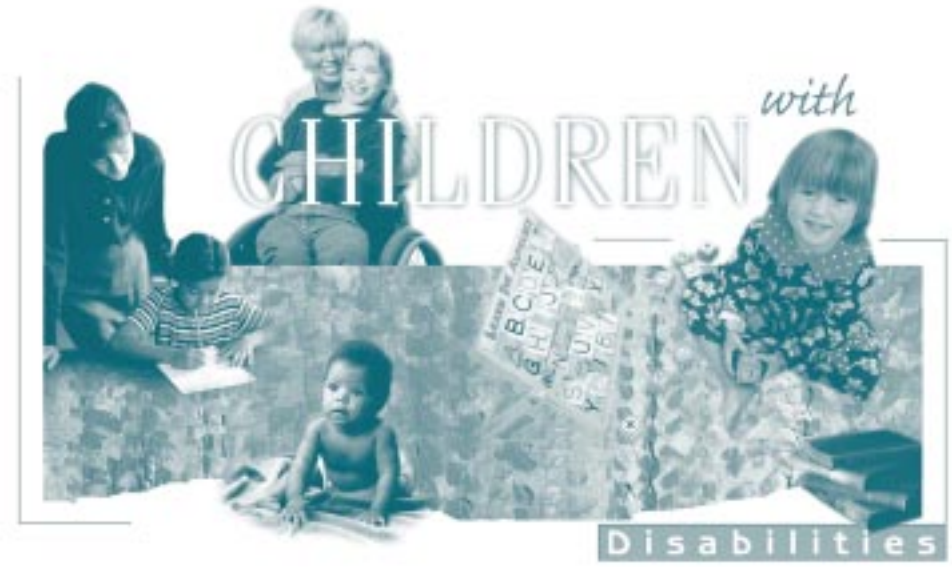
Call for Materials

The mental health needs of youth is a vastly growing topic of interest to professionals and researchers in the juvenile justice system. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) wants to assist you and your colleagues in learning about this topic via publications and other information resources. OJJDP's Juvenile Justice Clearinghouse and the National Criminal Justice Reference Service (NCJRS) offer an extensive library collection covering all aspects of criminal and juvenile justice and drug policy. Contribute to the NCJRS library and abstracts database (www.ncjrs.org/database.htm) by sending material related to mental health and youth. Contributions should be a minimum of four pages in length and must have been published within the past 5 years. Materials will be reviewed to determine eligibility, and they cannot be returned. Send materials or information to:

National Criminal Justice
Reference Service
c/o Patricia Cronin, Collection Development
2277 Research Boulevard, MS 2A
Rockville, MD 20850

A Network for Sharing

Children With Disabilities: An Online Guide to Resources for Parents and Children



Visit the Web site at: www.childrenwithdisabilities.ncjrs.org.

The new Web site includes the following sections:

- **Federal Resources.** Learn about Federal agencies and their funded and supported initiatives, information, and resources.
- **State/Local Resources.** Discover information about agencies, organizations, and programs in your area by State, Territory, or federally recognized tribe.
- **National Resources.** Access national organizations and associations that offer programs, information, and other resources.
- **Calendar of Events.** Visit the calendar for upcoming disability-related conferences and community events.
- **Grants & Funding.** Explore funding, grant, and other opportunities for Federal or private financial assistance.
- **Research & Statistics.** Secure the most up-to-date research and statistics along with a keyword list and tips for searching using the Children With Disabilities search engine.
- **Youth to Youth.** Share experiences, stories, and ideas with other children and participate in games, activities, and a moderated online bulletin board.
- **Highlights.** Find out about the latest news and most recent additions to the Web site.

JUVENILE JUSTICE

Juvenile Justice Order Form

Volume VII • Number I April 2000

PUBLICATIONS AVAILABLE FREE.

Single copies are available free. There is a nominal fee for bulk orders to cover postage and handling. Contact the Clearinghouse for specific information.

