SYSTEMS-BASED PRACTICE

JUVENILE JUSTICE SYSTEM

SYSTEMS-BASED PRACTICE: JUVENILE JUSTICE SYSTEM OBJECTIVES

Note: the parentheses refer to the core competencies for systems-based practice as outlined in the RRC Program Requirements¹. Please refer to Appendix 1 for the complete list of these competencies.

Knowledge
The resident will demonstrate an adequate knowledge of:

1. The primary mission and two main principles of the juvenile justice system. (1,2)
2. The concept of status offenses. (1,2)
3. Key federal legislation related to the juvenile justice system. (1,2)
4. Range of potential roles and responsibilities of the juvenile justice system. (1,2)
5. Goals of the youth service plan. (1,2)
6. Legal processes and protections that a youth may experience after entering the juvenile justice system. (1,2)
7. Critical issues of the juvenile justice system. (1,2)
8. Common dilemmas for professionals working with youth and families in the juvenile justice system. (1,2,4,5,9)
9. Common dilemmas for professionals working with juvenile probation officers and other court officials. (1,2,4-10)
10. The multiple roles of the child psychiatrist in the juvenile justice system. (1-11)
11. Two of the evidence based interventions and/or promising practices. (1,2,5,9,10)

Skills
The resident will demonstrate the ability to:

1. Evaluate a youth involved with the juvenile justice system. (1-5,10)
2. Differentiate the clinical role of the child and adolescent psychiatrist from the forensic role. (1,2)
3. Participate collaboratively in child and family teams with the youth, the family, juvenile justice system representatives and other stakeholders identified by the court and family. (1,2,4,5,10)
4. Communicate effectively with juvenile justice system representatives. (1,2,4,5,7,9,10)
5. Prepare a variety of reports needed, dependent on the needs of the court and the family. (1,2)
6. Encourage the development and use of natural supports in order to support desired mental health treatments, rehabilitation and decrease future recidivism. (1,2,4,5,10,11)

Attitude
The resident will demonstrate the commitment to:

1. Look at the youth and family from a strengths-based perspective and participate meaningfully in a child and family team. (1,2,4,5,10,11)
2. Support the work of juvenile justice professionals and offer feedback when indicated. (1,2,4,5,7,9,10)
3. Support collaboration and cooperation between system partners to maximize effective resources in juvenile justice to achieve maximum rehabilitation. (1,2,4-12)
4. Advocate for the needs of the youth and family within the juvenile justice system. (1,2,4,5,10,11)
OVERVIEW

Child and adolescent psychiatrists (CAPs) regularly work with children and adolescents involved in, and at risk of involvement in, the juvenile justice system. Therefore, it is important the mandates, definitions, roles, services, and responsibilities of the juvenile justice system be understood. It is also important that the culture and value system of juvenile justice be appreciated. Familiarity with evidence-based and promising practices in juvenile justice is also important, and there is much to be learned from each other.

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I. INTRODUCTION

The primary mission of the juvenile justice system is to provide rehabilitation for children and youth who are not old enough to be prosecuted for criminal acts under juvenile law. Juvenile law is governed by two principles that serve as a guide on the treatment of children and youth in response to their criminal acts. These two principles are “best interest of the child” and “parens patriae.” These two principles serve as a balance between the needs of the state and protection of its constituents.

The principle of “best interest of the child” authorizes the state to provide the necessary services and supports to a delinquent child or youth in order to remain in the least restrictive setting to receive rehabilitation for their behaviors. The state assists in supporting the youth by successfully re-integrating the youth into the family and community. The principle of “parens patriae” allows the state to act in the role of parent for youth in the juvenile justice system and authorizes the state to legislate for protection, care and custody of youth.

Status offenses are a unique concept of the juvenile justice system. Status offenses occur when the youth is engaging in behaviors outside their normal developmental role expectations. These offenses include curfew violations and truancy from school. The number of petitions entered in juvenile court for status offenses has increased over the last 20 years. State officials are torn between their desire to provide services for at-risk youth and families and the public pressure to respond to all forms of youth misbehavior with tough new sanctions, which may include
incarceration of status offenders. However, most states do not incarcerate youth for status offenses.

