

Juvenile Justice Resource Series

Transition Age Youth With Mental Health Challenges in the Juvenile Justice System



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About the Technical Assistance Partnership for Child and Family Mental Health

The Technical Assistance Partnership for Child and Family Mental Health (TA Partnership) provides technical assistance to system of care communities that are currently funded to operate the Comprehensive Community Mental Health Services for Children and Their Families Program. The mission of the TA Partnership is "helping communities build systems of care to meet the mental health needs of children, youth, and families."

This technical assistance center operates under contract from the Federal Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

The TA Partnership is a collaboration between two mission-driven organizations:

- American Institutes for Research—committed to improving the lives of families and communities through the translation of research into best practice and policy, and
- The National Federation of Families for Children's Mental Health—dedicated to effective family leadership and advocacy to improve the quality of life of children with mental health needs and their families.

The TA Partnership includes family members and professionals with extensive practice experience employed by either American Institutes for Research or the National Federation of Families for Children's Mental Health. Through this partnership, we model the family-professional relationships that are essential to our work. For more information on the TA Partnership, visit the Web site at <http://www.tapartnership.org>.

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Foreword

Each year, more than 2 million children, youth, and young adults formally come into contact with the juvenile justice system, while millions more are at risk of involvement with the system for myriad reasons (Puzzanchera, 2009; Puzzanchera & Kang, 2010). Of those children, youth, and young adults, a large number (65–70 percent) have at least one diagnosable mental health need, and 20–25 percent have serious emotional issues (Shufelt & Coccozza, 2006; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002). System of care communities focusing on meeting the mental health and related needs of this population through comprehensive community-based services and supports have the opportunity to not only develop an understanding around the unique challenges this population presents, but also to decide how best to overcome those challenges through planned and thoughtful programs, strong interagency collaboration, and sustained funding.

The Technical Assistance Partnership for Child and Family Mental Health (TA Partnership) recognizes the many challenges system of care communities face in working to better meet the needs of all of the children, youth, and young adults they serve. In an effort to help these communities meet the unique needs of young people involved or at risk of involvement with the juvenile justice system, the TA Partnership is releasing a resource series focused on this population. The TA Partnership has contracted with the National Center for Mental Health and Juvenile Justice (NCMHJJ) and other experts in the field to produce this resource series. Each brief examines a unique aspect of serving this population, from policy to practice, within system of care communities.

We hope that this publication will support the planning and implementation of effective services, policies, and practices that improve outcomes for young adults of transition age who are involved in or at risk of involvement with the juvenile justice system as well as their families.

Transition Age Youth With Mental Health Challenges in the Juvenile Justice System

Kimberly, now 18 years old, grew up in a poor neighborhood and experienced a lot of family conflict as a child. She was placed in foster care as a teenager because of allegations that her mother was physically abusive. After her foster parents discovered that Kimberly was involved in prostitution and also had stolen money from the foster family, they reported her to the police. Due to these charges, Kimberly has been involved with the juvenile justice system for the past two years. Because of her “problem teen” status, her caseworker was unable to find a foster family to place her with, and none of her own family members were willing to take her back in their homes after she was on probation. No other child welfare placements were available, so Kimberly was placed in a group home for delinquent girls, where she had a rough time adjusting to the placement. She told her probation officer that she was having trouble sleeping and having disturbing thoughts about an incident that had happened to her in one of her foster placements. When her probation officer pressed her for details, Kimberly disclosed that she had been sexually assaulted when she was out on the streets. Fortunately, her probation officer recognized that Kimberly was having symptoms related to her trauma history and helped her to schedule an appointment at a local mental health clinic. The probation officer also made sure Kimberly made it to her intake appointment. Unfortunately, after the assessment, the therapist discovered that Kimberly could not be seen at the clinic because it did not accept Medicaid. The probation officer helped Kimberly find another clinic in the community that would take her insurance, but her records from the first clinic were not transferred in time for her first appointment. Kimberly had to complete another intake and was frustrated that she had to tell her story to another therapist. Her therapist had a large caseload of adult patients and could schedule Kimberly for an appointment only every other week; Kimberly felt that her therapist did not really “get” what her life was like. When Kimberly started therapy, it became clear to her therapist that she needed a medication evaluation, but the next available appointment was not for two months. By then, Kimberly had dropped out of care. Kimberly missed three appointments in a row, and when her therapist tried to reach her, Kimberly’s prepaid cell phone had been

turned off. Due to the clinic's "no-show" policy, Kimberly's case was closed, and she was not allowed to return to the clinic.

Kimberly continued struggling with her group home placement. She was not getting along with her peers, and she wanted a more independent living situation. At 18, she felt she was too old to be living in a placement. She would leave the group home for days, staying with friends and wandering the streets. Kimberly's child welfare social worker found some information on a program to help former foster care children find and pay for housing. The one stipulation was that Kimberly would have to participate in supervision through child welfare until her 21st birthday. The supervision included random drug testing and a group-based skills development program. Kimberly wanted nothing to do with this type of supervision. She turned down the opportunity to participate in this program and stayed in the group home, waiting to age out of the child welfare system and leave.

Kimberly's social worker remained concerned about her transition from the group home to independent living because Kimberly had never had a job and didn't finish high school. Kimberly would not be able to afford housing without a job, so the social worker talked her into using the local vocational rehabilitation services in her community. The social worker told Kimberly that she could get a paid internship right away if she was willing to use their services. Unfortunately, the vocational rehabilitation center couldn't offer Kimberly an appointment until six weeks later. By the time her appointment came up, she had been moved to a new group home in the next town and was no longer eligible for the services where her appointment had been scheduled. Her social worker secured an appointment at the vocational rehabilitation center in Kimberly's new town, but she had to go to the back of the waiting list.

Kimberly's experience represents an all-too-common occurrence for young people with mental health problems in the juvenile justice system. The current system for rehabilitation often fails to address or even presents barriers to meeting the multiple needs of such youth. This is compounded by the multiple transitions in life roles that occur during this important developmental period. The purpose of this paper is to provide an overview for mental health practitioners, juvenile justice professionals, and policymakers whose work

brings them in contact with transition age youth with significant mental health needs in the juvenile justice system. Topics reviewed include normative developmental processes during the transition age, difficulties faced by transition age youth with mental health problems in the juvenile justice system, policies and programs that have been shown to help with transition for these youth, and additional suggestions for best practice and policy.

Overview

The term *transition age youth* refers to individuals aged 16 to 25 years. For the purposes of this review, we focus on ages 16 to 21, as this is the period during which transition age youth are likely to be involved with the juvenile justice system. Also for our purposes, our definition of mental health problems includes diagnosable mental health disorders exclusive of developmental disorders and mental health diagnoses due to a physical health problem. Substance use disorders will not be included in this definition but will be discussed as a common co-occurring condition. The most common mental health disorders among youth in the juvenile justice system are disruptive behavior disorders (e.g., attention deficit hyperactivity disorder, conduct disorder), anxiety disorders (e.g., posttraumatic stress disorder, generalized anxiety disorder), and mood disorders (e.g., major depression, bipolar disorder) (Skowrya & Coccozza, 2007). However, there is an important distinction between disruptive behavior disorders and other mental health problems for transition age youth. A disruptive behavior disorder diagnosis allows minors to access services in the child mental health system, but adults presenting solely with a disruptive behavior disorder are explicitly denied coverage in the adult mental health system (Davis & Koroloff, 2006). Thus, transition age youth with primarily behavioral disorders are often in the position of losing access to mental health services as they age out of child systems. Because this is an important problem for justice-involved transition age youth, differentiation between disruptive behavior and other disorders will be made throughout this review.

Development During the Transition to Adulthood

The transition from adolescence to adulthood represents a unique developmental period, with significant changes in educational, vocational, and relational roles and expectations in the face of reduced family influence and changing social networks (Arnett, 2000). This transitional period presents challenges for even the most well-adjusted youth as they navigate new roles in educational, vocational, and relationship domains. This is the time when many youth make long-term decisions about careers and families and move from their family of origin to more independent living situations. In fact, the capacity to make decisions for oneself is a critical skill to develop during this stage of life. Further, aspects of executive

functioning—including good judgment and decision making in the face of peer influence and the ability to pursue goals in the face of emotional distractions—also mature through this social interplay and critically influence behavior and future decision making. The normative transitions that occur during this age include the completion of schooling or vocational training, obtaining and maintaining gainful employment, contributing to household income, developing a social network outside of one’s family, and becoming a productive citizen. Success in these domains is determined by a complex interplay between youth, their families and neighborhoods, and available opportunities.

