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Availability of Treatment to Youth Offenders: Comparison of Public versus Private Programs from a National Census

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A B S T R A C T

Across the United States, the availability of mental health, substance abuse, and recidivism reduction programs in the juvenile justice system (JJS) varies from none or few to a rich variety of programs. Within the last decade, prison privatization in the adult correctional system has influenced the onset of privatization in the JJS. The differences between public and private sectors in their availability of mental health services and treatment programs to juvenile offenders are understudied. In this article, a secondary analysis of a national census of 3163 juvenile facilities was conducted to determine differences in treatment availability as well as the impact of treatment accessibility on the event of a suicide. Results indicate private facilities more likely to offer treatment services and schedule mental health personnel more frequently. Those facilities reporting family counseling treatment programs were less likely to have reported a suicide event. Policy implications and a review of progress towards improvement in the JJS are presented.

Keywords:

Juvenile justice
Mental health
Suicide
Private facilities
Public facilities

1. Introduction

The juvenile justice literature suggests that a high proportion of incarcerated youth have mental health diagnoses (Boesky, 2001). As many as sixty-five to seventy percent of youth in the JJS have a diagnosable mental health disorder (Shufelt & Coccozza, 2006; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, Ko, & McReynolds, 2004). Existing studies of prevalence rates amidst youth in custody reveal percent ranges between the fifties and low seventies. What is also known is these estimates are higher than those rates of youth with diagnosed mental health disorders in the general population (Holt, 2001). Among those youth found to have a diagnosable mental health disorder, “approximately twenty percent of youth meet criteria for a severe mental health disorder (meeting criteria for severity or have experienced a hospitalization for a mental health disorder)” (Coccozza & Skowrya, 2000). Often, these youth are detained or placed in the JJS for minor offenses due to lack of community options available to them (Skowrya & Coccozza, 2006). Those youth placed in the JJS may be assigned to a variety of facilities. The types of facilities included in this discussion are those that typically house juvenile offenders, either public or private and are included in the Office of Juvenile Justice and Delinquency Prevention’s (OJJDP) annual Children in Custody Census. Facility types in the census include detention centers, training schools/long-term facilities,

residential treatment centers, diagnostic/assessment centers, ranches, shelters and halfway homes.

1.1. Definitions

Gallagher and Dobrin (2007) provide the definitions that are useful in interpreting classification of programs. Detention centers are facilities that are similar to adult jail in that they provide short-term custody for youth offenders and tend to be the first facility juveniles come in contact with when entering the system. Training schools are similar to adult prison in level of security and are intended to hold adjudicated juveniles who are in state custody for lengthy periods. Residential treatment centers are long term facilities that provide specific treatment services to adjudicated youth, like substance abuse or mental health treatment.

Diagnostic/assessment centers are facilities that classify and diagnose delinquent youth and assign them to longer term placements. Ranches are shorter stay facilities with concentrated programming for adjudicated youth. Shelters are alternatives to detention for youth involved in minor charges, many of whom are involved in child welfare and foster care systems. Finally, halfway houses are classified as community based living arrangements in homes or facilities, most often providing transition into the community.

1.2. Mental health disorders in juvenile justice

In most cases, juveniles are considered youth under the age eighteen. In a few states, “juvenile” may extend into young adulthood when jurisdiction terminates. Common diagnoses among youth

offenders include mood disorders (depression and bipolar disorder); anxiety disorders (panic, generalized anxiety and post-traumatic stress disorder); and behavior disorders (conduct disorder and attention deficit/hyperactivity disorder) (Boesky, 2001; Shelton, 2010; Bonham, 2006; Teplin et al., 2002). High proportions of youth offenders experiencing mental health disorders affect the system's ability to provide proper assessment, treatment, and a therapeutic environment. With the emergence of "get tough" policies, many juvenile justice systems are supporting a movement to more punishment and control rather than treatment (Ashford, Sales, & Reid, 2001).

The establishment of the OJJDP in 1974 propelled changes in juvenile justice policy to address juvenile delinquency such as use of boot camps and other nontraditional institution based alternatives like diversion. In the mid 1990s, following many years of change the concept of resiliency prompted the discussion of risk and protective factors among adolescent offenders and "knowledge of risk and protective factors found its way into mainstream juvenile justice policy" in regards to juvenile (Barton, 2006, p. 52). These initial changes included modifying the ways juvenile offenders were handled in state courts. States made more attempts at balancing offender accountability, rehabilitation, and community protection. The implementation of resiliency theory in assessment of mental health risk and protective factors was a significant contribution to policy formulated by OJJDP. Specifically, policy makers were focused on addressing the juvenile justice system's unsuccessful attempts to identify the mental health needs of youth offenders and to provide treatment for them (Herz, 2001).

