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Severe Emotional and Behavioral Problems: Barriers for Texas Youth Accessing Mental Health Court Programs

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Severe Emotional and Behavioral Problems: Barriers for Texas Youth Accessing Mental Health Court Programs

Keywords: Conduct Disorder, Juveniles, Mental Health, Courts

Abstract

Conduct disorder is a constellation of continuous emotional and behavioral problems observed in children and adolescents, which may involve violent and non-violent antisocial behaviors. The symptomology of this psychological disorder includes: disregarding rules without clear reason, cruel or aggressive behavior toward people or animals (e.g., bullying, fighting, using dangerous weapons, forcing sexual activity, and stealing), skipping school, excessive substance use, pathological lying, manipulation, running away, and vandalism (American Psychiatric Association (APA), 2013). Texas Juvenile Mental Health Courts are designed to reduce the number of detained youth, divert at-risk children, maintain community safety, and utilize multidisciplinary approaches to treat conduct disordered youth. However, Texas Juvenile Mental Health Courts deny juveniles admission into their programs if they have a history of violent referrals, property offenses, sexual offenses, or significant gang involvement. This article questions the practice of mental health courts and how this particular practice may directly or indirectly affect youth suffering from conduct disorder. The policy recommendations are discussed after this examination.

Keywords: conduct disorder, mental health court, children, adolescents, Children At Risk

Introduction

The children advocacy organization, Children at Risk (CAR, p. 81, 2012) testified that a majority of Texas mental health courts deny admission into their programs if a youth was: (a) “significantly involved in a gang, (b) charged with a property crime (robbery), (c) has a violent referral, (d) sexual offense, and (e) substance abuse issue." Several of these youth cases relate to a mental health disorder called Conduct Disorder (APA, 2013; Frick, 2009; Frick 2006; Frick, 2002; Osho et al., 2016; Skeem et al., 2011); therefore, Texas Juvenile Mental Health Courts may inadvertently ignore a youth subpopulation suffering from psychological issues. This article questions whether these referral practices inadvertently discriminate against a subset of juveniles and then provides policy recommendations.

Children at Risk (2019) reported that approximately 34% of adolescents in Harris County report psychiatric issues, and over 70% of these children only receive psychiatric services in school. For instance, in 2015 and 2014, the Substance Abuse and Mental Health Service Administration (SAMHSA) reported that 61.7- 62.5% of Texas youth diagnosed with psychological illness and substance abuse problems did not receive treatment. Furthermore, in 2016 the Meadows Mental Health Policy Institute for Texas (MMHPI) revealed there are over 500,000 adolescents with diagnosable severe emotional disturbances (SED) in Texas. Severe emotional behaviors adversely affect an individual's performance. These severe emotional and problem behaviors include but are not limited to ADHD, conduct disorder, and depression (SAMHSA, 2015, 2014; APA, 2013). Secondly, a majority of youth suffering with SED are 200% below the poverty line; therefore, they lack the resources to access the services to improve (MMHPI, 2016). Thirdly, over 150,000 adolescents cope with serious SEDs such as conduct disorder, post-traumatic stress disorder, bipolar, and depression, and approximately 30,000 youth

with SED end up in the school to prison pipeline (MMHPI, 2016). Unfortunately, CAR (2014) reports that typically youth do not receive a diagnosis until assessed after an arrest. Therefore, mental health courts are essential to divert vulnerable youth from the justice system and into appropriate mental health treatment for their disorder (CAR, 2012; 2013; 2014).

Texas Juvenile Mental Health Courts

Juvenile Mental Health Courts (JMHC) were developed to remedy youth court issues associated with processing and ineffective monitoring. The goals for specialized courts include: (a) increasing and maintaining public safety; (b) enhancing the quality of life for participants; (c) reducing recidivism amongst juveniles; (d) and providing a cost-effective method for dealing with youth in the justice system (CAR, 2012). JMHC's provide numerous advantages for handling adolescents in the justice system. Specifically, JMHC's (a) utilize a multidisciplinary approach to develop individualized treatment plans; (b) prioritize community-based referral over residential treatment; (c) are more cost-effective than placement in the juvenile justice system; (d) reduce recidivism; (e) fosters collaboration between the juvenile justice system and mental health service providers in the community; (f) and undertake a multi-pronged approach for handling referred youth (CAR, 2012; 2014).