Potential Pitfalls of the Transition Age

The importance of this developmental period lies not only in the important tasks that are accomplished but also in the risk for substantial impediments. For example, the transition age is when onset of mental health problems peaks, and the vast majority of mental health disorders have onset by the early 20s (Kessler et al., 2005; Kim-Cohen et al., 2003; Newman et al., 1996; Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). Epidemiological studies have shown an increase in mental health problems beginning in middle adolescence and peaking in late adolescence and early adulthood, with past-year prevalence rates of 29 percent to 40 percent between the ages of 18 and 25, when substance use disorders were included (Newman et al., 1996; SAMHSA, 2012). Rates of serious mental illness, defined as a diagnosable mental health problem that results in significant functional impairment, are less common but still are more prevalent during the transition age (7.7 percent) than at any other developmental period (SAMHSA, 2012). At the same time, utilization of mental health services declines sharply during the transition age, presumably due to the multiple barriers to care that occur during this period, including loss of health coverage and the transition from child to adult service systems (Pottick, Bilder, Vander Stoep, Warner, & Alvarez, 2008).

This transition age also has the highest rates of onset of problematic substance use and substance use disorders (i.e., abuse, dependence) (Chassin, Flora, & King, 2004; Delucchi, Matzger, & Weisner, 2008; SAMSHA, 2009). A large majority (90 percent) of young adults reported having used alcohol in their lifetime, and 61 percent reported lifetime illicit drug

use (SAMSHA, 2008). Prevalence of substance use disorders follows a similar pattern, with the past-year prevalence of 9 percent among youth between the ages of 12 and 17, increasing to 21 percent among youth aged 18 to 25 years (SAMSHA, 2005). Criminal behavior tends to peak between the ages of 15 and 19 (Farrington, 2005), although there is evidence that this peak occurs later for youth with mental health problems (i.e., between 18 and 20) (Davis, Banks, Fisher, Gershenson, & Grudzinskas, 2007). Further, the rise in criminal activity is compounded by the transition into adulthood, as the justice system no longer views such behavior with a juvenile lens, and the youth may face criminal rather than juvenile delinquency charges. For youth who struggle during the transition to adulthood, having multiple problems is the rule rather than the exception (Osgood, Foster, & Courtney, 2010), as youth who develop one of these problems are at substantial risk for developing additional related difficulties.

Substantial adversity during this developmental period has the capacity to delay or derail the achievement of normative transitions, with the potential for setbacks associated with long-term negative outcomes. Thus, youth struggling with mental health problems and juvenile justice involvement are at a marked disadvantage compared with their peers as they enter the transitional age, a developmental period that typically necessitates substantial resources even under the best circumstances. Further, youth at the highest risk for experiencing these types of setbacks are those from disadvantaged psychosocial backgrounds who already have experienced multiple lifetime adversities (Chung, Little, & Steinberg, 2005). Specifically, these youth have accumulated disadvantage that often includes poverty, poor relationships with parents and other family members, school failure and/or dropout, negative peer groups, and the lack of adult role models. These histories of disadvantage often do not provide the resources necessary to overcome the substantial challenges faced by multiproblem transition age youth.

There is also compelling evidence that the brain, particularly as it relates to executive functioning, is not yet fully developed during adolescence and the transition to adulthood (Albert & Steinberg, 2011). Anatomical studies show that the prefrontal cortex and its links to other brain regions, including the amygdala and striatum in the limbic system, continue to develop through early adulthood (Casey, Galvan, & Hare, 2005; Yurgelun-Todd, 2007).

Adolescents and transition age youth show deficits in areas of executive functioning, including impulse control, planning, and decision making, compared with adults (Eshel, Nelson, Blair, Pine, & Ernst, 2007; Somerville & Casey, 2010). Indeed, tasks that require behavioral control over responses have a developmental brain maturation trajectory that continues until the early 30s (Hare et al., 2008; Liston et al., 2006). This continued brain development partially explains the challenges that many transition age youth face in making effective decisions, controlling impulsive behavior, and engaging in the long-term planning needed for success across all life domains.

Mental Health Problems and Juvenile Justice Involvement During the Transition Age

Transition age youth with mental health problems are at increased risk for involvement in the justice system compared with their peers (Davis et al., 2007; Grisso, 2004). Further, they represent an important and complex group in the juvenile justice system as they face both the developmental challenges of this period and present with substantial barriers to a successful transition to adulthood. They almost always experience multiple problems that can complicate both rehabilitation and the successful transition to adulthood. Thus, they have the capacity to incur significant costs to themselves, their families, the justice system, and their communities.

Juveniles in the Justice System

The very definition of *juvenile* varies by state, meaning that youth in many states remain in the juvenile justice system well into the transition age while youth in other states are transferred to the adult justice system. First, there is variability across states in the upper age of jurisdiction in the juvenile court—that is, the age at which an individual engaging in a law-violating behavior would be processed in the juvenile versus adult court system. As Figure 1 shows, the large majority of states consider crimes committed through the age of 17 as juvenile offenses. A few states have an upper age of 16, and New York and North Carolina process only crimes committed through the age of 15 in the juvenile system. There also is variability across states in the age at which juvenile justice system involvement is terminated. As presented in Table 1, only a few states' juvenile justice systems end their involvement

with youth when they turn 18. It is far more common for youth to remain under juvenile jurisdiction through the age of 20, with some states allowing for extension up to age 24 or to the full term of the disposition order. Thus, simply living in a different location can dramatically impact how a youth's behavior is addressed.

Views of young people involved in the justice system also have changed substantially over the past few decades. Separation of the justice system into juvenile and adult courts began at the state level in the late 1800s (Commission on Behavioral and Social Sciences and Education, 2001). This movement was based on the recognition that juveniles were developmentally distinct from adults and, thus, should be held to different standards regarding criminal behavior. In addition, juvenile justice was seen as an opportunity to rehabilitate youth rather than solely punish them for criminal behavior. However, during the peak of violent criminal behaviors among youth in the early 1990s, there was a public call for a more punitive approach, with the hope that more severe consequences would lead to decreased recidivism. Unfortunately, this movement has served to suppress rehabilitative approaches for juveniles and has increased the number of youth transferred to the adult justice system. These changes likely compound the barriers to effective services for youth with mental health concerns. Further, transferring youth from the juvenile to adult justice system can lead to poor outcomes for youth, including increased likelihood of arrest for future crimes (Centers for Disease Control and Prevention [CDC], 2007; Schubert et al., 2010). Currently, the juvenile justice system is struggling to find a balance between punishing delinquent acts and providing rehabilitative services in the best interest of the youth (for a review, see Weiss, 2013).

Transition Age Youth in the Juvenile Justice System

Transition age youth involved with the juvenile justice system are examples of “the perfect storm” of the potential perils of this developmental period. First, mental health problems are quite common in this group; however, it should be noted that due to a paucity of research on this age group, the majority of what is known about the prevalence of mental health problems comes from studies of adolescents (i.e., 13- to 17-year-old youth). One study of youth entering nonresidential juvenile justice settings (e.g., probation) estimated

that 45 percent of boys and 50 percent of girls meet diagnostic criteria for at least one mental health disorder (Wasserman, McReynolds, Ko, Katz, & Carpenter, 2005), and studies of residential juvenile justice facilities have shown higher rates, between 65 percent and 70 percent (Shufelt & Coccozza, 2006; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002). Further, even when behavioral disorders (e.g., substance use, conduct disorders) were not considered, 45.5 percent of youth in residential justice settings met criteria for a mental health disorder (Shufelt & Coccozza, 2006).

Similar to non-justice-involved youth, comorbidity rates are high for justice-involved youth, with an estimated 79 percent of youth with one mental health disorder also meeting diagnostic criteria for at least one other disorder, and more than 60 percent meeting criteria for a substance use disorder (Shufelt & Coccozza, 2006). Often, co-occurring conditions predict worse outcomes; for example, youth with co-occurring behavioral problems (e.g., substance use, conduct disorder) and emotional problems (e.g., anxiety, depression) are at elevated risk for recidivism (Cottle, Lee, & Heibrun, 2001; Hoeve, McReynolds, & Wasserman, 2013) and committing violent offenses during young adulthood (Copeland, Miller-Johnson, Keeler, Angold, & Costello, 2007). Given these high rates of mental health and substance use disorders, juvenile justice programs are responsible for a large proportion of youth who have mental health needs, highlighting the importance of effective management and treatment by this system (Coccozza & Skowyra, 2000).

Transition age youth with justice involvement and a mental health disorder often face other roadblocks to the successful negotiation of the transition age period. For instance, youth in the justice system often come from economically disadvantaged, single-parent households (Foster & Gifford, 2005). Successful transitions to adulthood increasingly depend on financial and other material support from families well beyond adolescence (Settersten, Furstenberg, & Rumbaut, 2008), an advantage that many justice-involved youth do not have. In addition, these youth show high rates of learning disabilities as well as a history of school failure. As a group, justice-involved youth tend to have intellectual functioning in the low-average to average range, and many show academic deficits in reading, math, and written and oral language, either due to learning disabilities or lack of educational engagement

(Foley, 2001). In one large study of juvenile offenders ages 10 to 20 in long-term custody settings, almost 20 percent had a specific learning disability, and youth with elevated mental health symptoms were even more likely to have a learning disability (Cruise, Evans, & Pickens, 2011). Justice-involved youth also have high rates of involvement with the child welfare system. More than 60 percent of transition age youth considered “serious offenders” in juvenile detention had a history of child welfare involvement due to child maltreatment (Langrehr, 2011). In another study, 58 percent of youth up to age 19 with mental health problems in the justice system had a family member who was the focus of a child protective services investigation (Sullivan, Veysey, Hamilton, & Grillo, 2007). Overall, youth with a substantiated history of maltreatment have approximately 50 percent more contacts with the juvenile justice system compared with youth without such a history, and approximately 16 percent of youth placed in foster care come into contact with the juvenile justice system (Ryan & Testa, 2005). Rates of juvenile delinquency are even higher among youth placed in group home settings as part of their involvement with child welfare (Ryan, Marshall, Herz, & Hernandez, 2008). Thus, most justice-involved youth with mental health problems have greatly compromised development and lack the “natural” supports for transitioning to adulthood. To facilitate successful adult functioning and reduce the likelihood of recidivism, the juvenile justice system should not only provide mental health treatment but also assess and provide supports for youth’s impending adulthood.