In 1998, the Council of Juvenile Correctional Administrators (Cocozza & Skowrya, 2000) implemented performance-based standards to assess facilities' services to youth with mental health needs. These standards were developed by a panel of substance abuse and mental health treatment experts. Current mental health intervention and treatment standards are typically achieved through appropriate screening, assessment, and treatment practices. However, there is an ongoing debate over what interventions jurisdictions can implement to meet youth needs. Some states have increased the number of secure beds offered by the mental health system for more severely disturbed youth to move back and forth between the mental health and juvenile justice systems (Cocozza & Skowrya, 2000). More often than not, youth who have committed serious crimes will stay in confined settings rather than move to community mental health placements. This creates a challenge for the juvenile justice system to meet the needs of these youth. Rogers, Zima, Powell, and Pumariega (2001) found in their study of a single correctional facility that detained youth may continue to have unmet needs for mental health treatment after identification. The authors attribute this to the very low proportion of juvenile justice facilities offering comprehensive mental health services.

1.3. Suicide in juvenile justice

In addition to the influx of youth placed in juvenile correctional facilities with mental health disorders, suicide among this population has been of national concern. Suicide is an outcome often resulting from untreated mood disorders and it is an important administrative concern in juvenile correctional management (Hayes, 2004). Hayes argues that confined youth are at heightened risk for suicide "because they have life histories that predispose them to suicide (e.g., mental disorders and substance abuse, physical, sexual and emotional abuse, and, perhaps most importantly, current and prior self-injurious behavior," (2004, p. 3). Re-examination of a previous national survey on the incidence of juvenile suicides in custody revealed that youth suicide in juvenile detention centers was more than four times higher in juvenile detention centers than for juveniles in the community (Memory, 1989). Re-examination of the 1980 Flaherty study was

needed due to errors in suicide calculation rates (Memory, 1989). Hayes conducted a national survey to examine suicide of youth in confinement and found that among the 110 youth suicides identified in the study, approximately 42% occurred in training school/secure facilities, 37% in detention centers, 15% in residential treatment centers, and 6% in reception/diagnostic centers. Over 40% of the suicides occurred in facilities administered by state agencies, while 39.2% took place in county facilities and 12.7% in private programs, (Hayes, 2004, p. ix).

Much of the Hayes study explored assessment practices and policy reviews. Limited attention was paid to the availability of mental health services, specifically, frequency of service availability to youth residing in facility care. Evaluating the presence of important supplemental treatment programs available to youth such as individual and family counseling, sex offender treatment and drug and alcohol treatment was outside the scope of Hayes' study. Further inquiry is needed to determine the presence of facility-based mental health services and how often they are offered to youth, as services may affect the incidence of suicide.

1.4. Public and private management of juvenile justice facilities

After the passage of the Juvenile Justice and Delinquency Prevention Act in 1974 and the establishment of the OJJDP, many communities and local governments were supportive of establishments that could serve as alternatives to incarceration (Bayer & Pozen, 2005). To offer a mechanism for the establishment of these alternatives, many private companies emerged to support community mental health systems of care in the early 1990s. Systems of care for children and adolescents were based on by the philosophy that adolescents should receive appropriate care in the least restrictive setting (Stroul & Freidman, 1986). Stroul and Freidman also asserted that the JJS plays a critical role in serving juvenile offenders with serious emotional disorders. Bayer and Pozen (2005) found "in 1999, there were approximately 1100 public and 1800 private juvenile correctional facilities in operation nationwide," (p. 2). More than half of the states had contracts with non-profit private companies and another half of the states had at least one contract with a for-profit company to manage their correctional facilities. With the competition of private management, questions have been raised about which is most effective in keeping the costs of custody down as well as which sector is more effective at reducing recidivism.

Very few investigations address whether public or private facilities are more effective in offering mental health and treatment services to youth offenders. Results from a study of the differences in environmental quality between public and private correctional facilities concluded "private correctional facilities neither add to nor detract from the level of environmental quality provided comparable to public sector facilities," (Armstrong & MacKenzie, 2003, p. 558). With this finding, Armstrong also advocated for continued research into the comparison of types of treatment programs offered by private facilities. In another study conducted by Blakely and Bumphus (2004), more private sector offenders participated in drug and alcohol treatment than public sector offenders. In one of the first comprehensive studies to explore effectiveness of public and private juvenile correction facilities, Bayer and Pozen (2005) found that for-profit management was less successful with reducing recidivism.

