JUSTICE POLICY INSTITUTE

MINDFUL OF THE CONSEQUENCES:

Improving Mental Health for D.C.'s Youth Benefits the District

Improving public safety in D.C. depends on a comprehensive approach that involves multiple strategies spanning all City agencies. One facet of such a comprehensive approach is to improve outcomes for youth so that fewer become caught up in the justice system, a victim of crime, or both. This brief is part of a series explaining how improving youth outcomes in D.C. can also result in better public safety outcomes for the District as a whole.

INTRODUCTION

The power of good mental health is underestimated in maintaining safety and well-being within D.C.'s communities. But, as our understanding of brain science expands, the connections between public safety and health promotion are increasingly clear. Historically, the role of mental health as a crucial component of overall wellness and health has been "misunderstood and often forgotten."[1] This is equally true when it comes to understanding

how untreated mental health problems lead youth into the juvenile justice system. Mental health problems in children are often perceived in extremes - as a severe condition requiring hospitalization and medication or as a behavioral issue to be addressed through increased discipline or confinement in a correctional facility. This misunderstanding of mental health not only prevents children and youth from getting the preventive and therapeutic services they need, but it allows ineffective public safety strategies to linger in our public policies and legislation. A "tough on crime" approach undermines public safety because it does not address the illness that's causing or contributing to the delinquency or crime. However, youth receiving the attention they need to improve their mental health will be enabled to overcome challenges and reach their potential within their schools, homes, and communities. Youth with good mental health will become vital members of our communities, as they are psychologically and physically able to contribute their skills and talents to the betterment of society.

OPTIMAL MENTAL HEALTH LEADS TO A HIGHER QUALITY OF LIFE.

Mental health – and conversely, mental illness – is the result of a complex interaction of environmental and biological factors. The World Health Organization defines mental health as the following:

> *"…a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."*

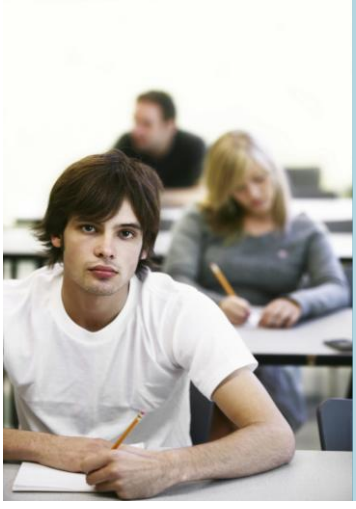
Unfortunately, for many youth, their mental health status makes them not only unable to achieve these life milestones but can result in justice system involvement that has lifelong consequences.

THE MENTAL HEALTH OF D.C.'S YOUTH AFFECTS THEIR EDUCATIONAL, EMPLOYMENT, AND SOCIAL SUCCESS.

Delivering quality mental health services to youth is vital for ensuring they are able to begin a lifetime of productivity during critical years of learning and to establish their place in society. Failure to treat or delays in treatment can result in poor school performance, teenage pregnancy, sporadic or no employment, and violence.[2] Unlike other chronic diseases, mental disorders often manifest early in life: [3]

- 50 percent of all lifetime cases start by age 14
- 75 percent of all lifetime cases emerge by age 24

One out of eight youth (ages 17 and younger) globally has a diagnosable mental disorder. However, of considerable concern is that one in five "disadvantaged" children has a diagnosable mental disorder due to the risk factors commonly found in the households and neighborhoods in poverty that are deprived of or lacking resources.[4] While 123,720 youth ages 0 through 19 lived in the District in 2010,[5] the Department of Health Care Finance reported



Significantly more D.C. high school students attempted suicide than their national counterparts; and, significantly more of them required medical attention as a result of these attempts

that 91,344 children and youth were enrolled in D.C.'s Medicaid system.[6] Enrollment indicates they were living in low income households or what is typically characterized as "disadvantaged" conditions. Based on the World Health Organization's estimates, about 18,269 of these youth/children were anticipated to need mental health care treatment and services. However, usage rates reflect that over half the youth in need are not obtaining mental health treatment despite coverage of services by Medicaid and other funding sources.[7]

The 2011 Youth Risk Behavior Surveillance (YRBS) findings revealed that about 25 percent of D.C.'s high-school students reported sadness or hopelessness interfering with usual activity during the prior year. Among D.C.'s middle school students, nearly a quarter of the participants (18 percent) reported seriously considering suicide in the previous year; about 11 percent of high school students reported the same.[8] Significantly more D.C. high school students attempted suicide than their national counterparts; and, significantly more of them required medical attention as a result of these attempts.[9] One limitation to this data is that the survey is administered within the school setting. Youth who are absent or truant due to mental health issues may impact survey findings and cause mental disorder rates to be lower than the actual rates. Furthermore, all data is self-reported, which may also impact findings.[10] Additional information regarding mental disorder prevalence rates within the District is not available from the Department of Mental Health. This lack of information prevents a complete picture of the youth's mental health status in D.C. The necessity for early identification and treatment should compel the District to obtain data for calculating mental disorder prevalence rates.

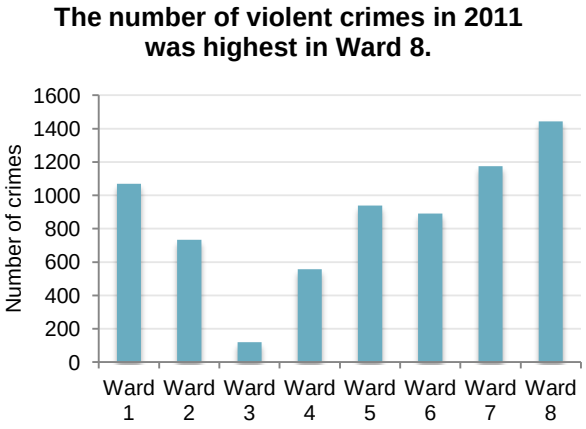
THE MENTAL HEALTH OF D.C.'S YOUTH COULD PUT THEM AT RISK FOR INVOLVEMENT IN THE CRIMINAL JUSTICE SYSTEM.