Juvenile Mental Health Courts employ a separate multidisciplinary docket with local mental health authorities, judicial officials, probation officers, and public defenders working in collaboration. This team manages juveniles identified with psychological issues in the justice system. JMHC's require consent from the legal guardians of selected youth and are voluntary (CAR, 2012). Through identifying the psychological needs of youth, collaborating with community psychological services, and positive reinforcement, JMHC's accomplish successful rehabilitation efforts for juveniles in the justice system (CAR, 2012). The majority of TMHC's

concentrate on pre-adjudicated youth with charges dropped and records sealed after successful completion. Failure results in movement into the conventional juvenile justice process. Currently, the only Texas Mental Health Court that works with convicted youth is in El Paso and serves as an alternative to traditional probation (CAR, 2012).

For example, CAR (2013) described a mental health docket for Harris County JMHC, as significantly different from criminal or civil cases. The docket starts with the court psychologist interviewing the youth regarding his/her progress since the last visit. These inquiries concentrate on activities during the youth's leisure time. Youth making adequate progress may report engaging in pro-social activities throughout the community. Alternatively, struggling adolescents may report boredom and ineffective use of spare time (CAR, 2013). Parental involvement concentrates on assisting youth accomplish their goals, attending counseling sessions and courts dates, and assisting youth with their medication regimen if applicable. Finally, the judge's role reflects that of a social worker or guardian. The judge focuses on assisting adolescents with setting attainable goals, such as drafting a paper, performing household chores, and increasing community involvement. The judge makes an effort to develop rapport with the juvenile and effectively administers positive and negative reinforcement to facilitate positive behavior (CAR, 2013). This environment fosters pro-social development amongst youth while removing negative stereotypes for both parents and youth (e.g., fear of the mentally ill, incompetence of the mentally, ineffectiveness of psychiatric services, biased justice system) of the justice system without labeling the family (i.e., criminal family).

In Texas, most courts require that juveniles must be diagnosed with an Axis I (i.e., adjustment disorder, anxiety disorder, attention deficit and disruptive behavior disorders, dissociative disorders, eating disorders, impulse-control disorders, mood, affective disorders,

psychotic disorders, sexual disorders and paraphilias, sleep disorders, somatoform disorders, substance abuse related disorders) psychological illness for consideration in these specialized courts. For instance, many disorders associated with severe emotional and behavioral problems fall under the broad categories in Axis I. Secondly, youth must have a willing, supportive adult to participate in the program, because Texas JMHC's utilize the wraparound method for treatment. The wraparound method involves providing treatment, educational, and training courses for the family, teachers, and other care providers, as well as the youth. For instance, guardians may receive education on advocating for their child/children within the school system or locating services to assist their families.

Some programs, such as in Travis and Harris counties, are stricter in their eligibility requirements. For instance, Travis County (where Austin is located) states that (a) juveniles cannot be charged with a sexually related offense, (b) pending charges should be unrelated to truancy or running away, (c) there should be no previous convictions, (d) the youth must have an Axis I diagnosis, (e) the mental health diagnoses must be comorbid not just conduct disorder or substance abuse disorder, (f) the youth must be appropriate for deferred prosecution, and, (g) and the guardians or parents must be willing to participate (CAR, 2012). Conversely, eligibility in El Paso includes (a) the risk of home removal, (b) allows a previous conviction, (c) allows an Axis 1 diagnosis other than or in addition to substance abuse, mental retardation, autism, or pervasive developmental disorder, (d) and the Global Assessment of Functioning (GAF) score may be below 50. Furthermore, El Paso does not screen every juvenile for psychological issues, in the youth justice system (CAR, 2012).

Juvenile Mental Health Courts in Harris County where Houston is located, accept youth with: (a) a mental health diagnosis between 10-17 years old, (b) a charge that is either a

misdemeanor or felony offense, and (c) family members willing to participate in the program. Ineligible juveniles are those: (a) charged with a sexual offense, (b) that have a substance abuse problem, (c) that suffer from mental retardation, and (d) that have significant gang involvement (CAR, 2012). Therefore, statewide Juvenile Mental Health Courts lack consistency regarding which youth are deemed eligible for participation.