Incarcerated Transition Age Youth and Reentry

Currently, there is substantial variability in outcomes for youth involved in the juvenile justice system. Among youth processed and adjudicated delinquent by the juvenile justice system in 2009, 27 percent were placed in residential settings, 60 percent were placed on probation, and 13 percent received other sanctions (Knoll & Sickmund, 2012). Thus, the majority of youth involved in the justice system are not incarcerated. However, the incarcerated youth make up a significant minority of the juvenile justice population. Many of the estimated 200,000 juveniles and young adults ages 24 and under returning from incarceration each year (Mears & Travis, 2004) will face reentry during their transition to adulthood. For the most part, reentry programs have been developed and studied with adult populations; thus, little is known about their effectiveness with transition age youth

(Farrington, Loeber, & Howell, 2012). Further, the reentry problems faced by transition age youth with mental health problems are likely to be even greater than those seen in adult populations. First, youth often lack the education and skills necessary to find gainful employment. In fact, one study found that only 31 percent of youth were engaged in either school or work 12 months after their release from juvenile correctional facilities (Bullis, Yovanoff, Mueller, & Havel, 2002). This may be due to the low likelihood of having obtained a high school diploma or GED and the lack of opportunity to gain relevant work experiences because of time spent in a locked facility. The situation is compounded by the fact that, upon reentry, these young adults often return to their former neighborhoods and rejoin peer groups that foster criminal behaviors. Incarceration prevents opportunity to develop positive peer groups, which, coupled with the lack of prosocial activities available upon reentry, makes the return to the youth's previous way of life more likely. Further, such youth often lack positive adult role models to guide them through the transition period from detention back into their neighborhoods (Steinberg, Chung, & Little, 2004).

Following reentry, transition age youth display low rates of engagement with community-based services such as mental health treatment and vocational rehabilitation. In one study, only 35 percent of juvenile offenders had been engaged in such services during the six months following reentry (Chung, Schubert, & Mulvey, 2007). Barriers to services include lack of sufficient health care coverage, inability to navigate multiple systems, and, for some youth, lack of service providers in their communities. Further, transition age youth often qualify only for adult-oriented care that is not well suited to meet the developmental needs of youth. Finally, upon reentry, transition age youth often face both the perception and reality of having "fallen behind" their same-age peers in terms of employment, education, and family roles, which can lead to hopelessness about their ability to catch up in these domains.

Successful Transitions from Adolescence to Adulthood for Justice-Involved Youth

Although transition age youth involved in the juvenile justice system are at a great disadvantage compared with their non-system-involved peers, the long-term goals for successful adulthood remain the same. Successful transitions involve some combination of

academic achievement (ranging from attainment of a high school diploma/GED to an associate degree, four-year college degree, or graduate degree); development of vocational skills and acquisition of gainful employment; establishment of stable romantic, peer, and familial relationships; and formation of a sense of self tied to being a productive member of families, neighborhoods, and society. However, the immediate goals for justice-involved youth with mental health problems are often different from many of their peers, with a focus on reducing recidivism, accessing mental health and substance use treatment, obtaining a stable housing situation, and completing justice system requirements. The overarching goal of the systems involved with these youth should be to facilitate the completion of these crucial immediate goals while providing access to resources that will allow for success in overarching goals, including those related to education, vocation, and healthy relationships.

Critical Issues Facing Justice-Involved Transition Age Youth With Mental Health Problems

Transition age youth face a myriad of potential issues with access to services, as they must deal with child-oriented systems, adults systems, and the connection, or lack of, between the two. Involvement with multiple systems is the rule rather than the exception for youth in the juvenile justice system, particularly those with mental health problems. For example, at least one in five youth involved in community-based mental health systems also have juvenile justice involvement (Cauffman, Scholle, Mulvey, & Kelleher, 2005; Rosenblatt, Rosenblatt, & Biggs, 2000; Vander Stoep, Evens, & Taub, 1997). Justice-involved transition age youth are often involved with child welfare, mental health treatment, vocational rehabilitation, substance use treatment, the housing authority, and various educational systems, among others. Although the availability of the various services provided by these systems may be seen as advantageous, the interplay between such systems is often counterproductive and can actually prevent youth from having their needs met. In some cases, services do exist in the community, but youth fail to qualify (e.g., they lack the proper health care coverage; they are too young or too old). At other times, appropriate services are completely lacking in the youth's community. As illustrated by Kimberly's case, navigating these separate systems can be incredibly challenging for a young person, particularly those who lack family support and are experiencing multiple psychosocial problems.

System Involvement

Involvement in a number of these systems is common among all ages involved in the juvenile justice system, but transition age youth also must begin to navigate new systems.

Relevant systems include the following:

- **Child Welfare.** Youth in the justice system often have current or historical involvement with child welfare due to a history of maltreatment or neglect and, in most severe cases, removal from their family of origin and placement with a foster family or in a group home (Malmgren & Meisel, 2004).
- **Special Education.** Youth receive these services, including individualized education programs (IEPs) and alternative school placements, because of learning disabilities, cognitive delays, and/or emotional/behavioral problems that affect their ability to learn. Youth with justice involvement are also at risk for school-related sanctions, including expulsion, due to behavioral problems. These youth are at particularly high risk for school failure, dropout, and lack of access to quality educational experiences.
- **Mental Health Services.** During adolescence, youth with mental health and behavioral problems are often involved with child mental health systems. At age 18, youth may become ineligible for continued care, as behavioral disorders are often not a qualifying diagnosis for adult mental health systems. Adult systems have more stringent qualifying criteria for care, requiring a more severe and debilitating diagnosis than is necessary in the child system. Transition age youth also sometimes face a change or loss in their health care coverage upon reaching an adult age, which can be an additional barrier to care. Even with the pending changes to managed care stemming from the Affordable Care Act (ACA), there will continue to be age-related changes in health care coverage that will affect transition age youth. Although state agencies are required to do outreach to reduce barriers to continuity in coverage for young people, these efforts have not yet been demonstrated to be effective. In fact, such programs aimed at adults with mental health problems have not been successful at ensuring continuity in health care coverage (Capoccia, Croze, Cohen, & O'Brien, 2013); thus, it remains to be seen whether ACA changes will benefit transition age youth with mental health problems. Finally, adult mental health

providers rarely have specialized training on transition age youth. Therapists' high caseloads make it all but impossible to target the unique and high-demand needs of justice-involved transition age youth. Similarly, after youth reach age 18, privacy law protections change in a way that is both helpful to them in protecting their health information and potentially harmful; specifically, adult therapists often fail to engage transition age youth's family members in mental health treatment despite their key role in the youth's well-being (Osgood et al., 2010).

- **Vocational Rehabilitation.** Goals of vocational rehabilitation include creating individualized employment plans; boosting job readiness through education and on-the-job training; and assisting with job seeking, applications, and retention. While all state vocational rehabilitation agencies provide some transition support services, there is wide disparity in intensity, quality, and efficacy. Youth with juvenile justice histories present additional challenges, as they often lack the basic skills necessary to maintain employment, including time management, communicating with authority figures, and professionalism. Many have no past workplace experience, and their interactions with authority figures have been punitive rather than professional. Also, due to high demand for services in many communities, there can be long waiting lists for vocational rehabilitation services as well as inflexible policies regarding appointment attendance that can alienate transition age youth.
- **Independent Housing.** Given barriers to successful employment and self-sufficiency, accessing independent housing is difficult. Public housing applications often cannot be submitted by youth under age 18, and the wait for housing can take multiple years. Further, youth who recidivate and receive a felony conviction can be denied public housing permanently. Although not as common for adjudicated juveniles, some housing authorities have the ability to deny public housing on the basis of disqualifying offenses committed by any family members, including juvenile offenders (Henning, 2004). This can mean that youth are either no longer permitted to live with their families or that their families are no longer able to live in public housing.