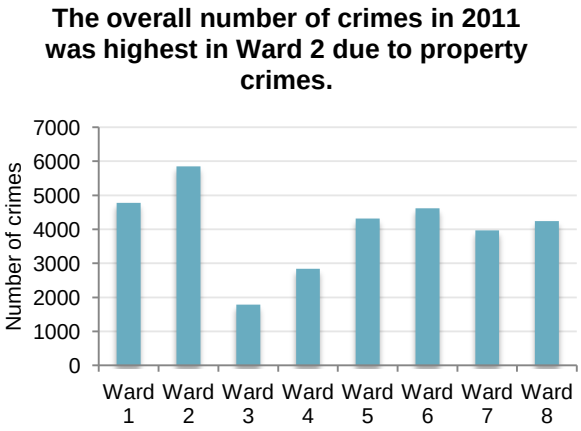
Among adults in prison in the U.S., over half have been found to have a mental health problem (56 percent in state prison, 45 percent in federal prison, and 64 percent in local jails).[11] Elevated rates for certain mental disorders are observed in this population, with schizophrenia/psychotic disorders four times higher, bipolar disorders three times higher, and post-traumatic stress disorder two times higher among adults in jail and prison when compared to the general population.[12] The imprisonment of adults with mental disorders is blamed on insufficient access to mental health services prior to arrest, punitive behavioral control policies, and a lack of community-based services to which those with mental disorders may be released for treatment, monitoring, and other supportive services.[13]

This is a concern for D.C.'s youth because adult mental disorders are often "extensions of juvenile disorders."[14] In a study of a representative sample of adults with mental illness,

- 74 percent and 50 percent of the sample were first diagnosed with a psychiatric disorder *before 18 years and 15 years*, respectively.
- Among adults receiving treatment, 77 percent received an original diagnosis before age 18 and 56 percent were given their first diagnosis between ages 11 and 15.
- Conduct and/or oppositional defiant disorders played a role in the mental health history of up to 60 percent of adults with psychiatric disorders.[15]

The Council of State Governments has recognized that "more accessible and effective mental health treatment for criminally involved





Source: Metropolitan Police Department, "Total number of crimes by ward that occurred between 1/1/2011 through 12/31/2011."

[people with severe mental illness] is viewed widely as the key to addressing the problem of the mentally ill in the criminal justice system at every stage in the process."[16] Of greatest concern is what is happening at the beginning of this process, involving our youth who have the most to lose in lifetime learning, productivity, health, and quality of life.

Disturbingly high rates of youth with mental health disorders are currently in the juvenile justice system. A national study of youth in juvenile detention found that, excluding conduct disorders, 66 percent of males and 74 percent of females met the diagnostic requirements for at least one mental health disorder.[17] Evaluations of youth in the justice system have long confirmed that these youth often have a deficit in "executive functioning" skills. These are mental processes that enable youth to form accurate perspectives, interpret social interactions, and solve interpersonal problems. Youth with difficulties may show a significantly reduced capacity to conceptualize and follow abstract reasoning.[18] These deficits are found in a range of mental disorders,[19] which confirms "keeping youths with emotional and behavioral problems out of the juvenile justice system should be a public health priority."[20]

It is important to remember that many youth in the juvenile justice system are not in confinement; and, many youth who engage in delinquent activities may have made bad choices or have other economic or social problems that don't involve a mental illness. However, in light of the recent declines in juvenile crime in D.C.[21], it is important to use this opportunity to shift funding into more proactive, preventative efforts that will reduce the number of youth coming into contact with the justice system due to mental health issues. A comprehensive, public health approach to safety should include improving the mental health and well-being of youth as a key component.

MANY OF D.C. YOUTH ARE EXPOSED TO TRAUMATIC EVENTS THAT CAN CAUSE OR EXACERBATE MENTAL HEALTH PROBLEMS.

Children who suffer from traumatic stress have been exposed to one or more traumas and have developed reactions which affect their daily lives after the stressful events have ended. Traumatic reactions can include intense and ongoing emotional upset, depressive symptoms, anxiety, behavioral changes, difficulties with attention, academic difficulties, nightmares,

physical symptoms such as difficulty sleeping and eating, and aches and pains, among others.[22]

Traumatic events include such occurrences as parental substance abuse, parental mental illness, parental criminality, family violence, physical abuse, sexual abuse, and neglect. Children can also be traumatized by life-threatening injuries, illnesses, and accidents. Research shows that some experiences that are not included in the clinical definition of childhood trauma exposure still play a role in causing post-traumatic stress disorder as well as impairing a child's ability to self-regulate their emotional and physical responses to stressful events. Such experiences may include psychological abuse, emotional abuse, separation from caregivers, neighborhood disadvantages, and traumatic loss.[23]

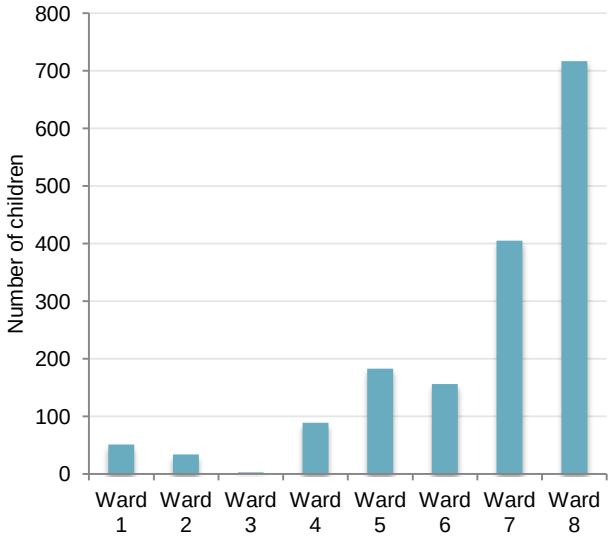
The experience of trauma has been linked to increased risk of mental health problems in youth, as well as the persistence of these illnesses into adulthood.[24] Exposure to trauma and related factors and trauma has been linked to:

- About 45 percent of childhood onset mental disorders[25]
- Up to 32 percent of adult onset mental disorders[26]
- Developmental delays, learning disabilities, and lower IQ[27]
- School truancy, drop-out, and expulsion[28]

The District has areas that show great disparities in risk factors leading to traumatic stress and mental disorders.

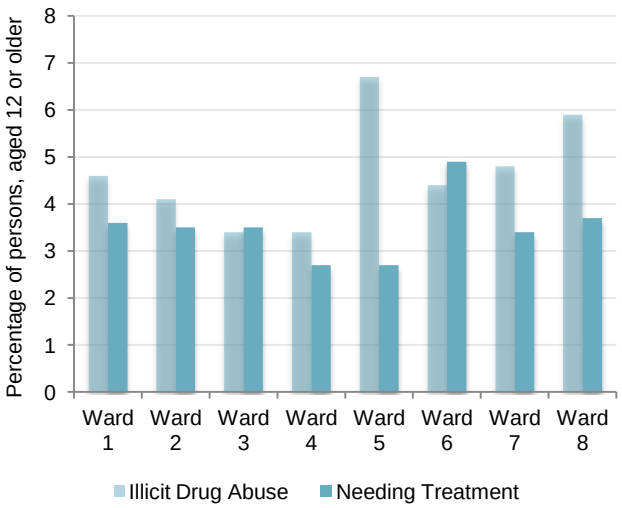
It is unclear what the prevalence rates of mental disorders are among D.C. youth; however, as mentioned above, disadvantaged youth have a higher incidence of mental health problems.

A majority of children in D.C. foster care are from Wards 7 and 8.



Source: District of Columbia Child and Family Services Agency, "Demographics of Children in Foster Care, as of February 29, 2012."