Validity of Mental Health Screening Devices utilized in Texas

Youth in Texas detention centers receive the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) and the Children's Global Assessment Scale (CGAS). However, scholars assert that the MAYSI-2 and CGAS suffer from various issues of reliability and validity (Ford et al., 2007; Kerig, Moeddel, & Becker, 2011; Lundh et al., 2010; Schorre & Vandik, 2003); therefore, the reliance of these instruments throughout the Texas Juvenile Justice system may be problematic. The MAYSI-2 is a 52-item self-report survey designed to examine a juvenile’s psychological risk and characteristics in juvenile justice settings. The instrument encompasses seven subscales termed: (1) Alcohol/Drug, (2) Angry-Irritable, (3) Depressed-Anxious, (4) Somatic Complaints, (5) Suicide Ideation, (6) Thought Disturbance (boys only), (7) and Traumatic Experiences (CAR, 2013; Kerig et al., 2011; McCoy et al., 2014). The CGAS, an adaption of the Global Assessment Scale, is a unidimensional scale utilized to evaluate functional impairment (Lundh et al., 2012). The CGAS ranges from 0 (insufficient information) to 100 (superior functioning) in 10-point increments (Australian Mental Health Outcomes and Classification Network (AMHOCN), 2017; Lundh et al., 2012). A score within the range of 71-100 suggests normal to superior functioning, while 51-70 indicates mild to moderate emotional and psychological functioning, and 50 and below suggests a significant probability for

externalizing behaviors that facilitate contact with the juvenile justice system (AMHOCN, 2017; CAR, 2013).

The MAYSI-2 an empirically validated and reliable instrument yet is susceptible to errors associated with most self-report instruments (Archer et al., 2010; Ford, et al., 2007; Kerig, et al., 2011; McCoy et al., 2014). This screening device is vulnerable to (a) state and trait features at the time of administration, (b) response styles (social desirability, random responses, exaggeration, under-reporting), (c) recall, and (d) time constraints of detention centers (Archer et al., 2010; Kerig et al., 2011; McCoy, et al., 2014).

Several studies found evidence of validity and reliability for the Children's Global Assessment Scale in samples of youth scale raters (Shaffer, Gould, & Brasic, 1983; Schorre & Vandik, 2003). Schoure and Vandvik (2003) performed a content analysis of 74 papers examining various aspects of the CGAS. The authors reported that only five studies examined the inter-rater reliability of CGAS and yielded somewhat mixed results. Two studies found moderate reliability between mother interview, all information, and child interview. They also found the CGAS has significant face validity, yet concurrent validity was inconsistent. Finally, CGAS is more useful for predicting outcomes and examining change in comparison to diagnosis and multi-dimensional scales (Schoure & Vandvik, 2003). Lundh, et al. (2010) utilized a quasi-experimental design in a sample of 703 raters to examine inter-rater reliability of CGAS. The authors found moderate inter-rater reliability amongst evaluators with no prior training on the CGAS. Finally, untrained raters were less likely to recognize psychological dysfunction than expert reviewers. Therefore, it is probable that the instruments utilized are not effectively examining the underlying processes involved in psychological illness resulting in numerous juveniles receiving an inappropriate diagnosis.

Referral Process

After arrest, juveniles are taken into custody and transported to a designated juvenile processing office, where they remain for up to six hours (Texas Attorney General Juvenile Justice Handbook (TAGJJH), 2016). While at the processing office, the child must be monitored by his/her guardian, parent, or attorney. Following this, adolescents not released are transported to a youth detention center (TAGJJH, 2016). While at the detention center or intake facility, youth are provided a mental health assessment and have a hearing. At the hearing, juveniles are referred to JMHC, Juvenile Drug Court, Juvenile Court, or adult certification (CAR, 2012; 2013). This process may differ by county. For instance, Austin youth are referred by the Travis County Juvenile Probation Center, probation officers, attorneys, and judges. While, in the Probation Center, youth are screened with the MAYSI-2. If a psychological illness is suspected, they undergo a 90-day assessment determining eligibility for JMHC (CAR, 2012). Following this, the case is examined by a JMHC team comprised of a Mental Health Court Project Judge, Assistant District Attorney, Juvenile Public Defender, and Collaborative Opportunities for Positive Experiences (COPE) Coordinator, two deferred prosecution officers devoted to COPE cases, and a psychologist. Once participants are selected, the probation officer meets with the family at the residence to discuss the program and offer the opportunity to participate (CAR, 2012).