Several federal legislative acts have shaped the juvenile justice system. The 8th and 14th Amendments outline the constitutional rights of youth. Federal law and most states set the age for criminal culpability at the age of majority (typically 18 years of age). An important early development of the juvenile justice system was the establishment of the first family court, which was designed as a court with jurisdiction limited to the legal matters of children and families. *In re Gault* juveniles facing criminal charges were given due process rights similar to adults. However, this ruling did not allow juveniles the right to a jury trial. *In re Winship* the burden of proof to convict a juvenile was raised as compared to the adult standard of beyond a reasonable doubt.

The United States Supreme Court, in a 5-4 ruling, declared that mandatory sentences of life without parole are unconstitutional for juveniles that are convicted of homicide. The court held that in *Miller v. Alabama* and *Jackson v. Hobbs* sentencing juveniles to life without parole is a violation of their 8th Amendment rights against cruel and unusual punishment. The argument was made based on the science of adolescent behavior and brain development. The brief asserted that adolescents behave differently because their brains are not fully developed and exhibit functional differences from mature adult brains. In writing for the majority, Justice Kagan said, “mandatory life without parole for a juvenile precludes consideration of his chronological age and its hallmark features – among them, immaturity, impetuosity and failure to appreciate risks and consequences.” This ruling builds on recent decisions by the court that noted the developmental and neurological differences between juveniles and adults.

The role of the federal government in advancing the juvenile justice system includes funding programs and setting standards for the care and rights of youth in the system. The federal government has made attempts to raise state standards for the juvenile justice system and to reduce the national burden of juvenile delinquency.

The Juvenile Delinquency Prevention Act of 1974 initiated a national policy of status offender "deinstitutionalization" supporting the development of community-based treatment programs and prohibiting incarceration of these youth. In the following years, most states embraced this policy, drastically reducing status offenders being held in detention. An important aspect of the act includes a requirement for states to help train individuals in occupations providing services within the juvenile justice system. This act defines juvenile delinquency as any act that is otherwise a crime, is committed by someone less than 18 years of age, and sets forth rules by which state laws must comply regarding juvenile court procedures and punishments. Finally, the law establishes a federal mandate to provide technical assistance in the juvenile justice system.

The U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention (OJJDP) is an outgrowth of this legislation. OJJDP’s mission is to strengthen the juvenile justice system's efforts to protect public safety and provide services that address the needs of juveniles and their caregivers/families. OJJDP also provides technical assistance to states to improve their juvenile justice systems.
II. ROLES AND RESPONSIBILITIES OF THE JUVENILE JUSTICE SYSTEM

- The juvenile justice system is supposed to balance “parens patriae” and “best interest of the child.”
- Integrates federal law mandates into the local children’s code and/or juvenile civil law.
- Involves youth engaged in juvenile delinquency or status offenses.
  - Provides legal counsel for the youth
  - Defines pathways for youth remanded to adult criminal court
- The juvenile justice system represents youth independent of caregivers/parents.
- Addresses the physical and mental health needs of youth while in custody.
- Provides appropriate educational services to the youth.
- The court process involves developing a youth service plan consisting of rehabilitation, societal sanctions, safety of the youth, and community safety.
  - The goals of the plan are to reduce the youth’s recidivism and maximize growth and development in accordance with juvenile justice law.
  - Post adjudicatory assessments are the most common referrals from juvenile court.
- Determines the safety of the child to remain in the caregiver/family home or in need of immediate out-of-home placement.