As previously mentioned, the presentation of youth identified as having a mental health disorder in the JJS creates unique challenges. Coupled with the finding that private facilities provide comparable environmental quality to that of public facilities, further examination of mental health and supplemental treatment programs may be needed. More information is needed on a national scale that provides information on the availability of mental health personnel in facilities. Identifying differences between sectors in specific treatment type (suicide specific, psychological treatment, family counseling, etc) is

necessary to systematically improve comprehensive mental health care to juvenile offenders. Still unanswered is the question, are there current differences between public and private facilities in the treatment programs and mental health personnel available to youth in custody?

1.5. Research questions

This secondary data analysis will explore the availability of mental health personnel accessible to youth and treatment programs. It will offer a descriptive analysis of treatment and facility characteristics and test if public and private facilities differ on these characteristics. It will explore whether or not availability of various types of treatment impact the occurrence of a suicide. The following research questions will be tested: What are the characteristics of juvenile, detention, and shelter facilities? What is the availability of treatment programs for youth in custody? How often are mental health personnel available to youth in custody? Are there differences in how often mental health personnel are available to youth in custody within facilities in public and private sectors? Are there differences between private and public sectors in the types of treatment programs available to youth in custody? Which types of facilities were likely to have reported a suicide event?

2. Methods

2.1. Dataset

This study is a secondary data analysis of the 1992–1993 Census of Public and Private Juvenile Detention, Correctional, and Shelter Facilities (U.S. Department of Justice. Office of Juvenile Justice Delinquency Prevention, 2007). The data used in this study were made available by the Inter-university Consortium for Political and Social Research (ICPSR). Data from the 1992–1993 Census was made accessible to the public in 2007.

2.2. Design and sampling

All juvenile justice facilities in operation in the United States on February 16, 1993 were contacted to participate in the 1992–1993 Census. The Census Bureau collected data by sending questionnaires designed for either public or private facilities to each state's responsible juvenile corrections authority. Private facilities were located by contacting local juvenile court and state correctional departments and identifying which private facilities were utilized for placement of juvenile offenders. Thirty facilities refused to answer the questionnaire, leaving 1037 public facilities and 2096 private facilities in the sample (U.S. Department of Justice. Office of Juvenile Justice Delinquency Prevention, 2007).

2.3. Measurement

Constructs such as type of facility, population, offense type, personnel, educational, treatment, and medical programs were examined in the survey. For example, an item from the survey measuring treatment programs is: "Please indicate whether the service is being provided for juveniles in your facility." Services listed included counseling programs: psychological/psychiatric counseling; family counseling; employment counseling; health and nutrition; AIDS prevention; other and specialized treatment programs for: juvenile sex offenders; violent juvenile offenders; juveniles with drug/alcohol dependency; suicide risks; juvenile arsonists; other. Respondents were asked to answer "yes" or "no" indicating program/service availability. An example of an item measuring number of juvenile deaths is: "How many juveniles died while under the jurisdiction of this facility between January 1, 1992 and December

31, 1992?" A list of categories including cause of deaths as illness/natural causes; acquired immune deficiency syndrome (AIDS); suicide; homicide by other residents(s); homicide (other); and other deaths – specify was given to respondents and were asked to state the numerical value for each category. Data collected on some variables were limited to a time specific measurement. Population data were collected by asking, "What was the juvenile residential population at the facility on the one day, February 15, 1993?" Respondents were asked to answer population values for both males and females. Therefore, some data represent one day versus an entire calendar year.

2.4. Analysis

The independent variables included sector (public or private) and dependent variables included facility characteristics (population and length of stay), treatment program types, mental health personnel availability, and incidence of suicide or suicides. Select independent and dependent variables were re-coded into categorical variables. Chi-square tests and odds ratios were used to determine the association of categorical variables. T tests and standardized mean difference effect sizes (Cohen's *d*) were used to determine differences between public and private sectors for treatment staff and average length of stay variables.