El Paso youth are screened for psychological illness during intake and released because their program concentrates on post-adjudicated youth. The probation officers, juvenile court judges, and attorneys have the ability to refer youth to Juvenile Mental Health Courts in El Paso. The referred cases are reviewed by a team comprised of the program coordinator, judge, probation officers, counselors, public defender, prosecuting attorney, and case managers over a

period of a week (CAR, 2012). Following this, each member except the judge has half a vote to decide whether to accept the case, with the judge being the tiebreaking vote. Finally, a referral packet including (a) Special Needs Diversionary Program (SNDP) referral form, (b) pre-disposition report, (c) psychological/psychiatric evaluation, and (d) available mental health history must be submitted by the coordinator. After reviewing this evidence, youth referral experiences are contingent upon the goals, location, and resources of the program.

Conduct Disorder

Conduct Disorder (CD) is the downward extension of adult psychopathy and antisocial personality disorder to juveniles. This psychological disorder is represented by a repetitive and persistent pattern of behavior which (a) ignores the basics rights of others, (b) ignores age-appropriate societal norms, (c) includes infringement of rules, and (d) presents callous-unemotional traits (APA, 2013; Frick, 2016). The American Psychiatric Association (2013) states, "that to be diagnosed with conduct disorder criteria in the past 12 months the child must display one of the categories below, with at least one criterion present in the past six months" (p. 469). "These symptoms involve: (1) aggression to people or animals, (2) destruction of property, (3) deceitful and theft, (4) serious violation of rules, (5) and possessing both academic and occupational impairments" (APA, p. 469-470, 2013) and under these broad terms are symptoms identified in the criminological literature as delinquent. APA (2013) reports actions associated with CD to include bullying, lying, fighting, temper tantrums, theft, setting fires, cruelty to people of animals, truancy, sexual assault, substance abuse, vandalism, and disregard for authority.

Throughout the extant literature, youth with conduct disorder traits (e.g., severe callous-unemotional) predict serious, stable, and aggressive patterns of antisocial behavior (Frick & White, 2008; Kahn et al., 2013; Pardini & Fite, 2010; Reidy, Shelley-Tremblay & Lilienfeld, 2011; Skeem et al., 2011). For instance, Pardini and Fite (2010) examined the incremental utility of conduct disorder (CD), oppositional defiant disorder (ODD), and attention-deficit hyperactivity disorder (ADHD) symptoms' ability to predict outcomes in various areas. Utilizing a sample of 1,517 adolescent males, the authors found that CD symptoms are the most significant predictor of future delinquency. Jain, Pattanayak, Bhargava, and Dhawan's (2016) case study also found a link between CD and substance abuse.

There is a significant amount of comorbidity amongst youth with CD symptoms, such as ADHD, ODD, anxiety, depression, and substance abuse disorder (Frick, 2016; Loeber et al., 2000; Pauli-Pott et al., 2014; Reebye, Moretti, & Lessard, 1995; Riggs et al,, 1998; Skeem et al., 2011). Satterfield and Schell (1997) found that males with CD and ADHD were less likely to have favorable outcomes in comparison to their non-comorbid counterparts. More recently, Morder et al., (2011) longitudinally examined if youth suffering from co-occurring disorders involving (CD) and other disorders were more likely to perpetrate criminality. They observed that hyperkinetic conduct disorder and severe CD youth predicted delinquency. Intriguingly, comorbidity was insignificantly related to future antisocial behavior. Sibley et al. (2011) investigated the outcomes of youth with ADHD comorbidity and without. These authors found that youth with CD and ADHD were at risk for various types of delinquency (e.g., theft, robbery, and assault, etc.).