Wards 7 and 8 were the 2nd and 3rd highest in percentage of illicit drug abuse.



Source: Substance Abuse and Mental Health Services Administration, "Section C: Tables and maps of model-based estimates for substate regions, annual averages based on National Survey for Drug Use and Health 2006 - 2008.

To fully understand D.C. youth's mental health and related outcomes, it is important to consider the big picture of what risk factors are present and whether or not protective factors, such as preventive services and resources, exist to help offset the impact of those risks. In 2011, youth in Wards 7 and 8 were impacted by high unemployment rates (16% and 24%, respectively)[29] and high child poverty rates (40% and 48%, respectively).[30] These wards ranked lowest in annual income with the average being $31,797 (Ward 7) and $26,661 (Ward 8).[31]

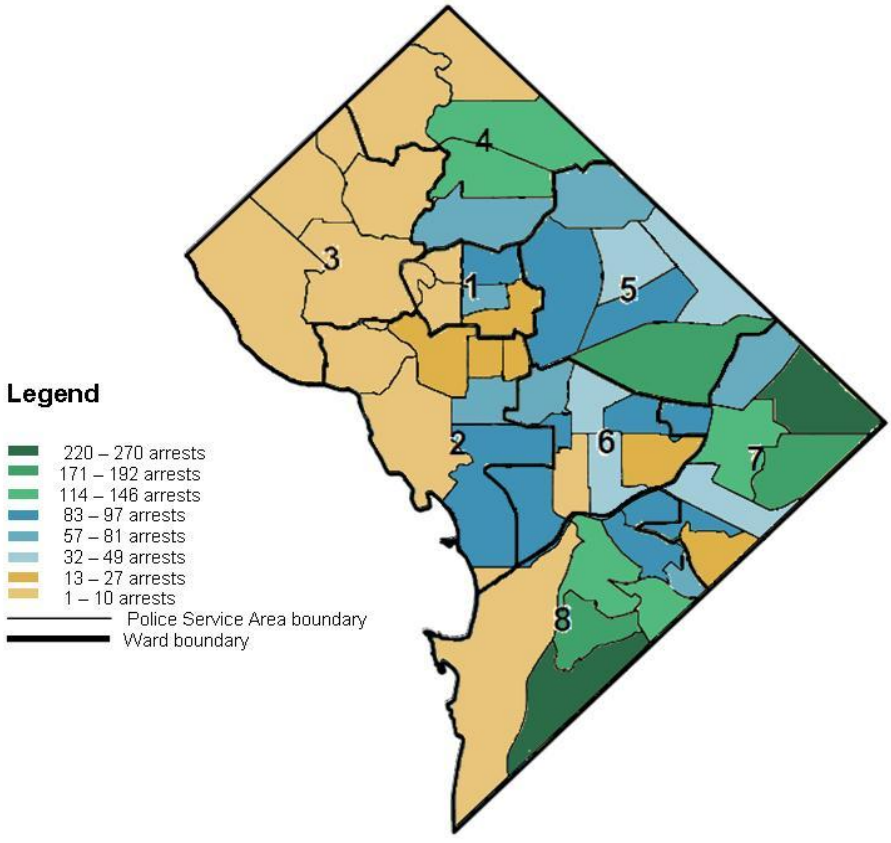
Exposure to violence and being a victim of crime are risk factors for trauma, as are abuse and neglect and parental substance abuse. Wards 7 and 8 had the greatest number of violent crimes.[32] The highest proportion of children currently in D.C.'s foster care system comes from Wards 7 and 8, with 41 percent of all children in foster care coming from Ward 8.[33]

Although Ward 2 led in rates of alcoholism in past month and past year, Wards 7 and 8 showed higher rates of illicit drug abuse and treatment needs.[34]

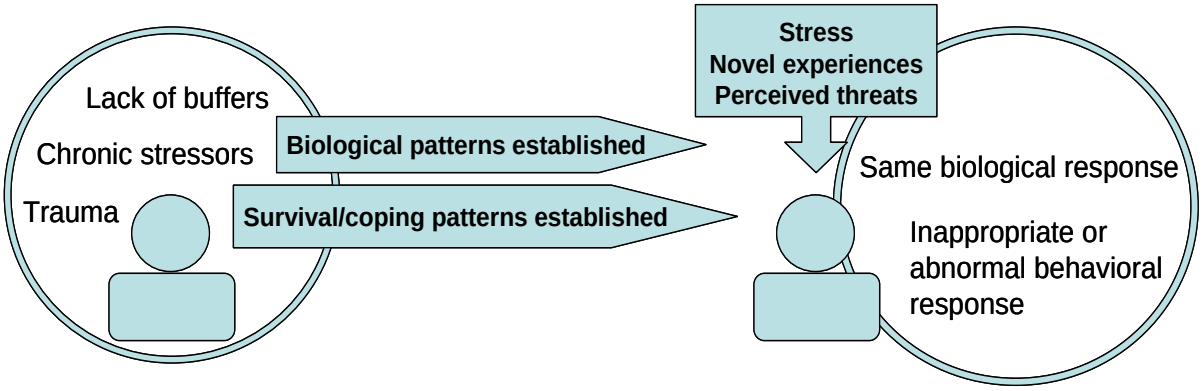
Nutrition is also noted for its role in poor mental health outcomes for youth[35] and the Food Research and Action Center documented large swaths of food deserts in Wards 4 and 7. This means that those areas have limited access to affordable and nutritious food. Food deserts intersected with poverty in large areas east of the Anacostia River, as well as, in certain pockets of Wards 5 and 6.[36]

Research has documented a connection between childhood histories of trauma, abuse, and

Map 1. Home addresses of youth arrested in 2011 indicate areas in need of targeted, appropriate mental health services.



Source: Metropolitan Police Department, "Biannual Data on Juvenile Arrests," 2011.



neglect and arrest rates for violent offenses.[37] And, this appears to be happening in D.C.: youth in areas with a high concentration of factors contributing to mental disorders experience higher levels of juvenile arrests.

Not only did 40% of juvenile arrests occur in Wards 7 and 8, but the home address of youth arrested in 2011 also falls predominately over Wards 7 and 8 (See Map 1). At least 1,689 of the juvenile arrests made in 2011 listed a home address within Ward 7 or 8, accounting for 49% of all the 2011 juvenile arrests.[38] While there are many reasons for higher arrest levels, including patterns of policing and presence of law enforcement in schools, these areas are higher in many of the factors related to poor mental and behavioral health, including poverty, unemployment, illicit drug abuse, violent crime, and child abuse and neglect when compared to other D.C. wards. It is likely that many of D.C.'s youth interfacing with the juvenile justice system have been exposed to multiple traumatic experiences.[39]

THE SCIENCE OF TRAUMA AND MENTAL HEALTH SHOULD INFORM D.C.'S APPROACH TO YOUTH DEVELOPMENT.

