Youth in the Juvenile Justice System And Their Mental Health Needs

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Youth in Juvenile Hall are often at a critical crisis point. By the time a youth reaches Juvenile Hall, they have often been metaphorically "screaming for help" for a very long time. In other words, it may be that no one is paying attention to the family's challenges and dysfunctions, the youth's trauma or emotional pain or serious learning disability. Often the youth enters Juvenile Hall without even knowing that they have been "trying to get attention" because their problems are long past the healthy time of grieving, are overwhelming, and no longer recognizable as a problem, but are experienced as ***a way of life.***

Mental Health Descriptions **Behavior That May Be of Concern to Mental Health**	**Juvenile Justice Descriptions**

Eyes
▪ Avoids eye contact—with authority, with peers
▪ Looks away or down only when spoken to
▪ Looks everywhere but where it seems appropriate
▪ Rolls eyes—with authority, with peers
▪ Eye movement from side to side—slow or rapid
  ▪ Appears to be thinking
  ▪ Appears to be distracted
  ▪ Appears to be responding to internal thoughts/stimulus
▪ Stares—at someone, non directional, into space, catatonic
▪ Frequent or constant scanning, darting eyes
	▪ Defiant
	▪ Disrespects authority
	▪ Threatens authority
	▪ Oppositional behavior
	▪ Non-compliant
	▪ Refusal to engage
	▪ Doesn't pay attention or listen to directives

Verbal ▪ Talking—constantly ▪ Mute ▪ Swearing—only at peers, only at authority ▪ Laughter—inappropriate to content ▪ Smirks/gaffs—only with peers, only with authority ▪ Interrupts—frequently but within context, frequently outside of context ▪ Volume—too low, high/shouting ▪ Intensity—too low for context, high-enraged, enraged inappropriate to context ▪ Speech—pressured, rapid, slurred ▪ Slow speech appears to have difficulty—explaining thoughts, organizing thoughts ▪ Incoherent ▪ Words are chopped and disjointed—Tangential/circumstantial, not due to ESL ▪ Stutters—when stressed, inconsistently, only episodically	▪ Aggressive ▪ Defiant ▪ Threatens authority ▪ Disrespectful ▪ Preys on Others ▪ Oppositional behavior ▪ Poor judgment ▪ Refusal to engage ▪ Self-Defeating behaviors ▪ Threatens authority

Mental Health Descriptions Behavior That May Be of Concern to Mental Health	Juvenile Justice Descriptions
Oral ▪ Spitting—to the side, at someone, when someone speaks ▪ Teeth—gritting as if trying to hold back anger, grinds teeth ▪ Chewing—own nails, small items (pencils/pens, straws, paper wads) ▪ Bites others ▪ Putting large items in mouth—holds there, sucks on ▪ Eating none edible items ▪ Drools—not when eating or drinking ▪ Breathing—heavy, slow, rapid—in what context ▪ Mouth sounds—clicking, clearing throat, sounds with throat, ticks	▪ Assaultive ▪ Defiant ▪ Disrespectful ▪ Oppositional behavior ▪ Non compliant ▪ Poor judgment ▪ Refusal to engage ▪ Engages in risky behavior—Joy riding, drugs ▪ Self-Defeating behaviors
Physical ▪ Personal Space ▪ Stands in others' personal space even when asked not to ▪ Doesn't allow anyone to come too close ▪ Throwing small objects—at someone, with no obvious point of direction ▪ Throwing large objects—at someone, across room ▪ Hits/Punches with closed fist—self, others ▪ Hits/slaps open handed—self, others ▪ Gestures—in context when angry, out of context ▪ Flexing muscles ▪ Postures at others	▪ Aggressive ▪ Assaultive ▪ Defiant ▪ Disrespectful ▪ "Lost it" ▪ Threatens authority ▪ Fighting ▪ Oppositional behavior ▪ Non compliant
Self Presentation ▪ General overall presentation: ▪ Sad, depressed ▪ Flat, expressionless, empty ▪ Angry, aggressive, red faced ▪ Affect out of context, fake smile constantly ▪ Hyper vigilance, scanning ▪ Poor hygiene ▪ Slumped—in chair, standing ▪ Arched back—in social settings, with authority, with parents/caregiver ▪ Facing others—away from conversation, away from peers, away from authority, away from activity, away from parents/caregiver ▪ Fists clenched—when angry, in context, out of context, frequently ▪ Hands up as if to keep space between self and others ▪ Fists up as if to protect ▪ Pacing, stomping, caged ▪ Constant wiggling, fidgeting	▪ Lack of motivation ▪ Non compliant ▪ Refusal to engage ▪ Aggressive ▪ Assaultive ▪ Defiant ▪ Disrespectful ▪ Threatens authority ▪ Fighting ▪ Delinquent ▪ Prowls ▪ Preys on Others ▪ Threatens Authority ▪ Oppositional behavior ▪ Disrespect for those in authority ▪ Poor judgment ▪ Hyper

Mental Health Descriptions **Behavior That May Be of Concern to Mental Health**	**Juvenile Justice Descriptions**

Commonly Known Behaviors of Concern
▪ Self Harm, suicide attempts
▪ Scratching ***self***
  ▪ To point of breaking skin
  ▪ Drawing blood
  ▪ Gouge—a little, deep
  ▪ Hair—grabs own hair, pulls to the point of bald spots, grabs other's hair
▪ Hallucinations—Visual, auditory, tactile
▪ Obsessions—thoughts
▪ Compulsion—behaviors
▪ Collects items—no obvious grouping, specific groups of items
▪ Hoarding
▪ Single focused/fixation/perseveration
  ▪ Out of context
  ▪ Specific topics
  ▪ Specific items
  ▪ Specific people groups or 1 individual
	▪ On suicide watch and line of sight or frequent checks
	▪ Anxiety
	▪ Depression
	▪ OCD
	▪ ADHD
	▪ PTSD
	▪ Psychotic
	▪ Odd behaviors
	▪ Confusing
	▪ Knows there's something wrong, but not sure what it is