3. Results

3.1. Facility characteristics

Among the 3163 facilities included in the study, 1037 (33%) were public and 2096 (67%) were private. Forty-one percent held male residents, 16% held females, and 43% held both males and females. State facilities represented 15% of the sample and county facilities represented 14%. Multi-governmental arrangement facilities only accounted for 2% of the sample and similarly, only 1% of the facilities identified as being from one municipality. Among facility types, 55% of the facilities were classified as halfway homes or group homes. Detention centers and shelters made up 15% and 12% respectively of the sample. Training schools accounted for 9% of the sample and the smallest percentages of facilities were reported as ranches/camps or farms (6%) and reception centers (1%). The mean juvenile population was 31.8 youth ($SD = 70.4$) and the average daily population across all facilities was 31.1 youth ($SD = 68.9$). The average length of stay in facilities among the total juvenile population was 6.83 months ($SD = 7.0$).

Overall, the average number of treatment staff was 7.3 ($SD = 24.9$). Treatment staff includes all staff reported as full-time, part-time, on payroll, and community volunteers who provided professional treatment services to youth. The most frequent reason for custody (72%; $n = 2269$) among facilities in the study was commitment status (placement for treatment). The second largest reason for custody (29%; $n = 917$) was detention (pending adjudication, commitment, or placement), followed by voluntary status. Voluntary status includes juveniles who admitted themselves or were referred to facilities without being adjudicated for an offense (28%; $n = 873$). Probation as a reason for custody was reported in 20% ($n = 638$) of the facilities in the study with diagnosis and/or classification reasons reported in only 14% ($n = 425$) of the facilities. Those reporting reason for custody as "other" included 5% ($n = 152$) of the sample.

In regards to the public vs. private split, public facilities had higher numbers of treatment staff ($M = 12$, $SD = 38.9$) than private facilities ($M = 5$, $SD = 12.9$), Cohen's $d = .24$, $t(3131) = 6.87$, $p = .000$. Youth held in public facilities had shorter lengths of stay ($M = 3$ months, $SD = 4$ months) than private facilities ($M = 8$ months, $SD = 7.4$ months), Cohen's $d = .84$, $t(3131) = -23.33$, $p = .000$. Public facilities held more juveniles ($M = 58$, $SD = 104.6$) than private facilities ($M = 19$, $SD = 38.6$),

Cohen's $d = .49$, $t(3131) = 15.32$, $p = .000$. Public facilities also had higher daily population averages ($M = 56$, $SD = 102.7$) than private facilities ($M = 19$, $SD = 37.6$ months), Cohen's $d = .48$, $t(3131) = 15.06$, $p = .000$.

3.2. Mental health personnel and treatment program characteristics

Table 1 displays mental health personnel and treatment programs available to youth by sector. Chi-square analysis was done to determine differential program availability between public and private facilities. Effect sizes were reported as odds ratios. Public versus private facilities differed on 8 out of 10 variables. Significant results included the finding that public facilities were 2.2 times more likely to offer mental health personnel only on an on-call basis. They were 1.2 times less likely to offer daily mental health personnel to youth in custody and 1.4 times less likely to have mental health personnel available on a less than daily basis. In respect to treatment programs offered to youth in custody, public facilities were almost twice as likely ($OR = 1.8$) to offer drug and alcohol and specific violent offense treatment to youth. Suicide treatment programs were more likely to be offered in public facilities ($OR = 1.3$). In regards to psychological treatment programs, public facilities were 1.3 times less likely to have these programs. Public facilities were 3.6 times less likely to offer family counseling to youth in their care.

3.3. Suicide outcomes

Among all facilities included in this analysis, thirteen facilities reported a suicide, of which nine were public and four were private. A chi-square test revealed significant differences between sectors, $X^2(2, n = 3133) = 7.70$, $p < .05$. Further analysis was conducted using variables of interest to determine if the presence of types of counseling and public sector type were predictors of facilities reporting a suicide. Odds ratios for incident of suicide given different types of facility characteristics are displayed in Table 2. The suicide rate for public facilities is 15 per 100,000 and the suicide rate for private facilities is 10 per 100,000. Specifically, training schools were 6.1 times more likely to report suicide, halfway houses were 4.2 times more likely to report a suicide and overall public facilities were 4.6 times more likely to report a suicide. Those facilities offering family counseling were 4 times less likely to have a suicide event during the survey year. Among public facilities, those reporting one county administration type were 3.7 times more likely to state a suicide occurred during the year of the survey. There was a higher rate of missing values for private facilities on the suicide variable. A follow-up logistic regression was conducted with suicide as a dependent variable and public/private facility size as independent variables. Public/private remained significant, controlling for facility size.

Table 1
Mental health personnel and treatment programs available to youth, public vs. private comparison.