Recent research continues to increase our understanding of how a child's long-term exposure to risk factors and trauma impacts their mental health, eventually contributing to behavior problems. Children growing up in environments having these risk factors without supports or buffers to counter the stress show a measurable physiological response.[40] This results in chemical imbalances within the body[41] and a persistent sense of heightened flight-or-fight which affects how the body is programmed to respond to future stressful events.[42] The National Council on the Developing Child termed this "toxic stress," which "in early childhood is associated with persistent effects on the nervous system and stress hormone systems that can damage developing brain architecture and lead to lifelong problems in learning, behavior, and both physical and mental health."[43] Prolonged stress exposure also disrupts the brain's ability to communicate across the left and right sides, resulting in reduced logic, reasoning, and problem-solving skills.[44]

Research continues to confirm that youth who have experienced trauma grow up with an impaired ability to self-regulate their behavior

when faced with stressors[45] as well as control their mood. They are unable to handle anxiety in a normal way as their bodies respond with the same patterns learned while under chronic stressful situations. For example, a child who has witnessed violence in the home may begin showing higher levels of aggression and anger at school. This may look like throwing a major temper tantrum inside the classroom or verbally or physically lashing out at another student.

When exposed to later stressful events, many of these youth act out and are labeled as "oppositional," "rebellious," "unmotivated," or "antisocial." In reality, though, these youth are demonstrating behaviors that previously have been necessary to cope or survive. With age, the chemical responses remain the same while the youth's reactions tend to resemble more adult-like anti-social behavior.[46] The same child witnessing violence in the home may grow up and continue to respond to stressful situations by fighting with other kids at school or in the neighborhood, by dropping out of school, and/or by antagonizing a teacher or other authority

It is important to recognize that youth with mental health problems are not more "dangerous" than the average youth; however, they do need services to treat these illnesses. Attempts to self-medicate with drugs or alcohol can exacerbate their problems.[47] Without treatment and supports, youth with many of these disorders are not going to have the capacity to accurately assess stressful situations and respond in an effective or appropriate way.[48]

"When professionals are unaware of children's need to adjust to traumatizing environments and expect that children should behave in accordance with adult standards of self-determination and autonomous, rational choices, these maladaptive behaviors tend to inspire revulsion and rejection."- Bessel van der Kolk[49]

D.C. STRUGGLES UNDER FAULTY UNDERSTANDINGS OF MENTAL HEALTH, LACK OF ACCESS TO SERVICES FOR YOUTH, AND A STIGMA ASSOCIATED WITH MENTAL HEALTH SERVICES.

Although the connection between trauma and later delinquency has been established, this is not reflected in many District laws, policies, and procedures. Stressful life events are connected with both property and violent crimes; however, as is common throughout the U.S.[50], many of

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD):

Historically, youth, particularly boys, with ADHD and conduct problems were more likely to be involved in the criminal justice system as adults. While initially there was skepticism around ADHD as "real" disease, studies show that brain scans of children with ADHD display functional abnormalities. The differing connectivity patterns in the brain may be contributing to differences in behavior and task completion. These differences may also be related to abnormal levels of certain brain chemicals that may cause impairment in completing tasks. Although the research needed to fully understand ADHD is incomplete, what is clear is that children with ADHD have serious physiological differences that need to be considered before they are expected to behave as other children or punished for their behavior.

Sources: J. H. Satterfield, and others, "A 30-year prospective follow-up study of hyperactive boys with conduct problems: Adult criminality," *Journal of the American Academy of Child and Adolescent Psychiatry* 46 (2007): 601-610; Kerstin Konrad, and Simon Eickhoff, "Is the ADHD brain wired differently? A review on structural and functional connectivity in attention deficit hyperactivity disorder," *Human Brain Mapping* 31 (2010): 904-916; National Human Genome Research Institute, Human Genome Project, "General information about ADHD," http://www.genome.gov/10004300 (accessed May 30, 2012).

D.C.'s youth are being channeled through the juvenile justice system to get mental health treatment rather than receiving those needed services prior to justice involvement. Once in the system, youth are not receiving appropriate services to address their mental health needs and protect them from further harm. The misunderstanding of what mental health is, as well as the use of ineffective strategies for handling inappropriate and illegal youth behavior are manifest in many different aspects of the D.C. government. This ranges from the lack of service delivery to youth in need, the dismissal and underuse of effective solutions, and the rampant use of detrimental treatment options.

Youth are not accessing the services they need to improve their health.

A substantially lower proportion of D.C.'s youth on Medicaid are receiving mental health services when compared to national rates.[51] Although the Medicaid system was expanded to include a greater number of youth, managed care organizations are not referring children to the Department of Mental Health for the care they need. The National Comorbidity Survey for

ONCE IN THE JUVENILE JUSTICE SYSTEM…

Of great concern is that youth who are interfacing with the justice system are being channeled into ineffective, even harmful "treatment" options. In 2011, the Department of Youth and Rehabilitative Services (DYRS) served 1,269 youth in custody and an additional 954 who were detained prior to court appearances. On December 30, 2011, nearly 50 percent of youth in custody of DYRS were located in secure facilities, including the Youth Services Center, New Beginnings, and Residential Treatment Centers (RTCs). Conversely, only 47 percent were being monitored through community-based alternatives, such as a family home or within the community. Whereas 243 youth were newly committed to DYRS in 2011, during the same year, 378 youth were placed in RTCs and Psychiatric Residential Treatment Facilities (PRTFs).

Based on a study of a representative sample of D.C. youth in RTCs/PRTFs in 2011, 57 percent of youth had community safety as a listed reason for placement; 45 percent had noncompliance with their community placement agreement or conditions of their probation listed as a primary reason for placement. This reflects inappropriate and costly use of RTC/PRTF placements, which are intended to provide intensive treatment in a therapeutic environment for youth in medical need. Risks levels assigned by the Structured Decision Making Instrument show that 60 percent of DC youth placed in RTCs/PRTFs have low to medium-high risk levels. However, studies consistently show that lower risk youth do not benefit from these placements:

- Low risk youth show worse outcomes in residential treatment than if they were placed in community-based programming. In fact, only "very-high" risk youth show any positive benefit from placement in an RTC or secure facility.
- Low risk youth in residential placement show worse outcomes and a higher likelihood of re-offending.

The fact that 46 percent of the youth's initial placement is in RTCs suggests that youth are not even being considered for community-based options but are channeled directly into secure facilities.