Services for Detained and Incarcerated Youth

The lack of access to mental health care among detained and incarcerated youth is well documented. Although this group could be considered a “captive audience” for the delivery of such services, the juvenile justice system is currently not well equipped to provide effective mental health treatment to the large numbers of youth who require it (Steinberg et al., 2004; U. S. Department of Justice, 2005). In fact, a large-scale study found that only 15.4 percent of youth with a major mental health problem received mental health treatment while detained (Teplin, Abram, McClelland, Washburn, & Pikus, 2005). Family involvement in mental health interventions, a factor that is likely to be key factor in successful treatment, is rarely available to incarcerated youth. This likely limits both treatment effectiveness as well as maintenance of gains past the time of incarceration, as the youth return home to their families. In addition, many mental health treatments in correctional facilities are delivered in a group format, which by definition means aggregating delinquent peers, a strategy shown to have an iatrogenic effect on group members due to “deviance training” or the learning of new delinquent behaviors from more deviant peers (Dishion, McCord, & Poulin, 1999). Further, there is often a lack of continuity of care for youth with mental health problems as they transition to treatment providers in the community. After their release, youth face the same barriers to mental health treatment faced by their peers on probation. Thus, although incarcerated youth often are screened for mental health problems (Pajer, Kelleher, Gupta, Rolls, & Gardner, 2007), most enter adulthood without having had access to effective mental health interventions.

Interplay Between Multiple Systems

A potentially wide array of services is available to justice-involved transition age youth with mental health problems. However, as noted, these services often are not well suited to meet this group’s needs. In addition, interacting with multiple systems can be overwhelming to youth, particularly because of the lack of seamless interplay between the systems (Davis, Green, & Hoffman, 2009) and youth’s lack of knowledge about systems with which they previously were not required to interact (e.g., vocational rehabilitation). In addition, there is often a lack of communication between systems, sometimes even between child and adult arms of the same system (e.g., child and adult mental health) (Osgood et al., 2010). This means that goal setting and interventions across agencies can be at odds with

one another. In one study of the role of interagency collaboration between child welfare and juvenile justice, two factors predicted successful coordination of mental health services: (1) having a single agency held accountable for the youth's well-being (i.e., either child welfare or juvenile justice) and (2) interagency sharing of administrative data (Chuang & Wells, 2010). Thus, effective coordination of care and agency accountability are necessary to ensure that youth do not "fall through the cracks." Furthermore, transition age youth are often simply unable to take full advantage of such services because of a variety of practical barriers, including lack of transportation, service systems that are not located in close vicinity of one another, and lack of familial support necessary to follow through on multiple appointments and responsibilities.

Effective Policies and Practices for Youth With Mental Health Problems

Garrett, age 20, is on probation with juvenile justice because of a long history of drug possession charges and probation violations. At age 17, he was diagnosed with bipolar disorder after several episodes of mania during which he took his mother's car, ran away from home, and went on drug and alcohol binges. Since his diagnosis, he has received mental health services from a therapist and psychiatrist housed under one roof at Garrett's local child mental health center. Luckily for Garrett, this center has recently started a young adult program that helps youth transition from the child to adult mental health systems, and his therapist has some expertise with Garrett's age group. Garrett's symptoms have been stabilized through a combination of medication management and counseling. He sometimes misses his appointments; although the clinic does not provide home-based services per se, his therapist has the flexibility to meet with Garrett in his home on occasion, and this has helped him to stick with treatment. In addition, the therapist recognizes the importance of Garrett's relationship with his mother, with whom he lives, and includes her in Garrett's treatment.

Recently, Garrett had a slip-up and took too many pills when he was hanging out with his friends. During this binge, Garrett stole one of his mother's rings and sold it at a pawn shop for money to buy drugs. Garrett wound up in the hospital because his friends were worried that he might have overdosed. Garrett swore that it was accidental and that he just lost track of how many pills he had taken. This incident scared and angered Garrett's mother.

This wasn't the first time that Garrett had ended up in the hospital, and she felt hopeless about her ability to help him. She decided that she didn't want to "enable" Garrett anymore and that she was going to cut him off from all financial support, including her health insurance. She also no longer wanted him in her home. The hospital released Garrett to a friend who offered to let him stay at his place for a while. Fortunately, Garrett's therapist got involved and begged his mother to continue his insurance so that he could continue receiving medication and therapy. Garrett's mother agreed that this would be important for Garrett's safety and continued to provide his health insurance, but no other support.

Garrett spent a significant amount of his adolescence in a juvenile correctional facility and had fallen behind in his education. He wanted a job in the medical field as a nurse or a lab technician, but he had not finished high school. Garrett's probation officer and therapist worked together to try to get him re-enrolled in his local high school, but Garrett wasn't comfortable returning because he was so much older than the other kids. The probation officer then got Garrett enrolled in an adult education program. Garrett didn't like this program either, as he reported it was "full of people who didn't look like him." He also struggled to keep his school materials organized and complete all of his work because he kept moving from one friend's house to the next.

Because of Garrett's bipolar diagnosis, the probation officer knew Garrett would be eligible for vocational rehabilitation services, so the officer arranged an intake appointment. Unfortunately, when the meeting occurred, Garrett was reluctant to admit that he had a mental health condition and answered questions in ways that made him ineligible for services. Garrett's probation officer continued to be persistent. He set Garrett up with a program that paid justice-involved transition age youth minimum wage when they spent hours volunteering at select sites. The probation officer ensured that Garrett got a volunteer slot at a hospital that would provide him with some experience in the medical field. The monetary incentive and work experience were enticing to Garrett, and he was able to build some job experience and get a work reference for his resume. The job also filled his free time and limited his opportunity to spend time with his friends, some of whom continued to get in trouble with the law. Although Garrett no longer had much contact with his mother, the probation officer helped him reconnect with a former teacher whom Garrett had admired.

This teacher became a mentor to Garrett, helped him complete some job applications, and provided some advice about his work behavior. The work program, coupled with Garrett's positive relationship with an adult mentor, continued access to appropriate mental health care, and a persistent and dedicated probation officer, set Garrett up for success in terms of finding a job and becoming a productive adult.

Garrett is another example of a youth facing serious roadblocks to a successful transition to adulthood, including a long history of justice involvement and significant mental health problems. For youth such as Garrett, multiple factors need to be addressed, including housing, mental health care, and education. In his case, Garrett was lucky to have mental health and juvenile justice providers who had knowledge about community resources, experience with transition age youth, and the resources to work together to meet his needs. The majority of justice-involved youth are not as fortunate. Even under the best circumstances, this fragmented system of services can fail transition age youth, and such youth have the capacity to fall through the cracks because of inappropriate services (in Garrett's case, traditional high school and adult education), failure to qualify for services (unwillingness to disclose mental health condition), and lack of family support, among other barriers. There have been some recent efforts to improve coordination of services, but much more needs to be done. In the next sections of this paper, we review what is known about best practices for justice-involved transition age youth with mental health problems and provide suggestions for further development. Although there are few specific policies focused on transition needs of youth in the juvenile justice system with or without mental health problems (Hoffman, Heflinger, Athay, & Davis, 2009), policies that may impact this group are highlighted.

Evidence-Based and Promising Practices and Policies

Unfortunately, there is very little information on evidence-based practices specifically for justice-involved transition age youth with mental health problems. Most of what we know is extrapolated from studies with adult or adolescent justice-involved populations or from studies of mental health treatments in the general population. These approaches may work differently for justice-involved transition age youth with mental health problems, given

the multiple complicating factors that must be addressed. Further, more research attention is needed on treatment of mental health problems in justice-involved populations of all ages. For example, a variety of treatments have been well validated to target delinquency among justice-involved adolescents (e.g., Multisystemic Therapy, Functional Family Therapy; for review, see Henggeler & Sheidow, 2012), but far fewer treatments are specifically designed for transition age youth or to address mental health problems among justice-involved youth from either age group. Thus, we will summarize what is known that may be applicable to transition age youth while identifying areas in need of further investigation and development.

Multisystemic Therapy

Multisystemic Therapy (MST) is a well-established, intensive, community-based treatment for delinquent behavior among justice-involved adolescents (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009). Two adaptations of MST are relevant to this review. First, MST was adapted for justice-involved transition age youth with serious mental health concerns (i.e., Multisystemic Therapy for Emerging Adults [MST-EA]). MST-EA integrates MST principles, evidence-based mental health treatments, and an on-staff psychiatrist for medication monitoring. In addition, MST-EA therapists target concerns relevant to transition age youth (e.g., educational/vocational goals, independent housing). A pilot study found reduced recidivism and mental health symptoms and effective engagement in school, work, or both (Sheidow, McCart, & Davis, 2012), but additional research is needed. Second, Family Integrated Transitions (FIT) is a MST adaptation for youth with co-occurring mental health and substance use disorders transitioning back home from incarceration (Trupin, Kerns, Walker, DeRoberts, & Stewart, 2011). FIT combines MST, dialectical behavior therapy, parent training, and motivational enhancement implemented two to three months prior to release through four to six months after release. A pilot study found reductions in felony (but not overall) recidivism among 12- to 19-year-old youth (Trupin et al., 2011). However, FIT was not designed for transition age youth, rather for justice-involved adolescents with mental health problems who are living with their parents.