	All facilities (n = 3163)	Public (n = 1037)	Private (n = 2196)	X^2	Odds ratios	CI _{95%}
<i>Mental health personnel</i>						
Daily	935 (30%)	27%	31%	3.50*	.85	.73–1.01
Less than daily	691 (22%)	18%	24%	15.21***	.69	.57–.83
On-call	503 (16%)	23%	12%	63.75***	2.2	1.79–2.64
Never	963 (31%)	32%	30%	.86	1.1	.92–1.27
<i>Treatment programs</i>						
Psychological	2575 (82%)	78%	82%	8.66**	.76	.63–.91
Family counseling	2422 (77%)	60%	85%	228.59***	.28	.23–.33
Sex offense	939 (30%)	29%	30%	.667	.93	.79–1.1
Violent offense	671 (21%)	28%	18%	47.02***	1.8	1.54–2.19
Drug and alcohol	1549 (50%)	59%	44%	64.70***	1.8	1.59–2.15
Suicide treatment specific	1211 (39%)	43%	36%	13.97***	1.3	1.15–1.55

Note: * $P < .10$; ** $P < .05$; *** $P < .01$. Each category of interest compared to all others. Private facilities serve as reference point.

Table 2
Cross tabulations for incident of suicide among different facility characteristics.

Facility characteristic	Suicide (N = 13)	No suicide	X^2	Odds ratios	CI _{95%}
Public	9	1028	7.70**	4.6	1.41–14.9
Private	4	2092			
One county	5	447	6.11**	3.7	1.22–11.48
All others	8	2673			
Training school	5	290	12.91***	6.1	1.98–18.77
All others	8	2830			
Offered family counseling	6	2416	7.22***	.25	.08–.75
Did not offer family counseling	7	704			

Note: $P < .05$; $P < .01$. Variables tested included sector type, facility type, administration type, and treatment programs. Reference category is no reported suicide.

4. Discussion

The purpose of this study was to explore the availability of mental health personnel and treatment programs accessible to youth in both public and private sectors. When examining the characteristics of juvenile, detention, and shelter facilities, the majorities of juvenile facilities held both males and females and were private facilities classified as halfway homes or group homes. Commitment status was the most common reason for custody among facilities. Investigating treatment programs available to youth in custody reveals public facilities offering violent offense, drug and alcohol, and suicide treatment programs to a greater extent than private facilities. Private facilities offered more psychological counseling, family counseling, and sex offense treatment programs. Private facilities also had mental health personnel available to youth with greater frequency, but had fewer treatment staff. Within the differences found between the public and private sectors, opportunities for improvement exist. Public facilities would benefit from consulting with private administrators to understand the value of offering family counseling and its possible effects on youth offenders' treatment success. Not only are there opportunities for enhancing treatment programs, it appears that those facilities that offer family counseling are also less likely to experience a suicide. Public facilities should consult with private counterparts in assessing the costs and benefits of instituting such family programs in closed custody settings. Given the dynamics and financial costs of providing substantive treatment efforts, public facilities would benefit from collaborating with their counterparts.

Between the public and private sectors, differences exist in both areas of mental health personnel and treatment programs. Finally, identifying which types of facilities were likely to have reported a suicide shows these facilities were mostly public, administered by one county and most likely to be training schools. Those facilities reporting family counseling as a treatment program available to youth were less likely to have reported a suicide.

Differences between sectors in availability of mental health personnel were expected due to the assumption that private sectors may have more financial resources to employ more staff. However, the finding that public facilities employed more treatment staff but had less frequent mental health personnel available to youth was surprising. This may be due to allocation of treatment staff and the various roles that were included in the treatment staff variable. For example, case managers are included as treatment staff but may not be able to serve in the capacity of a mental health provider. Even more intriguing is the finding that facilities offering family counseling to youth were less likely to have reported a suicide. This could be due to facility availability of treatment services for families and youth aimed at decreasing risk for suicide. Services aimed at resolving trauma from physical and sexual abuse while providing support for mental health and substance abuse disorders may have influenced this finding.

4.1. Progress since the 1992–1993 census

A definite need exists for further studies to examine progress since this 1992–1993 survey. [Gallagher and Dobrin \(2007\)](#) discuss a continued challenge of the JJS with the variability of care among facilities. They argue that care (i.e. health services including mental health) should not be tied to variations between facilities and should be a priority of detention centers and those in the JJS. They found that very few juvenile detention centers were meeting minimum standards of care prescribed by the Commission on Correctional Health Care. In examining progress specific to mental health services and treatment programs, the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) conducted a survey using the 1997 Survey of Correctional Facilities, which included over 7000 adult and juvenile correctional facilities to identify those facilities that offered treatment to their inmates or residents. Among the 1143 juvenile facilities, 92% offered individual counseling, 91% offered group counseling, and 72% offered family counseling (2000, p. 34). This shows evidence of some progress towards more facilities offering counseling and treatment. Additional studies, examining similar variables and research questions outlined in this manuscript would aid in contributing to the available literature.