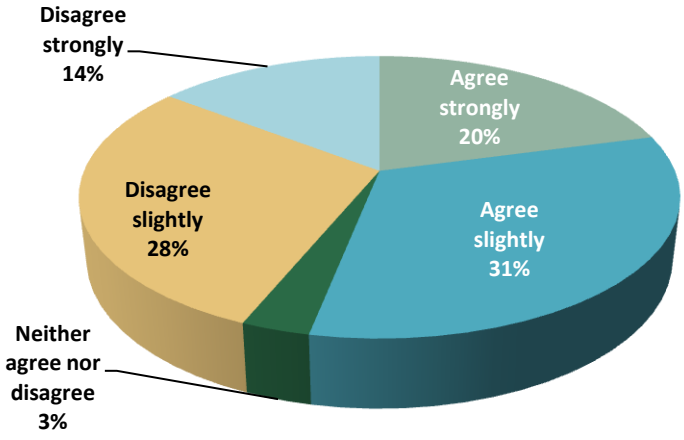
Sources:
Department of Youth Rehabilitation Services, "2011 DYRS Annual Performance Report."
Department of Youth Rehabilitation Services, "FY11-12 Agency Performance DYRS Responses, Attachment 8: Daily snap shot of DYRS wards."
Department of Youth Rehabilitation Services, "Report on DYRS' Youth in Psychiatric Residential Treatment Facilities and Residential Treatment Centers," December 2011.
C.T. Lowenkamp and E. Latessa, Evaluation of Ohio's RECLAIM funded programs, community corrections facilities, and DYS facilities, 2005. http://www.dys.ohio.gov/dnn/Community/RECLAIMOhio/tabid/131/Default.aspx
M.T. Baglivio, "The prediction of risk to recidivate among a juvenile offending population," 2007. http://ufdcimages.uflib.ufl.edu/UF/E0/02/15/69/00001/baglivio_m.pdf.

adolescents revealed that about 20 percent of adolescents experience a Serious Emotional Disturbance (SED).[52] Based on Census 2010 data for Wards 7 and 8, about 871 and 961 adolescents between the ages of 10 and 19 will experience a SED;[53] this is far more than the number of adolescents accessing care. Youth are also not getting care because many types of stressful experiences are not yet included in the clinical definition of trauma, which may allow those experiences or factors to be overlooked when assessing a child for current or potential mental health needs.[54] The District should be proactive in monitoring the health of youth who are exposed to these risk factors so that mental disorders do not go unaddressed.

D.C. officials and staff fail to understand the scope of mental health problems and appropriate solutions.

Too often, professionals lack a full understanding of what mental disorders and their causes are. As a result, youth are "held accountable" for delinquent behavior, while D.C. facilities and services fail to provide evidence-based services and conditions that would be conducive to the desired outcomes.

D.C. adults vary in their perception that people are caring and sympathetic to those with mental disorders.



Source: R. Manderscheid, and others, "Attitudes Toward Mental Illness," *Morbidity and Mortality Weekly Report*, Table 3.

In May, 2012, a clinical counselor working with DYRS youth through a master's degree program wrote in the *Washington Post* that few of these youth have a mental disorder. Certainly, there are youth whose justice involvement is unrelated to a mental health problem. However, the writer then goes on to describe a host of traumatic experiences that these youth have encountered: "forced prostitution, abandonment, rape by a family member, homelessness and death of friends through gun violence."[55]

It cannot be stated strongly enough that traumatic stress leading to mental health conditions should be addressed. District leaders need to embrace the fact that common punitive approaches are detrimental and that utilizing effective solutions does not denigrate the need for public safety. Rather, these solutions enable youth to begin the healing process so that they can comprehend the severity of their anti-social behavior and the impact of delinquency on victims and the community. Expanding current evidence-based services, such as multi-systemic therapy, functional family therapy, and therapeutic in-home services is key to decreasing dependence on punitive, ineffective treatment options and put D.C.'s youth on a better path to recovery.

Stigmas associated with mental health treatment persist.

The 2007 Behavioral Risk Factor Surveillance System survey revealed that 74 percent of adults in the District of Columbia strongly agreed that treatment can help persons with mental illness. However, fewer agreed that people are sympathetic to people with mental disorders. Among those receiving treatment for frequent, serious mental illness, over 50 percent strongly disagreed that people are caring and sympathetic toward people with mental disorders. Yet,

among people with no mental health problems, about 60 percent felt that people are generally caring and sympathetic toward people with mental disorders.[56]

The issue of stigma is a concern of mental health providers across the nation. In the District, concerns are raised about the role of stigma in preventing individuals from accessing treatment; however, practices that exacerbate stigma continue. The practice of sending youth without medical need for intensive treatments to Residential Treatment Centers may cause parents to not want to associate their children with mental disorders. Furthermore, the lack of evidence-based services with culturally appropriate approaches appears to further stigmatize youth as they are unable to communicate with their practitioners about their needs. Meanwhile, the practitioners may make faulty judgments about the youth's needs and progress due to a limited understanding of the youth's culture and family life.

D.C. AGENCIES ARE SHOWING PROGRESS IN IMPROVING THE DISTRICT'S MENTAL HEALTH SYSTEM FOR YOUTH

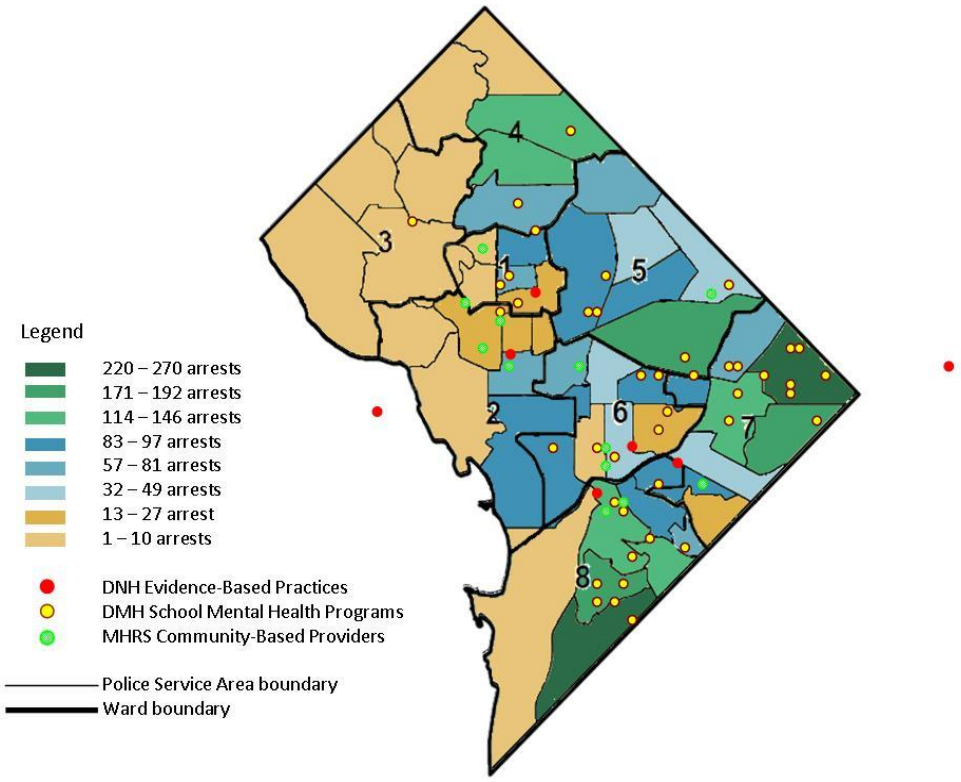
The D.C. Department of Mental Health (DMH) has made strides in shifting the District toward more preventive and effective mental health services; and in 2011, 5,040 children and youth were served in some capacity through their programs.[57] Currently, there are 17 certified community-based Mental Health Rehabilitation Services (MHRS) providers that serve children and youth. Seven facilities are providing one or more of the following types of community-based, *evidenced-based* mental health services with a total capacity to serve up to 684 of the District's children and youth this year:

- Trauma-Focused Cognitive Behavioral Therapy: Five agencies provide services to "overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence"to up to 260 youth annually.
- Functional Family Therapy: Two agencies provide this "empirically grounded" intervention for families and youth at risk for going into or already involved in the justice system.
- Multisystemic Therapy (MST): Only one agency in the metro D.C. area provides this proven type of "intensive treatment for youth with complex issues" to up to 130 youth per year.
- MST for Youth with Problem Sexual Behavior: One agency expands on MST to intervene with factors underlying problem sexual behavior.
- Parent Child Interaction Therapy: DMH provides this service at 821 Howard Road for "conduct disordered young children...improving the quality of the parent-child relationship and changing parent-child interaction patterns."
- Child Parent Psychotherapy for Family Violence: This service is scheduled to begin in 2012.

The Department of Mental Health is set to triple the number of youth in Functional Family Therapy and match the number youth receiving MultiSystemic Therapy in 2011.[58] They are also making strides in reducing the number of youth placed in Psychiatric Residential Treatment Facilities and diverting youth into community based, wrap around programs. However, this does not include youth under the custody of the Department of Youth Rehabilitation Services who are placed in Residential Treatment Centers, and at times, Psychiatric Residential Treatment Facilities. Youth under Court Social Services supervision may also be placed in Residential Treatment Facilities without the involvement or knowledge of the DMH although this does not commonly occur.

The 24-hour Access HelpLine is one of the main ways individuals in D.C. are connected to care;

Map 2. The locations of many mental health providers are not easily accessible to the highest risk communities of D.C.



Sources: Metropolitan Police Department, "Biannual Data on Juvenile Arrests," 2011; Department of Mental Health, "School Mental Health Program Phone Directory," February 2012; Department of Mental Health, "DMH Evidence-Based Practices Fact Sheet," March 2012; Department of Mental Health, "List of Community Based Service Providers," http://dmh.dc.gov/dmh/cwp/view,a,3,q,516001.asp.

youth are welcomed to call this line to receive phone support, as well as a referral to additional help as needed.[59] Youth may also interface with DMH and receive services through the School Mental Health Program in 53 schools across the District. This program provides prevention, standardized assessment, evidence-based early interventions, basic treatment, and referral to more intensive treatment outside the school, as needed. Within the Department of Health's Healthy Start Program, DMH provides mental health assessment, intervention, and supportive services to mothers prior to and following birth. This project particularly targets Wards 5, 6, 7, and 8.[60] Through their Healthy Futures Program, DMH provides mental health training and consultation to staff at 24 child care centers to promote positive mental health practices and healthier interactions with 1,286 children.[61]

DMH is also currently making efforts to reduce fragmentation of the mental health system through a Substance Abuse and Mental Health Services Agency systems-of-care grant. Through this grant, they are making plans to reduce problems related to having a system with both fee-for-service and managed care components.

AGENCIES NEED TO WORK TOGETHER TO BETTER PROVIDE MENTAL HEALTH SERVICES TO D.C. YOUTH.

However, as Map 2 shows, there is still a need for local providers and services in the most high-risk areas where youth are being arrested in greater proportions. Most private pediatric

specialists are located in Wards 2 and 3, miles from the most high risk areas for mental health problems. As of 2009, only one private pediatric psychiatry specialist was located east of the Anacostia River.[62] Only three MHRS providers and two evidence-based practices are currently operating east of the Anacostia River within the D.C. limits.[63] Six providers serving clients on Medicaid closed those programs or closed their business between 2010 and 2012; and many others were forced to lay off up to 75% of their mental health staff. This is due to the difficulty in obtaining certifications, licenses, and funds through the D.C. Medicaid system.[64]

Of the hundreds of youth needing community-based, evidence-based services, only 113 children have received Functional Family Therapy services and 64 youth are in MultiSystemic Therapy through DMH this year.[65] Tracking provision of mental health services by managed care organizations is difficult, as they are currently not required to provide extensive reporting to the District's Department of Health Care Finance.

The complexities of the system once a youth is assessed to be in need of services pose additional problems for assuring continuity of care. The responsibility for services and funding (for youth not in the justice system or foster care) may fall on Medicaid managed care organizations (MCOs) or DMH, depending on the severity of the child's diagnosis. Youth in the justice system or in foster care receive mental health services through the Medicaid fee-for-service program, but once their involvement with those departments end, their care must switch back to MCOs or DMH.[66]

Of the 53 school mental health programs, seven have a clinical psychologist on staff – with only one of those located east of the Anacostia in Ward 7. The school mental health programs are staffed with a mental health specialist in 10 schools and a social worker in 32 schools.[67]

Many youth may receive treatment and mental health services through DYRS, Court Social Services, foster care, or the education system, but that information is not shared through a central repository. This makes it very difficult to measure how many children are receiving needed services. The lack of communication between departments also creates a gap between the systems which may result in youth not receiving the monitoring or follow-up services needed as their care switches between systems. Additionally, the lack of organization among departments also allows for different standards in mental health assessment and services to persist – youth interfacing with one department may receive in-home treatment while youth in another may receive no treatment or may be placed in a RTC. This presents are barrier for youth in need of on-going, consistent, and appropriate mental health services.

The Juvenile Behavioral Diversion Program

One example of the systems beginning to work together for children's mental health is the

Of the 53 school mental health programs, seven have a clinical psychologist on staff – with only one of those located east of the Anacostia in Ward 7. The school mental health programs are staffed with a mental health specialist in 10 schools and a social worker in 32 schools

Juvenile Behavioral Diversion Program. Although treatment prior to involvement in the juvenile justice system is what the District should strive for, diversion programs that provide youth a chance to clear their justice record as they receive treatment is a step in the right direction. In 2011, the D.C. Superior Court implemented a mental health focused diversion court for youth with clinical mental disorders. Although court involvement is "late in the game" for addressing mental health issues, the advantage of this program is that it offers youth an opportunity to have their charges dismissed or have a shortened probation if they successfully complete the program. They also receive access to needed mental health services and treatment through the DMH.

The program works in three key steps prior to the court stepping out of the picture: orders of appropriate services, successful linkage to needed services, and monitored compliance with treatment requirements. One of the keys to success is that the youth's therapist and other providers are required to appear in court to provide updates. The presence of Department of Mental Health in court enables youth to receive the treatment/services needed without the multiple barriers that often come without having an advocate within the system.