- ❑ *America's Children: Key National Indicators of Well-Being, 1999* (Report). NCJ 171150.
- ❑ *Causes and Correlates of Delinquency Program* (Fact Sheet). FS 99100.
- ❑ *Families and Schools Together: Building Relationships* (Bulletin). NCJ 173423.
- ❑ **NEW** *Juvenile Offenders and Victims: 1999 National Report* (Report). NCJ 178257.
- ❑ **NEW** *Juvenile Arrests 1998* (Bulletin). NCJ 179064.
- ❑ *Mental Health Disorders and Substance Abuse Problems Among Juveniles* (Fact Sheet). FS 9882.
- ❑ *Relationship Between Mental Health and Substance Abuse Among Adolescents*. NCJ 177685.
- ❑ **NEW** *Reporting Crimes Against Juveniles* (Bulletin). NCJ 178887.
- ❑ *Treating Serious Anti-Social Behavior in Youth: The MST (Multisystemic Therapy) Approach* (Bulletin). NCJ 165151.
- ❑ **NEW** *Violence After School* (Bulletin). NCJ 178992.

PUBLICATIONS AVAILABLE FOR A FEE.

- ❑ *Online Safety for Children: A Primer for Parents and Teachers* (Video, VHS format). NCJ 178996. $17 (U.S.), $21 (Canada and other countries).

To order other publications listed on the inside back cover, please complete the following:

Qty.	NCJ No.	Title	Price
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____

International Subscribers Airmail Postage Schedule

All documents ordered by Canadian and other international users are sent airmail. **Postage is included in the cost of fee items but must be paid separately for free items. Use the schedule below to compute the postage cost for your free items.**

No. of free items	Canada	Other countries
1–2	$ 6.30	$ 5.75
3–4	6.85	11.50
5–6	7.40	17.25
7–8	7.95	23.00
9–10	8.50	28.75
11–12	9.05	34.50
13–14	9.60	40.25
15–16	10.20	46.00
17–18	10.80	51.75
19–20	11.30	57.50

For more than 20 items, write JJC, P.O. Box 6000, Rockville, MD 20849–6000, or call 301–519–5500.

Total $ _____

Enclose payment or provide account number.

All payments must be in U.S. dollars and drawn on a U.S. bank.

- ❑ Check or money order enclosed, payable to Juvenile Justice Clearinghouse.
- ❑ Deduct the total from my NCJRS Deposit Account.

Acct. No. _____

Charge my ❑ MasterCard ❑ VISA

Card No. _____

Exp. Date _____

Signature _____

Allow 6 to 9 weeks for delivery. You will be notified by mail within 30 days if your paid order cannot be filled.

Fee orders are shipped UPS. Because UPS cannot deliver to post office boxes, please provide a street address for shipment of orders requiring payment.

Please print your name and mailing address or affix your mailing label here.

Name _____

Address _____

City _____ State _____ ZIP _____

Phone ( ) _____

❑ Check this box if the information on your address label is incorrect and make corrections on your mailing label.

JUVENILE JUSTICE

FOLD, TAPE, BUT DO NOT STAPLE

_____

_____

_____

PLACE FIRST CLASS STAMP HERE

Juvenile Justice
Juvenile Justice Clearinghouse
P.O. Box 6000
Rockville, MD 20849–6000

Publications From OJJDP

OJJDP produces a variety of publications—Fact Sheets, Bulletins, Summaries, Reports, and the *Juvenile Justice* journal—along with videotapes, including broadcasts from the juvenile justice telecommunications initiative. Through OJJDP's Juvenile Justice Clearinghouse (JJC), these publications and other resources are as close as your phone, fax, computer, or mailbox.

Phone:

800–638–8736
(Monday–Friday, 8:30 a.m.–7 p.m. ET)

Fax:

301–519–5600

Online:

OJJDP Home Page:

www.ojjdp.ncjrs.org

E-Mail:

puborder@ncjrs.org (to order materials)
askncjrs@ncjrs.org (to ask questions about materials)

Mail:

Juvenile Justice Clearinghouse/NCJRS
P.O. Box 6000, Rockville, MD 20849–6000

Fact Sheets and Bulletins are also available through fax on demand.