III. THE JUVENILE JUSTICE LEGAL PROCESS

- Juvenile law is governed at the local (curfew and school attendance), state, and federal levels.
  - District courts serve as the court of jurisdiction for most juvenile offenses.
  - However, cases can occur in the state and federal appellate and supreme courts.
  - On rare occasions, there are federal juvenile cases.
  - Probation department staff monitor youth when delinquent behaviors lead to sentencing.
- Youth may be arrested by police officers, truant officers or members of the sheriff’s department due to a witnessed, reported or alleged violation of juvenile law.
- After the arrest, the youth moves through a series of legal proceedings after a petition is filed with the court.
  - These stages are known as pretrial, adjudication, sentencing and post-sentencing or post-adjudication.
  - **Pretrial stage** – Law enforcement representatives decide if the youth will be arrested and petition the court to charge the youth. The youth is then arrested and charged with an offense. The court representative decides to hold the youth in a state approved detention site or release the youth at this time.
  - **Adjudication** – The juvenile law in the jurisdiction defines the process of the court proceedings, which may include whether the judge or district court magistrate accepts the charges or diverts the youth into a rehabilitation program. If the charge is accepted and filed, the youth is provided with legal counsel to advise on making a plea of guilty versus not guilty. The court process includes the discovery of the facts, the judge or magistrate, in certain cases the jury, and renders a judgment of guilty or not guilty. For youth found guilty, they move into the sentencing phase.
o **Sentencing** – This phase may include probation, a specific rehabilitation site, or being housed in a detention facility if community safety is an issue. The youth may become a custodial ward of the state during this phase. Upon completion of this stage, youth enters a post-sentencing phase.

o **Post-sentencing** – This phase may include revocation of probation, entering a period of parole status, re-sentencing or placements in community transitional services.

### IV. CRITICAL ISSUES OF THE JUVENILE JUSTICE SYSTEM

- In the early 1990’s, the juvenile justice system was reformed due to an increase in violent crimes by juvenile offenders. This led to juvenile delinquents being relinquished into the adult criminal system.

- By the early 2000’s, a number of states revised the practice of treating juvenile delinquents as adult offenders based on emerging evidence regarding the youth’s inability to understand the consequences of their actions.
  - Juvenile courts ordered competency examinations, health/mental health evaluations, and treatments for mental health and substance use disorders.
  - Access to health and mental health services were added to many states’ juvenile justice systems.
  - Evidence-based treatments for youth in the juvenile justice system were enacted in many states.

- Female delinquency has increased significantly more than their male counterparts over the past decade.7
  - The needs of females in the juvenile justice system have been overlooked in the past.
  - There are unique mental health comorbidities in female delinquents and higher reported rates of physical and sexual abuse than in the general population.
  - Advocates have petitioned state systems to provide gender specific services and supports based on these findings.

- Minority youth are also disproportionately represented in the juvenile justice system compared to the percentage of their minority group residing in the state.8
  - Minority youth make up approximately 1/3 of the general population but consist of 2/3 of the juvenile justice population.
  - There has been significant concern that minority youth were disproportionately remanded to adult court to face adult charges.

- The increasing knowledge about the public health and mental health needs of youth in the juvenile justice system offer opportunities for child psychiatrists to improve their state’s response to successful implementation of the federal act.

- The American Academy of Child and Adolescent Psychiatry (AACAP) Task Force on Juvenile Justice Reform is an example of child psychiatry efforts to recommend improvements to the juvenile justice system by providing a continuum of medical and mental health services.
  - The Task Force’s mission includes pursuing reform to enhance integration of the juvenile justice system with other child-serving systems, such as education, child welfare and health.
The Task Force promotes child psychiatric involvement in the juvenile justice system through direct professional, advocacy, and legislative initiatives.

The Task Force also pursues policy strategies to improve delinquent youth’s access to community based, family centered, culturally competent and developmentally relevant mental health care.