Community strengths should be recognized and empowered within our most vulnerable communities.

Although poverty presents a major concern in many of the high-risk areas of D.C., those communities still have strengths and assets that should be celebrated and emphasized in overcoming barriers to good mental health. Such strengths should be used to bolster the social networks among residents, thereby increasing their community ties and ultimately their ability to self-govern and thrive.[68] Wards 7 and 8, the areas of high youth arrests and risk factors, have rich histories and distinct cultures which can serve as a platform to unite youth, inspire education and learning, and expand the beautification of those areas. Simply enriching the physical and social environments can result in increased well-being and enhanced mental health for all community residents. A number of organizations have mobilized to begin this work, such as Building Bridges Across the River, a nonprofit that built the Town Hall Education Arts Recreation Campus (THEARC) in Ward 8. This building houses 11 other nonprofit organizations that provide supportive services to children and families. Such programming includes mentoring, teaching and practicing the arts, sharing the history of the area, and educating residents on topics related to wellness and health. A Farmer's Market, held in the parking lot of THEARC, provides a wonderful step toward providing accessible, affordable nutritious foods in an area designated as a food desert.[69]

MORE EFFECTIVE APPROACHES TO YOUTH MENTAL HEALTH CAN INCREASE LIFE OUTCOMES FOR YOUTH, COST TAXPAYERS' LESS AND INCREASE PUBLIC SAFETY.

A concerted effort to improve the mental health system in D.C. would result in increased cost savings to the District. Children's mental health problems cost society three times more than infectious diseases.[70] Substantial financial returns are seen for investments in diagnosis and treatment of mental disorders prior to justice system involvement.

The cost return of expanded diagnosis and treatment of depression is $7 to every $1 invested; and a return of $5.60 is estimated for every $1 invested for prevention services.[71] One study that estimated the cost benefit of budgeting for mental health and substance abuse treatment found a 170 percent annual return on the cost of investment; this translated into a gain of $32.76 per dollar spent.

Changes in gross budget amounts from 2010 to 2012 among various District agencies:				
Agency	**FY 2010 (Actual $)**	**FY 2012 (Approved $)**	**Amount Change ($)**	**Percent Change (%)**
Department of Mental Health	216,423,000	177,651,000	-38,772,000	-18
Metropolitan Police Department	505,059,000	478,537,000	-26,522,000	-5.3
Department of Corrections	151,775,000	136,288,000	-15,487,000	-10
D.C. Lottery and Charitable Games Control Board	230,248,000	258,000,000	+27,752,000	+12
Source: D.C. Office of the Chief Financial Officer, Proposed Fiscal Year 2013 Budget by Agency Cluster, http://cfo.dc.gov/cfo/cwp/view,a,1321,q,647377.asp.				

An analysis conducted in the State of Texas revealed that if funding for mental health and substance abuse services was restored to FY2000 levels and adjusted for inflation, the returns would start at $1.65 billion and add a minimum of 9,782 permanent jobs. Estimating returns for funding mental health and substance abuse services to the national per-capita level resulted in 122 percent return on the investment.[72] Unfortunately, from 2009 to 2012, the District ranked in the top 10 for states with largest percent cuts to their general funds for mental health.[73] When comparing changes made to the gross funds of various District agencies, the Department of Mental Health took a substantial cut in its funding despite the obvious need for mental health services. Other enforcement and supervision agencies took smaller cuts, while some agencies received more funds, such as the D.C. Lottery and Charitable Games Control Board which increased its funds by nearly 30 million dollars.

From 2009 through 2012, three states increased their general funds for mental health by more than 15 percent, including Maine (15.4 percent), North Dakota (48.1 percent), and Oregon (20.9 percent).[74] During this time frame, North Dakota increased enrollment in the Medicaid program by 8,000 children.[75] They also changed their model from "symptom control" to a recovery model and began a partnership to mold their mental health system into a "Trauma Informed System."[76] North Dakota is reaping the benefits of their investments: North Dakota ranked 1st in the nation in 2010 and 2nd in the nation in 2011 for fewest "poor mental health days" among its residents.[77]

The District has made progress as well in expanding enrollment of children in Medicaid, opening community-based treatment providers, emphasizing prevention through school programs, and more. However, a greater number of programs should be funded and certified to provide services to a larger number of children and youth, particularly those in high-risk areas. Additionally, barriers to accessing DMH services should be eliminated so that existing evidence-based treatment options are not forced to close. Expanded mental health services could reduce the stigma associated with treatment, which is widely prevalent in D.C., helping to eliminate the perception that only youth with "severe" mental health episodes need treatment. Services for mental health disorders of all ranges and severities should be more readily available and utilized by the general public. Increasing access to treatment and services will benefit youth in the classroom, as they try to obtain or maintain employment, in their relationships with family and peers, and as they engage in other social activities that contribute to quality of life. As was noted in one study on the cost benefit of mental health investment: *"Expanding funding for both*

traditional and innovative treatment options would pay sizable economic benefits even beyond the immeasurable quality-of-life improvement for those involved and represents an appropriate and highly productive use of State funds."[78]

RECOMMENDATIONS

In light of the current decline in crime and the tight fiscal budget atmosphere, continued progress toward a public health approach to safety is imperative. While additional funding for prevention and treatment of youth mental health needs would be ideal, at the very least current dollars should be reallocated from less effective approaches toward efforts that will produce a greater return on the investment. The following recommendations provide action steps for various departments and parties involved in service delivery to assure funds and policies are in line to provide optimal care.

1. **The District needs to foster an attitude of understanding, acceptance and healing toward youth dealing with trauma.** Children should not be punished for displaying symptoms of trauma, PTSD, and other mental disorders inside or outside the justice system.
   a. A non-punitive approach must be standardized into protocol for a variety of D.C. departments to ensure that youth are getting the services they need before their health deteriorates to the point of delinquency or criminal behavior.
   b. If already in the justice system, youth should be provided treatment based on the effectiveness of the services, not the convenience of the services. Furthermore, youth should be treated appropriately, both medically and culturally, to reduce the stigmas associated with receiving mental health services.
2. **All professionals working with, or determining policies and procedures for, District youth with potential mental health needs should be trained in basic mental health science and terminology.** Each District agency interfacing with D.C.'s youth, particularly law enforcement, Department of Youth Rehabilitation Services, Court Social Services, Education, among others, should train each staff in basic mental health science and terminology. Each staff person should be trained in skills to effectively communicate with and foster healing in youth with mental disorders, rather than exacerbating the illness with ineffective and/or harmful responses to the youth's reactions and behaviors.
3. **Include mental health in all District agencies' policies.** District policies must consider that the wellness of youth's mental and emotional states is a key component in public safety. A "mental health-in-all-policies" approach is important as the mental health of this population has implications on the budgets and services of many D.C. public agencies and departments. It is difficult to tease out the costs and benefits of effective mental health services on these various sectors – therefore, *all* District agencies should consider mental health needs when creating and implementing policies and procedures. District agencies should each conduct a review of their policies and insert directives that account for the mental health needs of youth in a way that calls for existing resources and funds to be better utilized.