Fax on Demand:

800–638–8736, select option 1, select option 2, and listen for instructions.

To ensure timely notice of new publications, subscribe to JUVJUST, OJJDP's electronic mailing list.

JUVJUST Mailing List:

e-mail to listproc@ncjrs.org
leave the subject line blank
type *subscribe juvjust your name*

In addition, JJC, through the National Criminal Justice Reference Service (NCJRS), is the repository for tens of thousands of criminal and juvenile justice publications and resources from around the world. They are abstracted and placed in a database, which is searchable online (www.ncjrs.org/database.htm). You are also welcome to submit materials to JJC for inclusion in the database.

The following list highlights popular and recently published OJJDP documents and videotapes, grouped by topical areas.

The OJJDP Publications List (BC000115) offers a complete list of OJJDP publications and is also available online.

In addition, the OJJDP Fact Sheet Flier (LT000333) offers a complete list of OJJDP Fact Sheets and is available online.

OJJDP also sponsors a teleconference initiative, and a flier (LT116) offers a complete list of videos available from these broadcasts.

Corrections and Detention

Beyond the Walls: Improving Conditions of Confinement for Youth in Custody. 1998, NCJ 164727 (116 pp.).

Disproportionate Minority Confinement: 1997 Update. 1998, NCJ 170606 (12 pp.).

Disproportionate Minority Confinement: Lessons Learned From Five States. 1998, NCJ 173420 (12 pp.).

Juvenile Arrests 1997. 1999, NCJ 173938 (12 pp.).

Reintegration, Supervised Release, and Intensive Aftercare. 1999, NCJ 175715 (24 pp.).

Courts

Guide for Implementing the Balanced and Restorative Justice Model. 1998. NCJ 167887 (112 pp.).

Innovative Approaches to Juvenile Indigent Defense. 1998, NCJ 171151 (8 pp.).

Juvenile Court Statistics 1996. 1999, NCJ 168963 (113 pp.).

Offenders in Juvenile Court, 1996. 1999, NCJ 175719 (12 pp.).

RESTTA National Directory of Restitution and Community Service Programs. 1998, NCJ 166365 (500 pp.), $33.50.

Trying Juveniles as Adults in Criminal Court: An Analysis of State Transfer Provisions. 1998, NCJ 172836 (112 pp.).

Youth Courts: A National Movement Teleconference (Video). 1998, NCJ 171149 (120 min.), $17.

Delinquency Prevention

1998 Report to Congress: Juvenile Mentoring Program (JUMP). 1999, NCJ 173424 (65 pp.).

1998 Report to Congress: Title V Incentive Grants for Local Delinquency Prevention Programs. 1999, NCJ 176342 (58 pp.).

Combating Violence and Delinquency: The National Juvenile Justice Action Plan (Report). 1996, NCJ 157106 (200 pp.).

Combating Violence and Delinquency: The National Juvenile Justice Action Plan (Summary). 1996, NCJ 157105 (36 pp.).

Effective Family Strengthening Interventions. 1998, NCJ 171121 (16 pp.).

Juvenile Accountability Incentive Block Grants Strategic Planning Guide. 1999, NCJ 172846 (62 pp.).

Parents Anonymous: Strengthening America's Families. 1999, NCJ 171120 (12 pp.).

Prenatal and Early Childhood Nurse Home Visitation. 1998, NCJ 172875 (8 pp.).

Treatment Foster Care. 1999, NCJ 173421 (12 pp.).

Gangs

1996 National Youth Gang Survey. 1999, NCJ 173964 (96 pp.).

Gang Members on the Move. 1998, NCJ 171153 (12 pp.).

Youth Gangs: An Overview. 1998, NCJ 167249 (20 pp.).