Foster Care

Several policies and programs related to foster care are relevant for justice-involved transition age youth. The first is the John H. Chafee Foster Care Independent Living Program, which was expanded under the Foster Care Independence Act (FCIA) of 1999 to provide aid to youth up to age 21 to promote successful transition to independent living. Funds can be used for support services, including housing; educational, vocational training; and mental health treatment (Foster & Gifford, 2005). Thus, youth-serving professionals should be aware of how to access these funds in their states. It should be noted, however, that states have had difficulty providing comprehensive and well-coordinated services under this program because of limitations in available federal funds (Collins, 2004). Second, Multidimensional Treatment Foster Care (MTFC) is home-based family treatment developed for youth involved with child welfare as an alternative to group homes and residential settings (Chamberlain, 2003). MTFC utilizes specialized foster homes where caregivers are well trained and supported to handle delinquent behaviors, as well as coordination of care for individual and family therapy, educational programming, skills training for youth, and psychiatric care if needed. MTFC has shown effectiveness in reducing delinquent behaviors, justice system contacts, substance use, and teen pregnancy with adolescent populations (up to age 17) (Chamberlain, Leve, & DeGarmo, 2007; Leve, Chamberlain, Smith, & Harold, 2012; Smith, Chamberlain, & Eddy, 2010). MTFC has not been evaluated with transition age youth. However, given the extension of foster care services through the transition age, MTFC may prove to be useful for this group.

Wraparound Services

Wraparound services use a system of care philosophy, emphasizing the importance of maintaining youth in the least restrictive environment through intensive coordination of multiple services (Bruns et al., 2004). The Connections program in Washington state is one of the most rigorously studied wraparound programs for youth with mental health problems (Pullman et al., 2006). Each family is assigned to a team of professionals, including a mental health care coordinator, probation counselor, family assistance specialist (for emotional support, practical assistance), and a juvenile services associate (for mentoring, aiding with completion of the treatment plan). Youth in this program were less likely to recidivate in general and have a felony offense in particular, and they served less detention time than

comparison youth (Pullman et al., 2006). Other similar programs also have shown promising findings for reducing recidivism (Anderson, Wright, Kooreman, Mohr, & Russell, 2003; Kamradt, 2000), though one program produced positive effects on educational outcomes and police contacts but not on arrests or incarceration (Carney & Buttell, 2003). Interestingly, evaluations of these programs have not focused on mental health outcomes. Further, there have not been evaluations of wraparound services specifically for transition age youth.

Diversification Programs

Similarly, there has been research on a multitude of diversion programs for juvenile offenders, though not specifically for transition age youth (for a review, see Chapin & Griffin, 2005). Diversion programs provide alternatives to formal justice system sanctions, typically for first-time offenders, and often provide treatment in lieu of punishment. A recent meta-analysis failed to find a link between these programs for general juvenile justice system populations and a significant reduction in recidivism, even among diversion programs specifically for mental health needs (Schwalbe, Gearing, MacKenzie, Brewer, & Ibrahim, 2012). However, evidence-based interventions for adolescent delinquent behaviors, such as MST and Functional Family Therapy, were rarely included as part of the programs' diversion plans; when they were included, results were promising. Thus, diversion programs may be an effective tool when evidence-based treatments are available in the surrounding communities. These findings highlight the need to develop and disseminate effective treatments that can serve as viable diversion options specifically for transition age youth. Furthermore, diversion programs can effectively reduce the amount of time spent in locked settings, a known contributor to developmental delays in this age group (Chung et al., 2005). For these reasons, diversion programs tailored to meet the needs of transition age youth with mental health problems should be developed and examined as alternatives to formal sanctions.

Reentry and Aftercare Programs

A variety of reentry and aftercare programs have been developed for justice-involved youth, with a few designed specifically for transition age youth. Such programs are initiated either during the transition from incarceration to the community or soon after reentry, and

they aim to reduce recidivism through provision and coordination of services. In a meta-analysis of such programs for justice-involved adolescents and young adults (but not specifically youth with mental health needs), a small but positive effect on recidivism was identified (James, Stams, Asscher, De Roo, & van der Laan, 2013). Interestingly, results suggested a particular benefit for older youth compared with younger youth. Two of the reviewed programs were designed specifically for transition age youth. The Boston Reentry Initiative (BRI) involved individualized transition plans (e.g., acquisition of housing and employment, continuation of mental health treatment) as well as frequent contact with a mentor for ensuring program success (Braga, Piehl, & Hureau, 2009). BRI lowered re-arrest rates among young adults (18 to 32) with violent criminal histories. The second program, Lifeskills'95, also incorporated developmentally appropriate services, including job training and educational resources, skills training, and substance use services delivered through weekly meetings (Josi & Sechrest, 1999). Lifeskills'95 was superior to usual services on measures of recidivism, employment, substance abuse, and family relationships among youth aged 16 to more than 22. Although promising, these programs have not been tested within the juvenile justice system or specifically with youth with mental health needs.

A promising reintegration program that has been evaluated for adolescents is Multidimensional Family Therapy–Detention to Community (MDFT-DTC) (Liddle, Dakof, Henderson, & Rowe, 2011). MDFT is a family-based intervention originally designed for treatment of adolescent substance use (Little, Dakof, & Diamond, 1992). The DTC adaptation extended the MDFT model to justice-involved youth with substance abuse and related emotional or behavioral disorders. In a pilot study, MDFT-DTC showed promising results in terms of feasibility, implementation, and treatment engagement and retention (Little et al., 2011). It should be noted, however, that MDFT-DTC's family focus may preclude it from being effective for transition age youth, particularly those with strained or nonexistent relationships with parents.

Coordination of Care Programs

Given the wide array of services that youth must navigate, improving coordination of care and linkage to services is important. Although coordination of care is often included as

part of reentry and aftercare programs following incarceration, surprisingly few programs provide coordination services to justice-involved youth who are sentenced to probation. However, one such program, Project Connect, aims to link juvenile probationers with mental health and substance use services (Wasserman et al., 2009). Features include cooperative agreements between probation and mental health, facilitated mental health referrals, systematic mental health screening, and training for probation officers. In a sample of young probationers (mean age 14), this program successfully increased access to mental health services (Wasserman et al., 2009). Although it has been studied only with adolescents, Project Connect serves as an example of how to increase interagency collaboration, an outcome that is sorely needed for transition age youth.

Domain-Specific Services

In addition to programs developed specifically to meet the needs of justice-involved youth, there are some effective programs developed within specific domains relevant to youth with mental health needs. It is likely that none of these interventions alone will be sufficient to ensure a successful transition to adulthood for justice-involved youth, and coordination and individualization of such services will be needed to ensure effectiveness. However, they represent what could be the building blocks of successful programming for justice-involved transition age youth.

Mental Health Treatment

Few mental health treatments have been adapted specifically for transition age or justice-involved youth. A review of evidence-based treatments for behavioral and mental health problems for justice-involved youth has been completed by Sukhodolsky and Ruchkin (2006). As they note, very little is known about the effectiveness of evidence-based mental health treatments in justice settings, and such treatments are rarely available to justice-involved youth. Although this may reflect barriers to disseminating evidence-based treatments in general, the justice system presents unique challenges, including treatment of youth with multiple problems (e.g., delinquent behaviors, substance use) often not addressed in treatment for single disorders.

By definition, justice-involved youth with mental health problems have multiple problems, and the provision of an evidence-based treatment designed for single disorders is unlikely to be sufficient in ensuring a successful transition to adulthood. The Comprehensive Community Mental Health Services (CCMHS) for Children and Their Families Program, administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the U.S. Department of Health and Human Services, aims to address this issue among youth (up to age 21) with mental health problems (SAMHSA, 2010). CCMHS's goal is to coordinate systems of care for youth with mental health problems. In a large-scale evaluation, CCMHS improved functional impairment, school performance, mental health service utilization, arrest rates, and delinquent behaviors (SAMHSA, 2010). Importantly, 57 percent of these youth had conduct problems or delinquency, lending support for CCMHS's potential effectiveness for justice-involved youth. Evaluations of communities implementing CCMHS have shown increased availability of evidence-based mental health services and improved service delivery systems. Thus, CCMHS is a viable community-level intervention that could increase access to effective mental health care for youth.

SAMHSA also has funded demonstration programs focused on transition age youth. In 2002, the Partnerships for Youth Transition program funded five sites to develop transition support systems for youth (up to age 24) with serious emotional disturbance. Participants in this cross-site evaluation showed moderate improvement in employment and education outcomes, but mixed results for justice system involvement and substance use (Haber, Karpur, Deschenes, & Clark, 2008). Another program, the Emerging Adult Initiative, emphasized greater system change and policy work and funded seven sites in 2009. Because this program is still underway, outcomes are not yet known, but a preliminary report suggests positive results (SAMHSA, 2013). As the goal of these grants is to improve system coordination for this age group, including connections to adult services, these may develop into resources for transition age youth with mental health needs in the juvenile justice system.