Sexual ▪ Masturbation—in public, in private ▪ Genital Exposure ▪ Sexual promiscuity ▪ Sexualized presentation—stance, motions/behaviors, verbal content, reframes conversation using sexualized language ▪ Pornography	▪ Prowls ▪ Preys on Others ▪ Sexual Acting Out ▪ Sexualized behavior ▪ Sexual risky behaviors
Behaviors that by themselves *with none of the above* are Oppositional / Defiant ▪ Picks on others for no apparent reason ▪ Comes up behind or to the side of peers aggressively without provocation ▪ Animal injury, mutilation ▪ Pro-criminal attitudes and beliefs ▪ Glamorizes delinquent / criminal lifestyles ▪ Engages in risky behavior—joy riding, drugs, etc.	

Note: This document is not designed to address

- *Eating Disorders*
- *Fire setters*
- *Sexual Predators*
- *Chronic AWOLs*

Information Mental Health Needs/Questions Mental Health Will Have

- **Always describe the following:**
  - Onset
  - Frequency - How many times per day? Week?
  - Duration - How long? 15 minutes? 1 hour?
  - Intensity/Severity - From a scale of 1-5 (5 being the most serve)
  - Precipitating and antecedent factors (before and after) the symptom, behavior, problem

- **Life Domains**:
  - When & where is the behavior or identified problem occurring; home, school, community
  - Strengths
  - Cultural considerations—Community, extended family, chosen family, poverty/socio economic status, constructs that go beyond race/ethnicity and LGBTQ.

- **Avoid Labeling**—Shorthand codes to describe people can lead to implicit bias or unconscious bias…and increases stigma and shame.

- **Trauma Screening**—Besides obvious individual traumas, consider:
  - Self and/or parental gang involvement, community violence
  - Domestic violence
  - Persistent stress—poverty/lack of: health care, transportation, education, employment

- **Engagement**—How to engage with a youth and/or parents who refuse to accept the mental health services?
  - A Medical Necessity criterion is that the youth will benefit from the treatment. If the youth refuses services constantly, service is voluntary and cannot be forced.
  - Discuss at CFT and/or Interagency meeting—determine if services should continue or if another treatment intervention may be more effective

- **Developmental Growth**—there are times when the trauma is perceived by the individual that it was so great, internal self-protection kids in, and the individual may get "stuck" in a particular developmental phase, regardless of physical age. The individual must work through the stages of development. Mental health services must begin where the youth is at, and work forward.

- **Defense mechanisms**—Many youth have developed coping mechanisms that are equivalent to the age and development of the time of the trauma.
  - Example—If a youth was molested at latency age (4-5 years old to beginning of puberty), while a youth is 16 years old, the behavioral coping patterns may be that of a six year old, the age of molestation.

- **Support Systems**—Natural support systems, positive role models-crucial to emotional health.

- **Biological Parent(s)**—The youth may have lost respect for their parents given trauma, lack of support, absentee parents, those not living in the home at all. This may ***"transfer or project"*** onto others with difficulty showing respect for teachers, fellow students, law enforcement, counselors, etc. This impacts relationship at home, in school & community, often hinders following probation directives, ultimately impacting self-initiative to do self course correction.

Juvenile Justice Best Practices

Evidence Based Practices:
https://www.law.berkeley.edu/img/BCCJ_Mental_Health_Policy_Brief_May_2010.pdf

- **Aggression Replacement Training (ART)—**Also known as Teaching Pro-Social Skills (TPS), is aimed at reducing aggressive behavior among children and youth on probation, in custody, or returning to their communities following custody.

- **Functional Family Therapy (FFT)**—Is for moderate-to high-risk teens with delinquency, aggression and/or substance abuse problems. The therapy is delivered over a period of eight to 30 hours by trained providers, who range in background from paraprofessionals to mental health professionals (Alexander et al., 1998).

- **Multi-Systemic Therapy (MST)**—Serves moderate - to high-risk teens, and typically involves 60 hours of professional interventions over four months. The staff members are on call around the clock.

- **Multidimensional Treatment Foster Care (MTFC***)*—May be appropriate when home placement is not a viable option. Youth are placed with specially trained foster families that usually only work with one child at a time. Foster parents strictly monitor the youth's whereabouts, while professionals train teens in the social skills needed to avoid ghts or situations that can lead to further crime.

- **Seeking Safety**—Is a present-focused counseling model to help people attain safety from trauma and/or substance abuse. It directly addresses both trauma and addiction, but without requiring clients to delve into the trauma narrative (the detailed account of disturbing trauma memories), thus making it relevant to a very broad range of clients and easy to implement. http://www.treatment-innovations.org/seeking-safety.html

- **Return on investment studies—**There are returns in dollars and suggestions for re-investments in these practices. http://www.wsipp.wa.gov/BenefitCost?topicId=5

Other opportunities:
- **Wraparound and other Community Support Services**
- **School Support—**Through General Education, Alternative Education, and Special Education
- **General Aid as applicable--**Food, health care, etc.
- **Recreation Activates**—Sports, dance, clubs, faith based activities, etc.