V. DILEMMAS WITHIN THE JUVENILE JUSTICE SYSTEM

- Child psychiatrists may face clinical and ethical dilemmas when working with the juvenile justice system.
- First and foremost, individuals working in the system must understand the youth’s developmental stage and family culture in order to support them through the legal process.
  - The juvenile justice system representative should ensure the determination of Miranda rights for a youth is conducted in a manner that recognizes the youth’s level of development.
  - Grisso et al. reported that youth younger than fourteen are less likely to be competent to stand trial or understand Miranda rights.9
  - For example, this may be observed in alleged offenses in children who have been victims of abuse or failure to view youth responses to legal representatives with their developmental status in mind.
- The child psychiatrist may encounter a system that has failed in providing routine assessment for mental health and substance use disorders.
  - It is not uncommon that the youth is remanded into the adult court system without recognition of the youth’s evolving mental and cognitive processes.
- The youth and family may encounter difficulties during the legal process including:
  - racism
  - lack of knowledge about the impact of social economic status
  - lack of recognition of ethnic minority cultural values
  - conflicts with the legal system.
  - For example, a family may not question the steps of the pretrial process or volunteer ideas about their ability to address the youth’s issues that would support alternatives and thus prevent progression to the adjudication phase. The caregiver may not have a sense of how the juvenile justice system service options will support them in meeting the court requirements in order to allow the youth to remain in the home, but instead may look to the court to provide custodial supervision.
- A youth being held in a detention setting during the pretrial and adjudication stages may encounter a number of emotional difficulties.
  - The youth may be subject to overcrowding, culturally foreign and unsafe environments in detention or holding areas.
  - The supervising staff may have very little knowledge of child development and have minimal education about accessing health, education, mental health or substance abuse issues.
  - Youth may have difficulty accessing reasonable mental health care.
In detention, the youth may have limited contact with their family, community and natural supports leaving the youth vulnerable.

- During the adjudication process, the youth and family may not be provided with the legal resources for a developmentally informed representation of the youth’s actions in relationship to the charge and entering a plea.
  - A number of states provide training supports to the youth’s legal representative as well as court appointed advocates to assist the youth and family in negotiating the legal process.
  - The state may provide a guardian to represent the interests of the child, which may be needed for youth who are shifting jurisdiction to adult criminal court.
  - The juvenile justice system representative needs to recognize the level of the child’s development and capacity to understand criminal sanctions such as the death penalty.

- Many communities lack state or federal funding to adequately meet the developmental, education and treatment needs of youth placed back into their community.
  - Experts must know available services and be open to ongoing advocacy. Once a youth enters the system, they are no longer on Medicaid and once they are released, they must reapply. This delay keeps the youth from accessing the mental health services they need.
  - For example, youth with limited education success and untreated or undertreated mental health or substance use disorders have higher rates of recidivism. The juvenile justice system or the youth may not have access to services and, if the system or the family has limited health resources, then the service may be unmet.
  - Finally, although many states have procedures about the pathway of progression through the juvenile justice system and provide services for rehabilitation, many services may not be cost effective or have any positive outcome in rehabilitation.

- The juvenile justice system focuses on issues of public safety, justice and rehabilitation.
  - Many professionals working in the system have minimal knowledge about child development and a limited understanding about mental illness, mental health assessment and service delivery.
  - Often mental health resources in the juvenile justice system are inadequate to address the unique mental health issues of youth involved in the system.

VI. ROLES FOR CHILD AND ADOLESCENT PSYCHIATRISTS

Clinician
- The child psychiatrist can provide a psychiatric evaluation during the pretrial period.
  - This may include needing to define the intent of the evaluation for the court, differentiate the clinical findings from any expert’s finding, and provide psychotherapy and psychopharmacology services.
- The child psychiatrist should clarify issues of consent, assent and confidentiality with the youth and caregiver.
  - This may also involve making sure the youth and caregiver understand the court process, their professional role and obtaining consent and assent.
  - During the initial evaluation, the psychiatrist should review all available information through the juvenile justice system and may need to collaborate with
the family for additional information. It is important to include the current caregivers as part of this process for the youth whenever possible.
  - The evaluation should include a thorough family, developmental, trauma, illicit substance use education, placement, prior treatment and criminal histories.
  - Upon completion of the evaluation, an assessment, formulation, diagnosis, and a list of treatment recommendations serve as a useful guide in initiating psychiatric treatment of the youth.
- The child psychiatrist is a valuable member of the team and participates in the team meetings and planning for the youth.

