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Evidence-Based Practices Brief

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COMMISSION ON LAW ENFORCEMENT
AND CRIMINAL JUSTICE

Nebraska’s Community-based Aid Mental Health Services

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Mental Health and the Juvenile Justice System

Research finds that mental health symptoms are prevalent amongst youths in the juvenile justice system (Teplin et al. 2015), with clinical prevalence rates as high as 70% (Vincent et al., 2008), compared with an estimated 9 to 22% of the general population (Shubert & Mulvey, 2014). Studies have found that the prevalence rates of mental health disorders increases at each juvenile justice system point—with prevalence rates lowest when examining youth at intake (e.g., probation or family court) and becoming greater as we examine later system points, such as diversion (Wylie & Rufino), detention, and post-adjudicatory correctional facilities (Wasserman et al. 2010).

While a significant proportion of youths in the juvenile justice system experience mental health problems, the relationship between mental health and involvement in the system is complicated because it is difficult to disentangle correlational and causal relationships between the two (Shubert & Mulvey, 2014). As Shubert and Mulvey articulated, “**many youths who offend do not have a mental health problem, and many youths who have a mental health problem do not offend**” (2014, p. 3).

MENTAL HEALTH SYMPTOMS

Non-Justice | Diversion | Probation | Detention

The prevalence rates of specific mental health disorders are broadly categorized as internalizing disorders and externalizing disorders (Cosgrove et al., 2011).

- **Internalizing disorders** have the propensity to express distress inwards including: mood disorders (e.g., bipolar and related disorders, depressive disorders, anxiety disorders), trauma- and stressor-related disorders (e.g., posttraumatic stress disorder, adjustment disorder)
- **Externalizing disorders** have the propensity to express distress outwards including: substance-related and addictive disorders, disruptive/impulse control/conduct disorders, and neurodevelopmental disorders (e.g., intellectual disabilities, attention deficit/hyperactivity disorder, and autism spectrum disorders).

Criminogenic Risk Factors

Earlier research in this area often indicated a relationship between mental health problems and delinquency, but did not measure the underlying mechanisms that could explain this relationship. Recent research sought to understand whether mental health problems explained delinquency, even while accounting for criminogenic risk factors. While these studies found a significant relationship between mental health problems and offending, once controlling for criminogenic risk factors, mental health problems no longer uniquely explained delinquent outcomes (Guebert & Olver, 2014; Shubert et al., 2011).

Some identified criminogenic risk factors include:

- physical or verbal aggression
- short attention span
- poor emotion regulation
- inappropriate emotions (lack of remorse, etc.)
- antisocial/procriminal attitudes
- substance use
- academic problems (grades or absenteeism)
- lack of leisure/prosocial activity
- delinquent peers
- poor relationship with family
- poor parenting

(Vincent et al., 2012)

Identifying Mental Health Needs and Treatment Responsivity

While mental health problems are generally not direct risk factors for criminal behavior according to the risk-needs-responsivity (RNR) framework, RNR principles suggest that mental health may moderate the success of interventions targeted to criminogenic needs (McCormick et al., 2017). Even when mental health symptoms are not a *per se* risk factor for recidivism, participation in mental health treatment may serve as a protective factor (Haney Caron et al., 2019). As such, mental health services are important for addressing the responsivity component of RNR, even if mental health symptoms do not directly predict delinquency.

CBA-Funded Mental Health Services

Legislation directs that CBA establishes “community-based services for juveniles who come in contact with the juvenile justice system” (Neb. Rev. 43-2404.02). The intent of the CBA program is to fund services for youths at-risk for entering or going “deeper” into the juvenile justice system, yet not under formal supervision by probation or a detention/youth rehabilitation facility. To meet this intent, therefore, mental health services should be serving the intended higher-risk population to be effective under statute.