Finally, the empirical literature examining conduct disorder and delinquency provides evidence that this severe emotional behavior problem increases youth propensity to perpetrate

various forms of criminality (e.g. mild to severe). Additionally, the likelihood of the involvement increases tremendously when CD is merged with other severe emotional behavior problems. Therefore, it is likely that youth asocial behavior such as (a) involvement in gangs, (b) being charged with sexual offenses, (c) perpetrating burglary or theft, (d) and possessing violent referrals, may stem from underlying psychological issues that have not been previously diagnosed.

Effectiveness and Composition of Juvenile Mental Health Courts

Various Juvenile Mental Health Courts display a significant amount of effectiveness in successfully assisting youth suffering from psychological illnesses (CAR, 2012; 2013). Children at Risk (2012) reported in 2007 that 65.2% of juveniles in the Travis County JMHC successfully completed the program and did not recidivate during the first half of that fiscal year. Secondly, in 2008, 69.1% of Travis County JMHC participants successfully completed the program, with 34.8% recidivating within the following year. In 2009, 82% of Harris County JMHC participants successfully graduated, with 33% recidivating within the year (CAR, 2012). In 2010, 79% of Harris County JMHC youth successfully completed the program, with a 14% recidivism rate. In El Paso's JMHC program, 83% of participants in 2008 successfully completed the program and 16% recidivated the following year. In 2010, of the 77% participants that completed the program, 16% recidivated within the following year. The El Paso results should be interpreted with caution because new arrests, outcome of arrests, and prior adjudications were unknown during evaluation (CAR, 2012). Furthermore, there is only a 2% difference between El Paso JMHC participants and non-participants (CAR, 2012).

The majority of these programs are comprised of youth suffering from severe emotional and behavior disturbances (CAR, 2012; 2013) and display significant effectiveness. For instance,

Travis and Harris County and El Paso participants suffered from severe emotional and behavioral disturbances, including mood disorders, depressive disorders, major depressive disorder, disruptive behaviors, Bipolar Disorder, and ADHD. Furthermore, both El Paso and Harris County possess a significant number of youth with a violent referral and A/B misdemeanors. Overall these, programs display effectiveness remedying some behaviors (violent, theft) associated with conduct disorder. Secondly, the methods utilized by JMHC have been empirically proven to be effective for treating conduct disorder (Barkoukis, Reiss & Dombeck, 2008; Nam & Bahr, 2016; Ronan et al., 2016).

Recommendations and Conclusions

There are numerous reasons Juvenile Mental Health Courts ignore a subset of youth that make contact with the juvenile justice system. These include (a) funding, (b) psychometric instruments utilized for pre-screening, (c) selection bias, (d) restrictions regarding comorbidity,(e) separation of drug and mental health courts, and (f) developing more JMHC programs statewide. Considering the issues evident in JMHC, the probability of failing to detect conduct disordered youth is a reality. Therefore, the development of policies addressing these issues will significantly decrease the probability that conduct disordered youth are ignored.

Evidence suggest both the MAYSI-2 and the CGAS have validity and reliability (McCoy et al., 2014; Schorre & Vandik, 2003; Shaffer et al., 1983), although the MAYSI- 2 has fewer issues. Furthermore, neither is useful alone for psychological diagnosis due to their design weaknesses. Unfortunately, the MAYSI-2 is the only instrument youth are required to take within the first 48 hours; therefore, the CGAS is administered at the discretion of the practitioner. This is problematic considering the lack of inter-rater reliability and diminished ability to detect psychological dysfunction amongst untrained professionals. Therefore,

practitioners should be required to administer both MAYSI-2 and the CGAS within this period or another psychometric instrument in addition to the MAYSI-2. This will increase the validity and reliability of the pre-screening process. Furthermore, increasing practitioner and administer awareness regarding the weaknesses of these psychometric instruments will allow conscientious interpretations during mental health evaluations.

One recommendation is that policy should concentrate on the reallocation of funding for Juvenile Mental Health Courts across the state by merging both substance abuse and mental health courts designated for juveniles. Currently, substance abuse and mental health services are funded independently. However, per the healthcare expenditures for Texas in 2015, if drug and mental health courts had been merged, mental health programs would have received an additional $83 million in funding (Texas Health Care Spending Report (THCSR), 2015).