**Expert Witness**
- Forensic evaluation of youth involved in the juvenile justice system is significantly different from any psychiatric clinical evaluation.
- The child psychiatrist as a forensic consultant is not engaged in a therapeutic process but under contractual agreement with the court to perform an evaluation as specified by the court.
- The forensic evaluation provides information that is requested as part of the legal proceeding and is utilized in decision-making by the judge or magistrate.
- The child psychiatrist performing a forensic evaluation should:
  - review their role and task as requested by the court judge or magistrate
  - clarify issues surrounding reimbursement for the service
  - clarify their role as a consultant to the court
  - define the limited confidentiality afforded the youth and family.
- As with the clinical evaluation, the psychiatrist should systematically obtain significant collateral information, which may involve:
  - an evaluation of the youth and family interacting
  - identifying mitigating factors such as child development
  - the need to establish competency
  - the recognition of malingering and/or exaggeration of traits that will influence sentencing of the juvenile
- The child psychiatrist should never have a dual role as primary clinician and forensic evaluator.
- One can testify as a clinician, but this should only be done with written permission from the child and parent or by a court order. A subpoena does not substitute for a court order.

**Advocate**
- The child psychiatrist may serve as an advocate for the integration of mental health services within the juvenile justice system.
- This includes collaboration with juvenile justice professionals in each step of the legal process.
- The psychiatrist may collaborate with professionals in the system at the policy level by assisting in drafting developmentally appropriate policies; educating the appropriate legislative members about cost effective evidence-based interventions; partnering with consumer advocacy groups promoting access to mental health care; and, supporting implementation of medical practices and delivery systems of rehabilitation that are high quality, strengths-based and informed by the juvenile’s and the family’s goals.
Consultant

- The child psychiatrist may also serve in a consultant capacity.
- As a consultant, some of the roles may include training staff about mental illness and substance abuse issues for this population.
  - In addition, a child psychiatrist may play a role in how to intervene with the youth who are presenting with behavioral problems both in the detention facility and the community.
- This can also help the families to:
  - better understand the youth’s needs
  - understand how to better access services within the system
  - appreciate the role of family and community supports in the rehabilitation of the youth.
- The consultant may work directly with the agency director regarding ways to improve care and be asked to participate in service planning meetings.

Treatment Provider

- Many child psychiatrists contract with detention centers, residential programs and group homes to provide mental health treatment services for youth.
- As such, they do clinical evaluations and prescribe medications.
- They may participate in treatment team meetings and consult with staff on how to manage individuals with mental health issues.

VII. EVIDENCE-BASED MENTAL HEALTH INTERVENTIONS FOR YOUTH IN JUVENILE JUSTICE

- In the U.S., the juvenile justice population continues to expand based on:
  - mandatory sentencing laws
  - increased community pressure to activate the juvenile justice system rather than divert youth with delinquent behaviors
  - disparities in access to mental health and substance abuse treatment
  - increased involvement in the child welfare system
- Youth detained for specialized status offenses, violent and/or sexual offenses, as well as youth with mental illness and substance use disorders, traditionally have higher rates of recidivism than the general juvenile delinquent population.
- The cost of detaining these youth is greater than for other populations.9
- In the late 1980s, researchers started applying evidence-based principles in designing interventions to target improvement in juvenile justice outcomes.
  - This included examining the cost-benefit ratio of rehabilitation and level of confinement for sentenced youth.
  - Early outcome studies reported that residential programs were more effective if the youth was incarcerated for a longer period of time, if the program had a consistent structure, strong and positive staff relationships, use of cognitive behavioral therapy or other evidence-based therapies, and co-occurring treatment for health and substance use disorder issues.9
Multisystemic Therapy (MST) is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders.10