The Youth Gangs, Drugs, and Violence Connection. 1999, NCJ 171152 (12 pp.).

Youth Gangs in America Teleconference (Video). 1997, NCJ 164937 (120 min.), $17.

General Juvenile Justice

Comprehensive Juvenile Justice in State Legislatures Teleconference (Video). 1998, NCJ 169593 (120 min.), $17.

Guidelines for the Screening of Persons Working With Children, the Elderly, and Individuals With Disabilities in Need of Support. 1998, NCJ 167248 (52 pp.).

Juvenile Justice, Volume V, Number 1. 1998, NCJ 170025 (32 pp.).

A Juvenile Justice System for the 21st Century. 1998, NCJ 169726 (8 pp.).

Juvenile Offenders and Victims: 1999 National Report. 1999, NCJ 178257 (232 pp.).

OJJDP Research: Making a Difference for Juveniles. 1999, NCJ 177602 (52 pp.).

Promising Strategies To Reduce Gun Violence. 1999, NCJ 173950 (253 pp.).

Sharing Information: A Guide to the Family Educational Rights and Privacy Act and Participation in Juvenile Justice Programs. 1997, NCJ 163705 (52 pp.).

Missing and Exploited Children

Portable Guides to Investigating Child Abuse (13-title series).

Protecting Children Online Teleconference (Video). 1998, NCJ 170023 (120 min.), $17.

When Your Child Is Missing: A Family Survival Guide. 1998, NCJ 170022 (96 pp.).

Substance Abuse

The Coach's Playbook Against Drugs. 1998, NCJ 173393 (20 pp.).

Drug Identification and Testing in the Juvenile Justice System. 1998, NCJ 167889 (92 pp.).

Preparing for the Drug Free Years. 1999, NCJ 173408 (12 pp.).

Violence and Victimization

Combating Fear and Restoring Safety in Schools. 1998, NCJ 167888 (16 pp.).

Guide for Implementing the Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders. 1995, NCJ 153681 (255 pp.).

Report to Congress on Juvenile Violence Research. 1999, NCJ 176976 (44 pp.)

Serious and Violent Juvenile Offenders. 1998, NCJ 170027 (8 pp.).

Serious and Violent Juvenile Offenders: Risk Factors and Successful Interventions Teleconference (Video). 1998, NCJ 171286 (120 min.), $17.

State Legislative Responses to Violent Juvenile Crime: 1996–97 Update. 1998, NCJ 172835 (16 pp.).

White House Conference on School Safety: Causes and Prevention of Youth Violence Teleconference (Video). 1998, NCJ 173399 (240 min.), $17.

Youth in Action

Community Cleanup. 1999, NCJ 171690 (6 pp.).

Cross-Age Teaching. 1999, NCJ 171688 (8 pp.).

Make a Friend—Be a Peer Mentor. 1999, NCJ 171691 (8 pp.).

Plan a Special Event. 1999, NCJ 171689 (8 pp.).

Planning a Successful Crime Prevention Project. 1998, NCJ 170024 (28 pp.).

Stand Up and Start a School Crime Watch. 1998, NCJ 171123 (8 pp.)

Two Generations—Partners in Prevention. 1999, NCJ 171687 (8 pp.).

Wipe Out Vandalism and Graffiti. 1998, NCJ 171122 (8 pp.).

Youth Preventing Drug Abuse. 1998, NCJ 171124 (8 pp.).

An Online Guide

The Children With Disabilities online guide is a new initiative by the Coordinating Council on Juvenile Justice and Delinquency Prevention to make available a wide array of Federal, State, local, and national resources to children with disabilities and their parents. Visit the Children With Disabilities Web site at ***www.childrenwithdisabilities.ncjrs.org***, and join the network for sharing.

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Washington, DC 20531

Official Business
Penalty for Private Use $300

PRESORTED STANDARD
POSTAGE & FEES PAID
DOJ/OJJDP
PERMIT NO. G–91

NCJ 178256