Implementing such a policy requires policy makers and state practitioners to recognize the comorbidity of substance abuse and other mental health issues and their complex relationship with delinquency. Evidence suggests numerous mental health issues are comorbid with substance abuse including conduct disorder (Pott et al., 2014; Riggs et al., 1998; Skeem et al., 2011). Currently, Texas Juvenile Mental Health Courts do not admit youth suffering from substance abuse problems. Instead, these juveniles are referred to Juvenile Drug Courts (CAR, 2012; 2013; 2014). This restriction makes it difficult to detect conduct-disordered youth who also are suffering substance abuse disorders and may benefit from mental health interventions.

Programs in other areas have provided evidence of successful collaborative treatment for psychological illness and substance abuse issues (CAR, 2013). For instance, the Crossroads program in Ohio merges mental health and substance abuse courts and reports a significant number of successful graduations coupled with low recidivism rates (CAR, 2013). Furthermore,

approaching these issues from a collaborative perspective will make the programs more efficacious.

In addition to the above, allocating money for mental health services alleviates the stress other taxpayer programs bear (CAR, 2013). For instance, CAR (2012; 2013) indicated that numerous juvenile mental health courts (JMHC) report a lack of resources, staff, facilities, and insurance coverage. Therefore, allocating funds to combat some of these issues may be extremely effective; for instance, providing funds that assist families paying for these services will allow JMHC's to accept more cases. Furthermore, funds exclusively appropriated for mental health allow JMHC's to increase partnerships throughout communities and regions in their location.

Another recommendation is that policy requiring a statewide standard for inclusion and exclusion criteria regarding Texas Juvenile Mental Health Courts should be established once resources are allocated. This policy should explicitly state that youth refused admission for gang involvement, sexual offense, substance abuse, violent (e.g., serious & minor), and theft must have undergone an extensive psychological screening before the decision. The screening must last 120 days before a final decision is reached, considering the DSM 5 states symptoms must persist at least six months before a diagnosis of conduct disorder (APA, 2013). Providing practitioners with additional time to evaluate referred juveniles may increase the validity of their diagnosis resulting in acceptance. Furthermore, this policy compels mental health specialists to consult with other professionals involved in JMHC's regarding their decisions to include or exclude juveniles. This policy removes the probability of selection bias, cultural misinterpretation, and issues associated with the current MAYSI-2 and CGAS. Considering that

youth perpetrating these delinquent behaviors are typically refused admission into Juvenile Mental Health Courts, adopting these policies is vital.

Evidence suggest that the methods utilized by Juvenile Mental Health Courts are effective treatments for conduct-disordered youth (CAR, 2012; Eyeberg et al., 2008; Henggler & Lee, 2003; Webster-Stratton, Reid, & Hammond, 2004). A majority of minors involved in these delinquent acts are: (a) victims themselves, (b) from impoverished neighborhoods, (c) possess several neurological malfunctions, and (d) lack a support system (Chapple & Hope 2003; Frick, 2006; Raine, 2013; Rosenfeld, Bray, & Egley 1999). Similarly, majority of conduct-disordered youth suffer the same plight (Frick, 2016; 2006; 2002). Finally, expanding the amount of JMC's in large cities will provide youth with psychological issues the opportunity to receive treatment. Counties that could benefit from the development of Juvenile Mental Health Courts include Hidalgo, Fort Bend, Montgomery, and Tarrant County. Extending the reach to these counties will provide youth suffering from conduct disorder and other psychological issues to receive treatment within their areas. Furthermore, these policies should decrease the phenomenon termed the "cradle to prison pipeline" throughout the state and the number of juveniles referred for adult certification.

Implementing these policy recommendations will provide and require practitioners throughout criminal justice to critically examine more severe psychological issues. Considering, the overwhelming evidence of abuse perpetrated within youth detention centers and prisons by staff, adult inmates, and youth inmates (Annie E. Casey Foundation, (ACF) 2015; CAR, 2013; Mendel, 2011), these facilitate may exacerbate CD symptoms. Adoption of these recommendations will require a significant amount of funding but will increase the juvenile justice system chance for providing juveniles with assistance, especially conduct disordered

youth. Conduct disordered youth may be viewed by juvenile justice practitioners as future criminals due to their behavior problems and personality deficits. The evidence that conduct disordered youth can be effectively treated utilizing methods implemented in juvenile mental health courts is apparent.

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