- The multisystemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors.
- Intervention may be necessary in any one or a combination of these systems.
- MST targets chronic, violent, or substance abusing male or female juvenile offenders, ages 12 to 17, at high risk of out-of-home placement, and the offenders’ families.
- MST addresses the multiple factors known to be related to delinquency across the key settings, or systems, within which youth are embedded.
- MST strives to promote behavior change in the youth’s natural environment, using the strengths of each system (e.g., family, peers, school, neighborhood, indigenous support network) to facilitate change.
- The major goal of MST is to empower parents with the skills and resources needed to independently address the difficulties that arise in raising teenagers and to empower youth to cope with family, peer, school, and neighborhood problems.
- Within a context of support and skill building, the therapist places developmentally appropriate demands on the adolescent and family for responsible behavior.
- Intervention strategies are integrated into a social ecological context and include strategic and structural family therapy, behavioral parent training, and cognitive behavior therapies.
- MST uses a home-based model of service delivery to overcome barriers to service access, increases family retention in treatment, allows for the provision of intensive services (i.e., therapists have low caseloads), and enhances the maintenance of treatment gains.
- The usual duration of MST treatment is approximately 60 hours of contact over four months, but frequency and duration of sessions are determined by family need.
- Difficulties can include the expense and lack of community and state support.
- This tends to be less effective with severe delinquents.

Multidimensional Treatment Foster Care (MTFC) is a cost effective alternative to group or residential treatment, incarceration, and hospitalization for adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency.

- Community families are recruited, trained, and closely supervised.
- Provides MTFC-placed adolescents with treatment and intensive supervision at home, in school, and in the community
- Clear and consistent limits with follow-through on consequences
- Positive reinforcement for appropriate behavior
- A relationship with a mentoring adult
- Separation from delinquent peers
- MTFC targets youth with histories of chronic and severe criminal behavior at risk of incarceration and those with severe mental health problems at risk for psychiatric hospitalization.

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o MTFC Training for Community Foster Families emphasizes behavior management methods to provide youth with a structured and therapeutic living environment.
o After completing a pre-service training and placement of the youth, MTFC parents attend a weekly group meeting run by a program supervisor where ongoing support and supervision are provided.
o Foster parents are contacted daily via telephone calls to check on youth progress and problems.
o MTFC staff is available for consultation and crisis intervention 24 hours a day.
o Family therapy is provided for the biological (or adoptive) family, with the goal of returning the youth back to the home.
o The parents are supported and taught to use behavior management methods that are used in the MTFC foster home.
• Several studies have shown that MST or MTFC are cost effective.9-13
  o These studies demonstrated that youth who participated in MST or MTFC had decreased recidivism rates.
o They also noted that identifying and treating all of the youth’s conditions in an integrated fashion provides better treatment outcomes, and addressing educational issues and providing environmental structure decreases recidivism rates.
• Promising interventions for adolescent substance abuse treatment include:
o Cognitive behavioral approaches including the Cannabis Youth Treatment Series (CYT) and The Seven Challenges.14,15
  o A substance abuse approach using system of care principles and developed by the Robert Wood Johnson Foundation is the Reclaiming Futures Model.16
• Good examples of community based treatment programs can be found in Seattle, WA, Portland, OR and Dayton, OH.

VIII. CONCLUSION

The goal of the juvenile justice system is to provide rehabilitation to youth offenders. The complexities of the juvenile justice system strive to re-integrate youth offenders back into the community. In order to assist youth offenders, the juvenile justice system must assume the role of “parens patriae” and provide the “best interest of the child.” The state assumes the parental role of the youth with “parens patriae.” The “best interest of the child” provides the necessary services to the youth in the least restrictive setting to rehabilitate the youth offender back into the family and community. Laws regarding juvenile offenders may vary from state to state but all states work under the principles of “parens patriae” and the “best interest of the child.”

Youth offenders are commonly charged with status offenses, which may include curfew violations and truancy from school. Most states do not incarcerate youth for status offenses. Sentenced juvenile offenders proceed on to the pre-trial, adjudication, sentencing, and post-sentencing phases that are charged with more serious offenses. These phases of the juvenile justice system process determine if the youth offender will be housed by the state in a detention center, transitioned to a residential treatment center, or released back into the community with their family. Each phase of the juvenile justice process aims at rehabilitating the youth back into the community.
Evidence based treatment consisting of Multisystemic Therapy (MST) and Multidimensional Treatment Foster Care (MSFT) have been the most successful in outcomes of youth offenders. MST and MSFT are community based programs with the goal of reducing recidivism rates of youth offenders and successfully re-integrating them back into the community. These youth often exhibit difficulties in many different systems of care, and these programs help coordinate the different systems to provide the most benefit for the juvenile offender.