Substance Use Treatment

Substance abuse is the most common co-occurring problem in this population, and there are a handful of substance use treatments with a strong evidence base for adolescents and for adults. These include family-based treatments, contingency management, motivational interviewing, and cognitive behavioral approaches (Kaminer & Burlison, 1999; Martino, Carroll, O'Malley, & Rounsaville, 2000; Steinberg, Ziedonis, Krejci, & Brandon, 2004; Waldron & Kaminer, 2004; for review, see Waldron & Turner, 2008). Less is known about the effectiveness of these treatments for transition age youth, particularly those with co-occurring mental health problems (Sheidow, McCart, Zajac, & Davis, 2012). For example, although family involvement has been shown to be an important predictor of positive treatment outcomes in adolescent samples, it is less clear how to involve families in developmentally appropriate ways for transition age youth. Further, among youth with co-morbid mental health problems, an integrated approach to mental health and substance use treatment is recommended.

Educational and Vocational Supports

The Individuals with Disabilities Education Act (IDEA) has important implications for youth with special education needs. IDEA-mandated individualized education programming requires transition planning for higher education and employment, including goal-setting; assessment; and services related to postsecondary school education, employment, and independent living skills. Further, special education services can continue for youth through age 21 who are seeking a diploma. However, transitional services are not consistently and effectively implemented and can be poorly suited for youth who qualify for special education for emotional or behavioral disorders (Geneen & Powers, 2006; Wagner & Davis, 2006).

Although there are no evidence-based interventions to support postsecondary education for transition age youth with psychiatric disabilities (Rogers, Kash-MacDonald, & Maru, 2010), some programs have been developed to support secondary education. For example, Check and Connect aims to increase students' educational engagement through systematic monitoring of academic performance; building of individualized problem-solving skills; and provision of a trained mentor who partners with the family, school, and community. In a pilot study, Check and Connect reduced dropout and improved school

performance of secondary students with emotional disturbance (Sinclair, Christensen, & Thurlow, 2005). It is currently undergoing testing in a larger clinical trial. The Jump On Board for Success (JOBS) program provides developmentally tailored wraparound services (VanDenBerg & Grealish, 1996) focused on career development. JOBS specialists coordinate wraparound care and supported employment for youth aged 16 to 22 with serious emotional disturbance who are served in the children's system or adult corrections (Clark, Pschorr, Wells, Curtis, & Tighe, 2004). Participants increased engagement in school and/or competitive employment from 23 percent at baseline to 96 percent at graduation (Clark et al., 2004). Finally, Individualized Placement and Support (IPS) is an evidence-based employment intervention for adults with mental illness. Across four studies, individuals receiving IPS had almost double the employment rate and about three times the number of weeks with employment compared with controls (Bond, Drake, & Becker, 2012). There were some caveats, however. Young adults in IPS were not employed for most weeks, and the average number of weekly work hours was still fewer than 20. Thus, although IPS is more effective than usual services, outcomes were well below a desirable amount of work.

Another resource, *Guideposts for Success*, is an evidence-informed handbook developed by the National Collaborative on Workforce and Disability for Youth (2005) to provide guidance on support services for transition of youth with disabilities from school to work. The guideposts are developmentally appropriate for transition age youth, including work-based experiences, youth empowerment, family involvement, system linkages, and Social Security Administration waivers and benefits counseling. In a multisite evaluation of *Guideposts for Success*, youth in programs that delivered more hours of employment services had significantly more work hours and higher wages than control groups. However, there were no significant differences between participants of *Guideposts for Success* and the control group at the one site that targeted youth with serious emotional disturbances (Wittenburg, Mann, & Thompkins, 2013), highlighting the need for additional research.

Currently, the National Institute on Disability and Rehabilitation Research (NIDRR) funds two research and training centers relevant to justice-involved transition age youth: one focuses on educational and vocational supports for transition age youth with serious mental health concerns (<http://labs.umassmed.edu/transitionsRTC/>), and the other is focused

broadly on interventions to promote successful transitions to adulthood for youth with mental health problems (<http://www.pathwaysrtc.pdx.edu/>). These federal initiatives are an acknowledgement of the importance of research on and services for transition age youth with mental health problems. Furthermore, these centers have developed and begun to evaluate interventions for this age group (e.g., MST-EA described previously). Currently being evaluated, the Thresholds Young Adult Program is a transitional living program for youth aged 16 to 21 that provides educational, vocational, case management, and mental health services while encouraging independent living skills (Transitions RTC, 2012). This model is augmented by peer mentors, same-age support persons who provide guidance and support related to vocational activities. The Better Futures Program focuses on coordination of care across multiple systems through the use of individualized coaching, peer support, and connection to community resources to support postsecondary education among transition age youth with serious mental health conditions in foster care (Pathways RTC, 2013). An evaluation of this program is underway.

Health Care

For many youth, the justice system provides their first access to much-needed health care (Golzari, Hunt, & Anoshiravani, 2006; Rogers, Pumariega, Atkins, & Cuffe, 2006). Further, transition age youth are at particular risk for insufficient health care coverage. Thus, medical care is an additional consideration in the maze of service needs for justice-involved youth. This is particularly important because this population has high rates of risky sexual behaviors, which in turn increases risk for sexually transmitted infections (STIs). In fact, transition age youth have the highest rates of new HIV diagnoses, the worst treatment engagement and retention, and the poorest adherence to medication regimens (Braithwaite et al., 2005; MacDonell, Naar-King, Murphy, Parsons, & Harper, 2010; Metsch et al., 2008). Young adults with chronic health conditions not only must negotiate the transition to adulthood but also frequently must face significant transitions in care as they become less dependent on their parents' involvement, shift from pediatric to adult care settings, and face the loss of health care coverage (MacDonell et al., 2010).

Physical health resources for incarcerated youth are different from those for justice-involved youth in the community. Many youth who have Medicaid coverage prior to incarceration are unenrolled upon arriving at the facility. This can be problematic, as re-enrolling is a difficult process in some states. Incarcerated youth also present with significant health needs, including chronic medical conditions and high rates of STIs (Bradley & Kalfs, 2003; Feinstein et al., 1998; Mertz, Voigt, Hutchins, & Levine, 2002). The large majority of juvenile correctional facilities provide health screenings at admission and access to psychotropic medication management within the facility (Pajer et al., 2007). Reentry planning is needed to ensure continuation of medical treatments and access to health care upon leaving the facility.

Housing and Transportation

Obtaining and maintaining independent housing poses a significant challenge for many transition age youth. Justice-involved youth often have not had the opportunity to develop independent living skills and lack the family support that many of their non-justice-involved peers receive during this transition. For low-income youth, housing subsidies are in short supply and have long waiting lists. One solution is for juvenile justice or mental health agencies to develop collaborations with public housing agencies to allow rapid access to housing options and assistance (Koyanagi & Alfano, 2013). Transportation barriers are similar to those for housing. Systems that justice-involved youth must access require that youth are mobile and can attend multiple weekly appointments. There is no guarantee that service providers are located in close proximity to one another. Youth often lack the financial resources to have independent transportation and must rely instead on family members, friends, or public transportation. This barrier is even more pronounced in rural areas where distances between service providers can be great, and public transportation is not available. There are currently no known programs or policies addressing these important problems.

Pregnancy and Parenting

High rates of risky sexual behaviors also put justice-involved females at risk for pregnancy and early parenthood. In a study of female adolescents (ages 13–17) involved in both the juvenile justice and child welfare systems, between 22 percent and 30 percent

reported a pregnancy during their lifetime (Kerr, Leve, & Chamberlain, 2009). This number undoubtedly increases as youth reach transition age, with a larger number of young women becoming parents. Researchers have recognized the need for gender-specific programming in the juvenile justice system to address needs related to pregnancy and parenting (Bloom, Owen, Deschenes, & Rosenbaum, 2002), but evidence-based programs are not currently available.

For youth with a mental health diagnosis, parenting can be an overwhelming task, and intensive services are often necessary to ensure support for the youth and her child. One such program is the Nurse-Family Partnership (NFP), an evidence-based home visitation program that provides services during and following pregnancy for low-income, first-time mothers (for a review, see Olds, 2006). NFP has been shown to improve both the mother's care of her child and her own well-being, generates significant reductions in subsequent pregnancies, and generates greater vocational success. More recently, an augmentation of NFP for mothers with mental health problems (i.e., depression, partner violence) has been developed but has not yet been evaluated (Boris et al., 2006). Although NFP has not been evaluated with justice-involved mothers, it has the potential to be a helpful tool in the arsenal of programs for this group.

Policy and Practice Recommendations

Justice-involved youth with mental health problems are at a serious disadvantage as they navigate the transition from adolescence to adulthood, a period that can be challenging even without the significant barriers faced by this group. Current policies and programs are not sufficient in addressing the needs of these youth and, in some cases, put them at greater risk for continued mental health problems, recidivism, and a failure to transition to productive adult roles. Thus, substantial reform is necessary to ensure the success of such youth. As suggested by others, an overarching recommendation is that federal policies, including IDEA and the Chaffee Act, are fully implemented in the juvenile justice system (see Gagnon & Richards, 2008; Koyanagi & Alfano, 2013). Most of the policies relevant to juvenile justice are at the state rather than federal level; however, two federal programs provide funding that can be used by juvenile justice programs: federal block grants and Title V Local

Community Prevention Incentive Grants. Federal block grants currently only fund programs for youth up to age 18, precluding their use for transition age youth in juvenile justice systems beyond age 18. It is strongly recommended that federal block grants, as well as other federal policies that set upper age limits of 18 for “child” programs, extend the upper age limit minimally to age 21, and ideally to age 25. The Title V Local Community Prevention Incentive Grants program is not age restrictive but is highly competitive, making it difficult for many local programs to secure this funding.