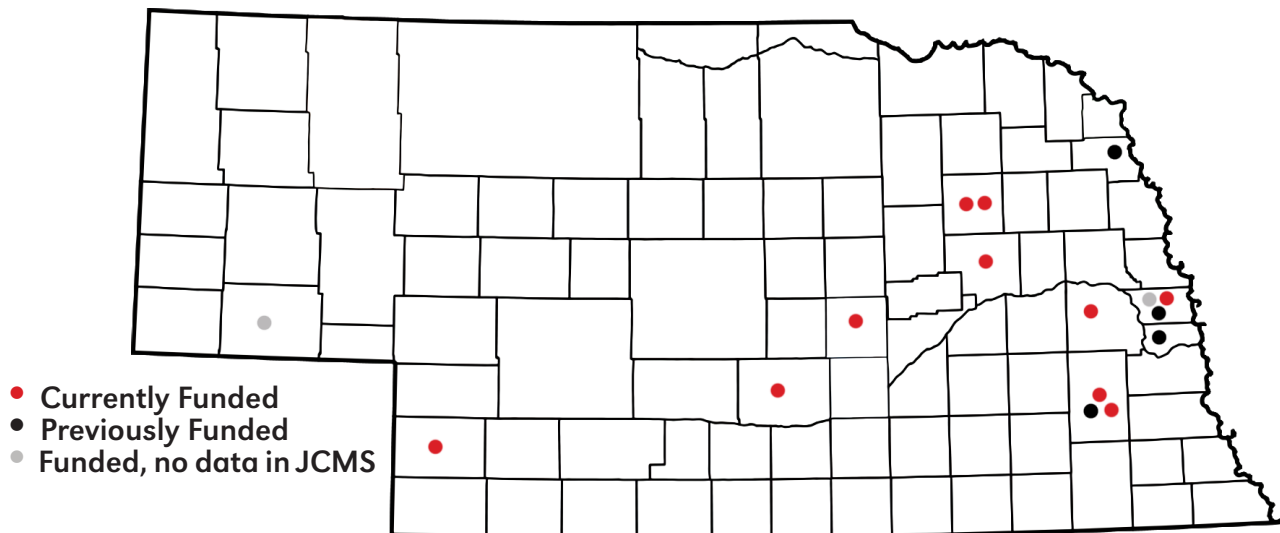


Figure 1. Nebraska map of CBA-funded health services

Method

As part of the Nebraska Community-based Juvenile Services Aid (CBA) program, mental health services that receive funds are required to enter youths served into the Juvenile Case Management System (JCMS), a research-only database, maintained for the purposes of evaluation (Neb. Rev. 43-2404.02).

The JCMS included cases from 14 services/providers that received funds from FY 15/16 to FY 19/20. Of the 14 programs, 10 utilized individual and family therapy, two utilized group therapy, one offered individual and group therapy, and one used animal therapy in a group session. For the 11 programs using individual therapy, nine included multiple interventions (e.g., cognitive behavioral therapy, journaling, workbooks, and discussion). There is a cluster of programs in the metro areas, but fewer in rural parts of the state (see Figure 1).

To measure provider perspectives, we emailed an online survey to the contact person for all currently-funded mental health services ($n = 12$; see Figure 1).¹ Each program received one reminder email and those who had not yet completed the survey received a second reminder email; providers representing nine programs completed the survey.² Fourteen total respondents completed the survey because one community contracts with several providers who each completed the survey (Platte County; $n = 5$).

Data and sample

We obtained the data from the JCMS, which included 863 youths referred to one of 14 mental health services (as extracted on 9/5/2019). The mean age was 12.7 ($SD = 2.9$, 5 to 19 years old) and 52.5% female. Approximately half of the youths were White (51.0%) followed by Hispanic (24.2%), Black (10.7%), Native American/Alaskan Native (5.2%), Asian (1.9%), and Multiple races/unspecified/other (6.9%).

Results and Discussion

1. What are the criminogenic risk factors of youth served by CBA-funded mental health services?

In JCMS, there are three variables to measure level of risk for delinquency based on Lipsey and colleagues' (2010) meta-analysis, including prior legal violations (65% missing), history of aggressive behavior (80% missing), and whether youths are from a high-risk environment (80% missing). Unfortunately, missing data rates are too high for analysis at this time.

As part of the online survey that program staff completed, we asked respondents to indicate whether the youths served in their program demonstrated any of the following criminogenic risk factors. Overall, it appears CBA-funded mental health services have youths that *sometimes or often* demonstrate these criminogenic risk factors with short attention span, poor emotion regulation, and academic problems the most often (Table 1).