Child psychiatrists have many roles in the juvenile justice system such as performing forensic examinations for the court, acting as a consultant in treatment, being a clinician for the patient, and advocating for the juvenile during this process. The roles of consultant and clinician are very important in providing psychiatric treatment and advocating for the juvenile offender. Serving as an advocate may involve many different systems of care (educational, community) in addition to the juvenile justice system. Being an advocate involves working closely with federal and state legislation to examine and improve current policies in order to better serve those in the juvenile justice system. The U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention (OJJDP) is one legislative program working to strengthen the juvenile justice system's efforts in providing services to address the needs of juveniles and their caregivers/families. In addition, the American Academy of Child and Adolescent Psychiatry (AACAP) works closely with policy makers to advocate for the best possible care to children in all systems of care.
APPENDIX 1

Systems-Based Practice Competencies

RRC Program Requirements, Section IV.A.5.f

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;
2) coordinate patient care within the health care system relevant to their clinical specialty;
3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
4) advocate for quality patient care and optimal patient care systems;
5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,
6) participate in identifying system errors and implementing potential systems solutions.
7) know how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, assuring quality, and allocating resources;
8) practice cost-effective health care and resource allocation that does not compromise quality of mental health care for children and adolescents;
9) advocate for quality patient care and assisting patients in dealing with system complexities, including disparities in mental health care for children and adolescents;
10) work with health care managers and health care providers to assess, coordinate, and improve health care;
11) know how to advocate for the promotion of health and the prevention of disease and injury in populations; and,
12) instruct in the practice of utilization review, quality assurance and performance improvement.
REFERENCES

OTHER RESOURCES

Web sites
National Center for Juvenile Justice: http://www.ncjj.org

Texts

Practice Parameters

Articles

Policy Statements
Juvenile Justice System – Discussion Vignette I – Trainee Version

Ethan Fount is a 16 year old Caucasian American male who was sentenced for up to two years for assaulting a student at school. He has completed five out of six months of a boot camp program and is preparing for a return to his community where he will be on a one year mandatory parole. Ethan had been living with his mother, younger sister and aunt in an inner city apartment complex. His mother says that prior to his arrest she had little control of his behavior; he would stay out late most nights often not returning home to sleep. His mother was never sure who he was with. He is currently a high school freshman with a history of difficulty in school for several years with poor grades, multiple absences in the last year, and several suspensions for aggressive behavior. At the time of his arrest his “tox screen” was positive for cannabis. The previous year, his father was arrested, charged and incarcerated for distributing cannabis. Ethan’s mom is seeking aftercare services that his parole officer stated he has to secure. She is meeting with the case manager to set up appointments. She states he needs anger management services and she wants help to make sure that he stays out of gangs. The case manager is reviewing Ethan’s information in the clinical staffing team.

1. What kind of services might Ethan benefit from in his efforts towards rehabilitation?

2. How may Ethan have progressed through the juvenile justice system?
   a. Discuss a typical scenario for progression through the juvenile justice system.

   b. Discuss effective mental health program components for incarcerated youth.
Juvenile Justice System – Discussion Vignette II – Trainee Version

Maria is a 15 year old Hispanic female who has had chronic behavioral problems since first grade. She was removed from her biological mother’s home at 7 years old and has been in multiple foster homes. Maria started using alcohol at 9 years old and marijuana at 11 years old. By age 12, Maria was caught stealing a car and breaking into homes. She was placed on probation and had mandated services, including mental health and substance abuse services. In the last three years, she has had multiple felony offenses, has spent time in detention and now she has been committed to a training school for 16 months. Most recently, while in detention awaiting placement at the training school, she experienced suicidal ideation.

1. As stated above, Maria spent some time in a detention center before she was sent to the training school and became suicidal. What are some reasons for increased emotional difficulties in detention sites?

2. A possible alternative placement for Maria is multidimensional treatment foster care. Why would Maria be a good candidate for MTFC?

3. Describe MTFC.