Clearly, additional funding streams must be identified in order to support programs for this age group, and federal policies affecting this population must be fully implemented. In addition, this section of our review offers nine suggestions for policies to promote systemic reform of the multiple systems currently serving this complex group of youth.

Recommendation 1. Rehabilitation Versus Punishment

There is a continued need to encourage a rehabilitative, rather than punitive, approach in the juvenile justice system in general and, further, to extend this approach to transition age youth. The abrupt change from rehabilitation to punishment on or around the 18th birthday is arbitrary and has not been effective at deterring future crime. Policymakers are encouraged to extend programs for juvenile justice to cover the full range of the transition to adulthood (through age 25), as youth in this age group are likely to be developmentally more similar to adolescents than adults. In addition, specific policies should be made for the young adults in this age group; it is recommended that these policies take a rehabilitative approach similar to the juvenile justice system while incorporating age-appropriate supports, including educational supports, and vocational supports, and mental and substance use treatment.

Several states have implemented specific programs for youth between mid-adolescence to young adulthood within their criminal justice systems. The following are two such examples:

- In South Carolina, the Department of Corrections has established a Division of Young Offender Services to comply with the South Carolina Youthful Offender Act. Youth

under age 25 are eligible for Young Offender programs, which take a rehabilitative approach and allow for less severe sentencing compared with adult criminal justice system processing. Such programs offer access to specialized intensive probation officers who aid in coordination of care, mental health and substance use services, and educational/vocational supports. Although this program encompasses many of the policy recommendations related to this age group, it is fairly new and evaluations are needed to determine its efficacy. Additional information can be found online (<http://www.doc.sc.gov/pubweb/programs/young.jsp>).

- In 2009, Colorado expanded its Department of Corrections' Youthful Offender System (YOS) to include 18- and 19-year-olds. The YOS program had formerly been for youth ages 14–17 who had been sentenced as adults. Program components include annual staff training on issues specific to this age group, mental health services, and specific programming for female youth. A recent evaluation of this program has found high completion and encouraging recidivism rates (Colorado Department of Public Safety, 2012).

Recommendation 2. Mandatory Transition Planning in the Juvenile Justice System

Transition planning should be a required element for youth ages 16 or older who are involved in the juvenile justice system. The majority of these youth will require some specialized supports as they transition to adulthood. Transition planning is already a requirement for youth who receive special education services and those in foster care (through the Fostering Connections Act), and the educational and child welfare systems have models for how to implement such planning. These plans should include provisions for smooth transitions from child to adult systems of care (e.g., mental health) and also assess and plan for needs in key areas crucial to success in adulthood (e.g., education, vocation, community participation). It is recommended that these plans be integrated with any transition plans already in place for youth in foster care and/or special education services, and that stakeholders from key community agencies (e.g., mental health, child welfare, vocational rehabilitation, school districts) have input in transition planning. Specifically, coordination with other relevant systems should be attained through memoranda of

understanding (MOUs) to achieve the commitment needed for ensuring services that prevent recidivism and promote young-adult functioning.

Policies should be developed requiring transition planning for the juvenile justice system that is modeled on the requirements set forth in the IDEA but with more frequent review and updating of the plan. IDEA is comprehensive, as it requires annual updates, involvement of the family, transition goal setting as youth leave the school system, and linkages to the programs that will help them continue with those goals. It also requires participation of the state agencies that will implement the plan after youth leave high school. A potential area of concern is how to link youth effectively with community services and how to ensure that these agencies are held responsible for the youth's care. One compelling example of how to coordinate care between service systems can be found in an annual report from the U.S. Government Accountability Office (2008) in regards to transition planning for young adults with serious mental illness.

Recommendation 3. Coordination of Care Across Service Systems

There is a clear need for improvements in collaboration and coordination of care among the many service systems involved with transition age youth with mental health problems in the juvenile justice system. Adult service systems, including adult mental health and vocational rehabilitation, must be included. Policies aimed at improving coordination of care should hold agencies accountable for youth outcomes related to the services they are provided, so as to ensure youth do not fall through the cracks and are meeting the goals of each system. The most pervasively practiced model of coordination of care for youth with mental health conditions is the wraparound approach described above, though not all wraparound teams place such emphasis on the juvenile justice population and its needs. Policies that support full implementation of wraparound, extend wraparound to age 21, and require relevant agency involvement in the oversight of the wraparound team and presence on the local wraparound committee should facilitate care coordination. A practice model for coordination of care is Project Connect, also described above, though this program would need careful modification to meet the needs of transition age youth.

The Los Angeles County Department of Mental Health (LACDMH) implements a program that presents another example of coordinating services between juvenile justice and mental health systems. LACDMH provides a range of mental health and supportive services for transition age youth ages 16 to 25 with serious mental health problems and identifies youth aging out of the juvenile justice system as a priority population. In addition to mental health treatment, services include system navigation teams of mental health and housing specialists who guide youth through the various human services systems, as well as supports related to housing, juvenile justice aftercare, and drop-in centers where youth can access peer support and vocational/educational services. It has not been examined empirically, but more information can be found online (http://dmh.lacounty.gov/wps/portal/dmh/our_services).

Tennessee's Department of Children's Services (DCS) developed a practice model to coordinate care across the juvenile justice and child welfare systems that aimed to unify the competing perspectives and philosophies of these youth-serving systems in the state while balancing community safety issues with youth development and welfare (see Altschuler, Stangler, Berkley, & Burton, 2009 for more details). For juvenile-justice-involved youth, the results of this model were an increased focus on family-centered practices and increased coordination of care. Although this policy change has not been formally evaluated, it stands as a model for integration of two systems relevant to justice-involved transition age youth.

A care coordination policy example is the state of Connecticut, which has a consolidated child agency (containing juvenile justice, child welfare, and child mental health systems) and has developed a MOU that describes the process of linking young people receiving services in the children's system to adult mental health services. This MOU defines the application process that young people must follow to request adult mental health services, designating financial responsibilities for services identified in the transition plan. It also requires the children's system to designate a transition coordinator for each youth and to identify youth populations who do not meet adult services criteria but who still may receive services through the adult system's Young Adult Services Division, which serves 18- to 25-year-olds (<http://www.ct.gov/dmhas/cwp/view.asp?q=334784>).

Whenever possible, service systems should be condensed either under one roof or in close physical vicinity to one another. Transition age youth face many barriers to receiving services and, given the multiple systems with which they come into contact, increasing the convenience of attending appointments can go a long way toward improving engagement with services. An alternative to this is allowing service providers the flexibility to meet with youth in the youth's home or community.

Recommendation 4. Availability of Evidence-Based Mental Health Treatments and High-Quality Services

One commonly cited barrier to offering evidence-based mental health treatment is lack of health care coverage, although there are expectations that the ACA will address this problem. Many provisions in the ACA should increase availability of coverage for young adults in general. However, there also are reasons to be skeptical about the effectiveness of such reforms, at least for transition age youth with substantial mental health morbidity. Each step of preventing disenrollment or obtaining alternative health care coverage requires individuals to engage in the application process, which may be a substantial barrier for this group. Indeed, studies of health care reform in Massachusetts have found increased enrollment for young adults in Medicaid and through health care exchanges (Gettens, Mitra, Henry, & Himmelstein, 2011; Long, Yemane, & Stockley, 2010) but worse enrollment among adults with behavioral health problems (Capoccia et al., 2013). Thus, the effects of ACA on access to health care coverage should be closely monitored among vulnerable youth such as those we focus on here; if compromised, efforts should be made to improve access to care for this group.

Improving access to and coordination of care and linkage to services are important but will only be effective if high-quality mental health services are available in the community with which to link youth. Local mental health agencies should train providers to work with transition age youth, and, when possible, specialized caseworkers and mental health providers should be available for this age group.

Recommendation 5. Training for Professionals Who Work With Transition Age Youth

Professionals who work with transition age youth with mental health problems must be trained on the specific needs of this population. This is true for juvenile justice, mental health, and vocational rehabilitation systems. Services provided by adult or child systems of care often are not appropriately tailored to meet the unique needs of this age group. When there is a large enough pool of justice-involved transition age youth in a given area to sustain it, it also is recommended that there be a specialized group of probation officers who are trained to work with transition age youth and who are knowledgeable about the age-specific services available for youth in the surrounding areas.