Table 1: Provider Perspectives on Youths' Criminogenic Risk Factors ($n = 14$)			
	Never	Sometimes	Often
Physical Aggression	1	12	1
Verbal Aggression	0	7	7
Short Attention Span	0	5	9
Poor Emotion Regulation	0	1	13
Inappropriate Emotions	1	11	2
Antisocial/Pro-Criminal Attitudes	1	12	1
Substance Use	1	8	5
Academic Problems	0	5	9
Lack of Leisure/Prosocial Activity	0	10	4
Delinquent Peers	1	8	5
Poor Familial Relationships	0	8	6
Poor Parenting	0	9	5

2. How do youth in CBA-funded mental health services compare to “deeper end” youth on probation or in detention from previous research?

We compared youths in our sample to previous research. Most—if not all—national research includes juveniles who are formally system-involved (i.e., system intake, detention, and secure post-adjudication). The youths in CBA-funded programs should have lower rates of mental health problems because mental health problems are more prevalent deeper in the juvenile justice system (i.e., the funnel). The comparison data derived from the Pathways to Desistance study (Shubert et al., 2011) and a Multisite Study (Wasserman et al., 2010).

Overall, more youths in our sample demonstrated trauma symptoms, but fewer demonstrated mood disorders than the youths in later system points from previous research. Notably, youths in our sample also demonstrated less symptomology for substance-related disorders, as compared to previous research.

Table 2. Youth Diagnoses (%) for Those Served by CBA-Funded MH Services as Compared to Previous Research (n = 685)			
Mental Health Disorder	CBA Programs (n = 685)	Pathways to Desistance Study (n = 1300)	Multisite Study (n = 9819)
Trauma- and Stressor-related Disorders	24%	12%	-
Mood Disorders	19%	52%	28%
Attention or Hyperactivity Disorders	8%	14%	-
Behavioral/Conduct Disorders	6%	-	30%
Family Issues/Home Environment	5%	-	-
Substance-Related or Addictive Disorders	2%	76%	34%
Neurodevelopmental	2%	-	-
No Diagnosis	34.1%	-	-

Note. We present proportions as the percent of each diagnosis over the total number of diagnoses because staff may select more than one diagnosis; $n = 77$ youths (8.9%) had more than one diagnosis entered.

3. What, if any, are the barriers for mental health providers and youth referred to mental health services?

Many of the providers saw youth almost exclusively or mostly at the school ($n = 6$), while others saw them at a non-school office ($n = 5$), in youth homes ($n = 2$) and equally between school and office ($n = 1$). On average, they reported driving 46 work-related miles per day ($SD = 55.6$) and 195 work-related miles per week ($SD = 255.81$).

To improve service utilization, we asked about the barriers to mental health treatment. Table 3 presents the provider perspectives for whether the barriers listed are a problem in their community. In addition to those listed, providers also indicated that waiting lists for school-therapy are long and another indicated a lack of bilingual providers (i.e., Spanish and French). Overall, the greatest barriers are distance to services and cost of services.

On average, providers drove **46 miles per day** to provide services...



...to youth in schools, offices, and their homes.

Table 3. Provider Perspectives on Barriers to Mental Health Treatment (n = 14)			
	Not at All	Somewhat	A Considerable
Distance to Services	2	8	4
Availability of Services	2	10	2
Cost of Services	4	6	4
Lack of Insurance	2	9	3
Mental Health Stigma (by Youth)	2	12	0
Mental Health Stigma or Distrust (by Parents)	0	12	2

Conclusions and Recommendations

- **CBA program funds are earmarked for youths at-risk of entering the juvenile justice system; therefore, mental health services should serve youth at highest risk for delinquency.**
- **Previous research indicates that mental health symptoms alone do not predict delinquency; as such, mental health services funded by the CBA programs should be working with youth who demonstrate criminogenic risk factors in addition to mental health problems.**
- **To reduce the likelihood for reoffending, treatments should focus on the reduction of criminogenic needs.**
- **Programs should complete the fields in JCMS that are proxy measures for risk level (history of aggression, prior law violations, and high-risk environment) or provide a risk assessment score from a validated risk assessment tool.**

Footnotes

¹ Most of these programs overlap with the 14 that had cases in JCMS with the exception of Cheyenne County mental health services and Douglas County Intensive Family Preservation, which were newly funded and did not have data in JCMS; and Cass County Spirit Horse Ranch, Winnebago Tribe mental health services, Lancaster County Lincoln Public Schools, and Douglas County Capstone, which are not currently funded through CBA.

² Those who did not complete the survey: Cheyenne County mental health services, Chase County mental health services, and Douglas County IFP.

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