Providers who understand the cultural nuances of the communities they serve can more effectively improve community well-being

The United Kingdom is currently implementing this approach with positive outcomes and cost-benefits impacting their public health, public welfare, and other sectors.[79]

4. **Reduce the fragmentation, complexity of the mental health system to ensure the sustainability of mental health services.** The difficulty in understanding and accessing the fragmented and complex system of mental health services, as well as, the various challenges in funding, credentialing, and organization of mental health organizations in the District is challenging and beyond the scope of this paper. However, other organizations such as Rand, the Children's Law Center, and the Medical Care Advisory Committee Behavioral Health Subcommittee have produced papers that cover it well.[80] The District of Columbia may invest millions of dollars in mental healthcare; however, the fragmentation of the system is a major barrier to ensuring children with mental health needs are cared for and shielded from involvement in the juvenile justice system.
5. **Prioritize spending for mental health services in the city budget.** Although the fiscal climate has put a tremendous burden on states to reduce spending, some agencies of the District received increased funds while the Department of Mental Health took serious cuts. Mental health prevention and treatment services should be a priority to city officials as a decline in mental health can lead to so many undesired outcomes both for the youth and the District as a whole.
6. **Expand culturally appropriate services and ensure provider locations within the communities being served.** As Map 2 demonstrates, many services providers are located outside the communities that most need prevention and treatment. However, the effects of culture on a child are pervasive and not only impact behavior but also a youth's "values, aspirations, and expectations."[81] In order to provide effective services and overcome persistent stigma barriers, providers with a cultural understanding must be placed in areas they are servicing.
7. **Enable access to timely, appropriate mental health prevention and treatment for youth and their families prior to and without justice system involvement.** Services should be obtainable without a court order. Youth should also be able to access needed services without becoming involved in the justice system. A structure and process should be followed to ensure that families can access needed evidence-based services without being lost in the "system" and consequently, never receiving the assistance needed. Efforts should be continued and expanded to help parents of these youth – particularly parents with their own mental health and/or substance abuse needs who may need additional supports and services in order to provide better parenting for their children.
8. **Substantially reduce the use of Residential Treatment Centers and Psychiatric Residential Treatment Facilities.** Most kids in the justice system, like kids in the community, need treatment in a community or home-based setting for their treatment to be effective. A disproportionate number of youth continue to be placed in RTCs/PRTFs instead of local, more effective community-based programming. The cost of confining youth in these facilities generally average around $10,000 to $30,000 for one month;[82] and studies have consistently confirmed the ineffectiveness of RTCs on recidivism, as well as the negative impacts on youth confined without severe treatment needs. [83] The use of these facilities should be a "last resort" option: Low to medium risk youth should be placed in community-based treatment options; and, other treatment options should be tried prior to a youth's placement in RTCs/PRTFs. Although the District may spend millions of dollars on mental health, using these funds for RTC/PRTF placements is resulting in poorer

health and worse outcomes for hundreds of youth.

9. **Mental health data collection and analysis should be a priority for D.C.** General prevalence rates of mental disorders, usage of mental health services, or other measures for mental health among youth should be readily available as a service to the people and professionals of D.C. This impacts local organizations' ability to understand youth's mental and behavioral health needs, as well as, to explain the need for support and funding with potential grant makers.

COMMON MENTAL HEALTH TERMS, DISORDERS AND SYMPTOMS

Attention-deficit disorder/Attention-deficit and hyperactivity disorder – The most diagnosed childhood behavioral disorder, it is characterized by problems with "inattentiveness, over-activity, impulsivity, or a combination." Comorbidities may include depression and/or learning disabilities, among others.[84]

Bipolar disorders – mood disorders characterized by a cycling between manic and depressive states. Bipolar I is characterized by periods of depression as well as at least one manic episode, defined as a "distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week." Bipolar II is characterized by depressive periods in addition to low-levels of mania (called hypomania). Associated with high risk of suicide and substance abuse.[85]

Comorbidity – the co-occurrence of diseases and/or mental disorders.[86] For example, anxiety disorders in children are very often comorbid with other neuropsychiatric disorders. In other words, children diagnosed with an anxiety disorder will commonly be diagnosed with an additional neuropsychiatric disorder.[87]

Conduct disorder – diagnosed in children and adolescents with "long-term (chronic) behavior problems, such as defiant or impulsive behavior, drug use, [and/or] criminal activity…often associated with attention-deficit disorder."[88]

Depression – a mood disorder characterized by chronic "feelings of sadness, loss, anger, or frustration" for at least two weeks. Commonly associated with low self-esteem and may be triggered by stressful life events coupled with poor coping skills; often comorbid with bipolar disorder.[89]

Mood disorders – a group of mental disorders characterized by disturbance in mood resulting in marked distress. Includes manic and depressive disorders, each of which are conceptualized as chronic problems in mood regulation.[90]

Oppositional defiant disorder – a "pattern of disobedient, hostile, and defiant behavior toward authority figures." Most often diagnosed before adulthood, ODD is associated with a higher risk of being diagnosed with a Conduct disorder, ADHD, and other impulse control problems. [91]

Post-traumatic stress disorder – an anxiety disorder following a traumatic experience characterized by intrusive thoughts of the event, emotional disturbances (e.g. agitation), and increased arousal (e.g. hypervigilance).[92]

Psychotic disorders – a group of disorders characterized by abnormal thinking and perceptions. Delusions, false beliefs, and hallucinations, perceptions of non-existent sounds or things, are common aspects of psychotic disorders.[93]

Schizophrenia – a psychotic brain disorder characterized by hallucinations, delusions, disorganized speech, negative symptoms (e.g. lack of emotional expression), and/or catatonic behavior. Schizophrenia is diagnosed in 1% of the population and is associated with increased risk of substance abuse disorders as well as cognitive deficits.[94]

Self-regulation – the ability of an individual to change or adapt in relation to the world around it.[95]

Serious emotional disturbance – children up to 18 years of age with diagnosable mental, behavioral, or emotional disorder meeting diagnostic criteria specified within DSM-IV that inhibited normal daily activities at school, in the family, or in the community.[96]

Suicidal idealization – thoughts of committing suicide, with or without a plan to do so; serves as a major risk factor for self-harm and suicide.[97]

Toxic stress – prolonged activation of physiological stress mechanisms, triggered by negative life events, aggravated by problematic or non-existent coping and social support systems. Associated with higher risk of being diagnosed with a mental disorder as well as impairments in normal brain development.[98]

Trauma – an emotional response to a significantly terrible event, characterized by shock and denial. Long-term psychological reactions may include "unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea."[99]

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