We are unaware of training opportunities specifically for those working with justice-involved transition age youth with mental health problems; however, there are various training sources that focus on this age group's mental health needs, disabilities, or foster care. The Transitions RTC (<http://labs.umassmed.edu/transitionsRTC/index.htm>) and the Pathways RTC (<http://www.pathwaysrtc.pdx.edu/>), two rehabilitation research and training centers, offer a variety of training materials and technical assistance on the service needs of transition age youth with mental health problems. In addition, some state or local departments of mental health have developed training resources for professionals working with transition age youth, as follows:

- The Youth and Family Training Institute was formed to assist Pennsylvania's Department of Public Welfare's Office of Mental Health and Substance Abuse Services Children's Bureau (<http://www.dpw.state.pa.us/>) in bringing High Fidelity Wraparound to the Commonwealth (<http://www.yftipa.org/>). This institute offers training for professionals in preparing youth for the transition to adulthood.
- As part of its Mental Health Services Act, California developed a plan to address workforce training deficits in, among other topics, transition age youth (<http://oshpd.ca.gov/LawsRegs/MHSAWETFiveYearPlan.pdf>).
- The National Collaborative on Workforce and Disability offers a variety of workforce training opportunities (<http://www.ncwd-youth.info/professional-development>) and provides a library of resources on the transition process that can orient staff to the issues facing this age group.

- Finally, the Jim Casey Youth Opportunities Initiative (<http://jimcaseyyouth.org/browse-resources/practice-tools>) provides numerous reports related to the transition to adulthood for youth in foster care.

Recommendation 6. Additional Research and Program Development

Additional research and program development focused on mental health treatments and transition services is needed specifically for transition age youth in juvenile justice settings. Current programs for adolescents and adults can be used if carefully adapted for this age group, but thorough evaluations of the efficacy of such programs are sorely needed. Transition age youth have specific needs related to the transition to adulthood that are unique to this developmental period.

Recommendation 7. Assessment of a Wider Range of Transition-Related Outcomes

The majority of existing programs have primarily focused on outcomes related to recidivism and have neglected other important outcomes for this group, including mental health and vocational/educational outcomes. Assessments of these outcomes further into adulthood also are needed. Without examining adult outcomes (i.e., up to five years after aging out of the juvenile justice system), it is unclear whether programming is actually working. Related to Recommendation 3, coordinating with other systems to assess outcomes important to those systems (mental health, education) will help share the burden of these evaluations while helping to hold individual agencies accountable for their priority aims. The development of MOUs with other state agencies can help assess these further into adulthood.

Recommendation 8. Smaller Caseloads

The high caseloads seen across the multiple systems serving transition age youth preclude the individualized intensive services often required for justice-involved youth with mental health problems. This problem can be seen among mental health providers, juvenile justice probation officers, child welfare case managers, and vocational rehabilitation providers. Without an increase in the time allocation for these complex cases, it will be difficult for youth to receive the level of service they require.

Recommendation 9. Promotion of Appropriate Involvement of Families

As youth transition to adulthood, they often require the support of their family; however, family involvement is likely to decrease as youth progress through this developmental period. The aim should be to move youth progressively into “the driver’s seat” while encouraging support from family members. This is likely to be a helpful framework across all systems, including juvenile justice, mental health, vocational rehabilitation, and child welfare.

Conclusion

Youth with both juvenile justice involvement and mental health problems are a vulnerable group, particularly during the transition from adolescence to adulthood. The multiple problems faced by such youth present barriers to meeting the normative developmental milestones of this age, including vocational and educational success, development of stable relationships, and maturation into productive adults. Current policies and practices in the juvenile justice system are not well suited to meeting the multiple needs of these youth and, at times, can exacerbate existing problems. However, given the high prevalence of youth with mental health problems involved with the juvenile justice system, providers and policymakers have the opportunity to impact a large number of vulnerable youth through the implementation of effective programming in this system.

Substantial changes in the juvenile justice and mental health systems will be required to ensure successful transitions to adulthood for this group. An overarching theme of this review is the need for developmentally appropriate policies and interventions. An effective approach will take into account factors that differentiate this age group from both adolescents (e.g., less family involvement, greater focus on developing vocational and independent living skills) and adults (e.g., continued brain development, transitions between systems of care). At the same time, effective coordination of the various systems that transition age youth must navigate is key to overcoming barriers to the access of such services, and providers must be well versed in the specific needs of transition age youth. Although policies and programs that support the principles discussed in this review are currently rare, initiatives have been developed and implemented that target some aspects of

this problem in various jurisdictions. It is our hope that the discussion and examples provided here can serve as a springboard for continued policy and program development for transition age youth with mental health problems in the juvenile justice system.

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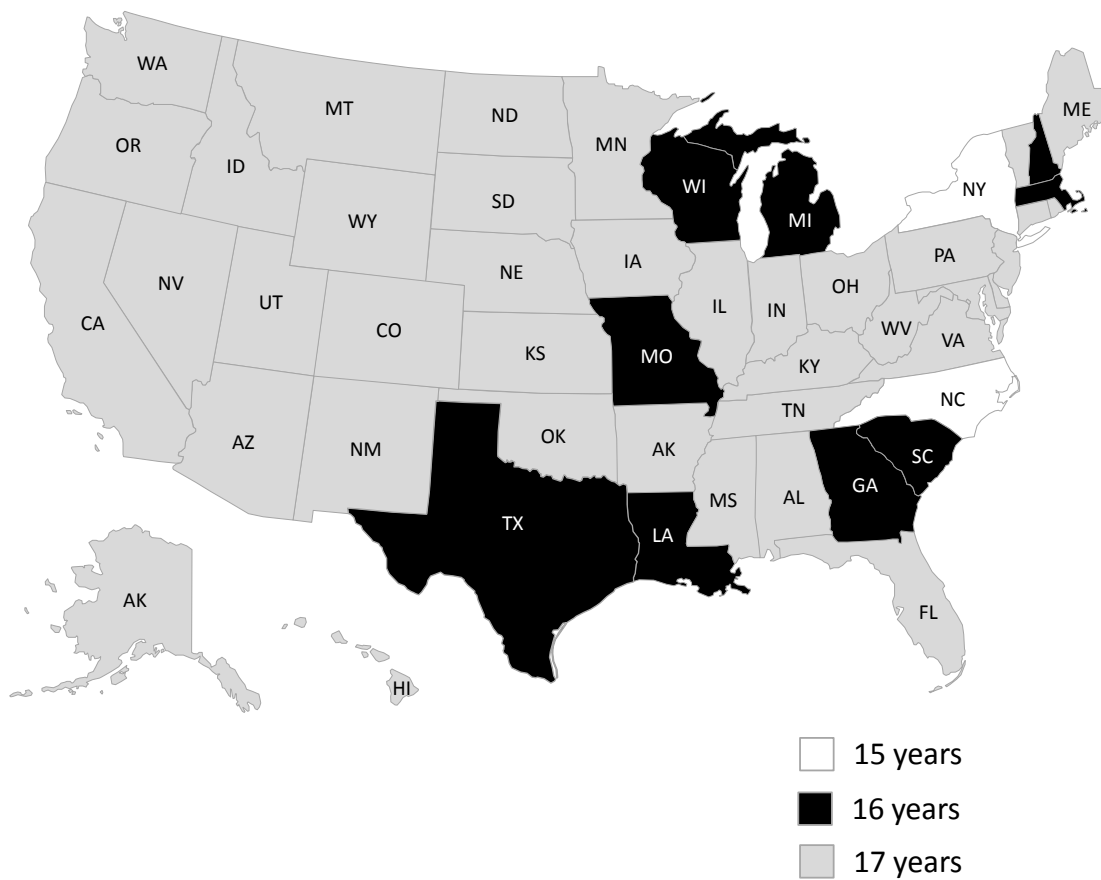
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Figure 1. Upper Age of Original Juvenile Court Jurisdiction, 2013



Source: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. (2012). *Statistical Briefing Book*. Retrieved from http://www.ojjdp.gov/ojstatbb/structure_process/qa04101.asp?qaDate=2011

Table 1. Extended Age of Juvenile Court Jurisdiction, 2011 (OJJDP, 2012)

State	Through Age 18	Through Age 19	Through Age 20	Through Age 21	Through Age 22	Through Age 24	Full term of disposition order
Alabama			X				
Alaska	X						
Arizona*			X				
Arkansas			X				
California						X	
Colorado							X
Connecticut			X				
Delaware			X				
District of Columbia			X				
Florida				X			
Georgia			X				
Hawaii							X
Idaho			X				
Illinois			X				
Indiana			X				
Iowa	X						
Kansas					X		
Kentucky	X						
Louisiana			X				
Maine			X				
Maryland			X				
Massachusetts			X				
Michigan			X				
Minnesota			X				
Mississippi		X					
Missouri			X				
Montana						X	
Nebraska	X						
Nevada**			X				
New Hampshire			X				
New Jersey							X
New Mexico			X				
New York			X				
North Carolina			X				
North Dakota			X				
Ohio			X				
Oklahoma	X						
Oregon						X	
Pennsylvania			X				
Rhode Island	X						
South Carolina			X				
South Dakota			X				
Tennessee							X
Texas	X						
Utah			X				
Vermont				X			
Virginia			X				
Washington			X				
West Virginia			X				

Wisconsin
Wyoming

x

x

Source: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. (2011). *Statistical Briefing Book*. Retrieved from http://www.ojjdp.gov/ojstatbb/structure_process/qa04106.asp?qaDate=2011. Released on December 17, 2012.