Based on the available research, promising practices exist for treating youth with mental health issues in the JJS. For example, Cognitive Behavioral Treatment is a useful modality to use with incarcerated youth in reducing anti-social behavior ([Gacono, Nieberding, Owen, Rubel, & Bodholdt, 2001](#)). Approaches like Aggression Replacement Training (ART) have been found to be valuable in promoting prosocial skills among aggressive and assaultive youth ([Glick & Goldstein, 1987](#)). Additionally, multisystemic therapy (MST) has been determined to be a successful family based intervention used with youth in the JJS to enhance family cohesion and to reduce arrests ([Gacono et al., 2001](#)). [Gacono, Nieberding, Owen, Rubel, and Bodholdt](#) identified MST after conducting an extensive literature search for family based interventions targeting behavioral and psychological symptoms of conduct disorder among youth.

Facility administrators should invest in family based approaches as they have been observed to be a promising practice. MST along with mental health treatment and after care is essential to treatment planning of youth experiencing severe and persistent mental illness. However, additional rigorous research is needed to demonstrate efficacy of these interventions. In 2000, the OJJDP began their largest investigation in mental health research aimed at providing a framework for those in the JJS working to meet the needs of youth with mental health disorders. That framework suggested continued and enhanced research, securing scientifically sound mental health screening assessments, greater advocacy efforts, and continued work on collecting prevalence rates ([Cocozza & Skowryra, 2000](#)). These efforts outlined in the framework are still being carried out by the JJS.

4.2. Limitations

Limitations of this study include the low occurrence of the outcome variable suicide and the limits of statistical power to conduct a multivariate analysis. As stated earlier, this study included a number of facility refusals to answer question items. The results on suicide outcomes should be interpreted with caution. It is possible facilities did not report suicide deaths. Since data were collected as a “snapshot” of facility description and not an overall representation of an entire calendar year, caution is needed when interpreting facility characteristics. The possibility that facilities could answer some questions during later periods is a possibility and limits the interpretations. Other facility characteristics like costs and quality of treatment programs is limited in the available data. Finally, the age of the census is a limitation in identifying policy implications. With these limitations, the findings suggest many areas that should be addressed with additional research and a re-evaluation of the variables examined in this study.

4.3. Policy implications

Implications for policy include the need to develop organizational goals and priorities which reflect the mental health needs of youth in custody. Reducing recidivism is a goal of the JJS, but the need for enhanced and supported goals to address the mental health needs of youth offenders is warranted. With changes in policy reflecting evidence based interventions, JJS policy should also reflect those organizational changes needed to sustain such effective practices. For example, in Oregon and Washington, state legislatures have enacted measures to ensure publicly funded institutions and programs are offering “effective” interventions and services ([Senate Bill 267 Summary, 2005](#); O.R.S. 182.525). Funding is conditional upon the program’s ability to adhere to legislation requirements. Juvenile corrections administrators across the nation should be prepared to offer comprehensive mental health services to youth beyond identification and screening. Perhaps accreditation through the Commission on Correctional Health Care should be required for all juvenile facilities housing a substantial number of youth with diagnosed mental health disorders. Furthermore, standards of care should outline expectations for frequency of mental health personnel availability. There are many implications for mental health service providers in juvenile justice settings. Service delivery and monitoring mechanisms should be a priority of the juvenile justice mental health provider. Without the continued monitoring of services, youth offenders’ mental health symptoms may go untreated and create long term difficulties for youth as they return to the community. Not only will youth become frustrated but the JJS will be a “revolving door” for those youth needing extensive services.

4.4. Conclusion

Additional research is needed to explore if policy and practice have progressed since the time of this census and to find out if the prevalence of mental illness among juvenile offenders has changed over time, given improvements in the JJS. There is a need for subsequent research to enhance the effectiveness of community-based mental health interventions in more restrictive settings. Research on effectiveness, plausibility, and allocation of mental health funding and resources will help advance this agenda. The unanswered question investigating continuing differences between public and private facilities among treatment programs and mental health personnel availability to youth in custody is one that should be addressed in future research to assess progress made in quality and effectiveness of mental health services offered to youth.

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