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Juvenile Justice, Mental Health, and the Transition to Adulthood: A Review of Service System Involvement and Unmet Needs in the U.S

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Abstract

Although adolescents are the primary focus of juvenile justice, a significant number of young people involved with this system are considered transition age youth (i.e., 16–25 years of age). The aim of this review is to summarize the specific needs of transition age youth with mental health conditions involved with the juvenile justice system, identify the multiple service systems relevant to this group, and offer recommendations for policies and practice. A comprehensive search strategy was used to identify and synthesize the literature. Findings highlight the paucity of research specific to transition age youth. Thus, we also summarized relevant research on justice-involved adolescents, with a focus evaluating its potential relevance in the context of the unique milestones of the transition age, including finishing one's education, setting and working towards vocational goals, and transitioning from ones' family of origin to more independent living situations. Existing programs and initiatives relevant to transition age youth with mental health conditions are highlighted, and nine specific recommendations for policy and practice are offered.

Keywords

transition age youth; juvenile justice; mental health; service utilization; evidence-based practice

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1. Introduction

Each year, more than 2 million children, adolescents, and young adults formally come into contact with the juvenile justice system in the U.S. (Puzzanchera, 2009). The majority of these youth (65–70%) have at least one diagnosable mental health problem, and 20–25% have serious emotional problems (Shufelt & Cocozza, 2006; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002). The current system for rehabilitation often fails to address or even presents barriers to meeting the multiple needs of such young people. Transition age youth are a particularly vulnerable subgroup in the juvenile justice system, as this age group has the highest rates of mental health problems (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012) and also face multiple transitions in life roles during this developmental period. This paper provides an overview of service system issues for mental health practitioners, juvenile justice professionals, policymakers, and allied professionals whose work brings them in contact with transition age youth with mental health needs in the juvenile justice system.

Though the predominant focus of the juvenile justice system is on adolescents, a significant number of justice-involved youth fall into the developmental period known as the transition age, which refers to youth ages 16 through 25 years (Davis & Vander Stoep, 1997). The number of transition age youth served by the juvenile justice system varies by state for two reasons. First, there is variability across states in the upper age of jurisdiction in the juvenile court—the age at which an individual who breaks the law would be processed in the juvenile versus adult court system. Figure 1 shows that the majority of states consider crimes committed through age 17 as juvenile offenses. Only a few states have an upper age of 16, and two currently have a limit of 15. Second, there is variability in the age at which youth are transferred from the juvenile to adult justice systems. Figure 2 shows that only a few state juvenile justice systems end their involvement with youth at age 18. It is more common for justice-involved youth to remain under juvenile jurisdiction through age 20, with some states allowing extension to age 24.

Given the large number of transition age youth involved with the juvenile justice, it is important for this system to be well-informed about the significant changes in educational, vocational, and relational roles, including reduced family influence and changing social networks, inherent to this age group (Arnett, 2000). This developmental period poses challenges for even the most well-adjusted youth as they make long-term decisions about careers and move from their family of origin to more independent living situations (Institute of Medicine [IOM] and National Research Council [NRC], 2014). Normative transitions include completing school or vocational training, obtaining and maintaining gainful employment, developing a social network, and becoming a productive citizen. Success is determined by a complex interplay between youth, their families and neighborhoods, and available opportunities.

2. Search strategy

Several strategies were employed to reviewing the relevant literature, integrate findings, and identify areas for continued study. First, published papers were located through database

searches of PsychINFO and PubMed for keywords, titles, abstracts, and text containing the words: a) “emerging adult,” or “transition age youth,” or “transitional youth” or “transitioning youth” or “young adult” or “adolescent” cross referenced with b) “mental health,” or “mental illness” or “mental disorder” and c) “juvenile justice” or “criminal justice” or “juvenile delinquency” or “criminal rehabilitation.” Next, the reference lists of relevant articles were reviewed to identify papers that might have been missed in the database searches. Preference was given to empirical papers published in peer-reviewed journals and, whenever possible, papers with the most recent and comprehensive data were summarized. Due to space limitations, not all papers identified as a result of this search are listed.

3. Mental health problems and other pitfalls of the transition age

The importance of this developmental period lies not only in key milestones but also in the risk for impediments. Rates of mental health problems peak during the transition age, and the majority of mental health disorders have onset by the early 20s (Kessler et al., 2005; Kim-Cohen et al., 2003; SAMHSA, 2012). Past-year prevalence rates for mental health problems, excluding substance use disorders, are 29–40% between ages 18 and 25 (Newman et al., 1996; SAMHSA, 2012). Serious mental illness (i.e., mental health disorders causing significant functional impairment) is less common (7.7%) but still more prevalent during the transition age than other developmental period (SAMHSA, 2012). At the same time, utilization of mental health services declines sharply, presumably due to multiple barriers to care including healthcare coverage loss and transitions to adult service systems (Copeland et al., 2015; Pottick et al., 2008). An important distinction for transition age youth is that a disruptive behavior disorder diagnosis allows minors to access services in the child mental health system, but adults presenting solely with a disruptive behavior disorder are typically denied coverage in adult systems (Davis & Koroloff, 2006). Thus, transition age youth with primarily behavioral disorders often lose access to mental health services as they age out of child systems and into adult systems.

Similarly, transition age youth have the highest rates of problematic substance use and substance use disorders compared to other age groups (Chassin, Flora, & King, 2004; Delucchi, Matzger, & Weisner, 2008; SAMSHA, 2009). A majority report lifetime alcohol (90%) and illicit drug use (61%; SAMSHA, 2008), and the past-year prevalence rate of substance use disorders increases from 9% for youth ages 12 to 17 to 21% for ages 18 to 25 (SAMSHA, 2005).

For youth who struggle during the transition to adulthood, having multiple problems is the rule rather than the exception (Osgood, Foster, & Courtney, 2010). Adversity during this developmental period can delay or derail the achievement of normative transitions. Youth struggling with mental health problems and juvenile justice involvement are at a disadvantage as they enter the transition to adulthood. Those at the highest risk for these types of setbacks are those from disadvantaged psychosocial backgrounds who have experienced multiple lifetime adversities (Chung, Little, & Steinberg, 2005), including poverty, poor relationships with family members, school failure and/or dropout, negative peer groups, and a lack of adult role models. These histories of disadvantage do not provide

resources necessary to overcome the substantial challenges faced by multi-problem transition age youth.

4. Transition age youth in the juvenile justice system

Transition age youth in the juvenile justice system are “the perfect storm” of the potential perils of this developmental period. First, mental health problems are common. The most common mental health disorders among youth in the juvenile justice system are disruptive behavior disorders (e.g., conduct disorder), anxiety disorders (e.g., posttraumatic stress disorder), and mood disorders (e.g., major depression) (Skowyra & Coccozza, 2007). Further, many youth with mental health diagnoses have a co-occurring substance use disorder (Armstrong & Costello, 2002). Due to a paucity of research on this age group, the majority of what is known about rates of mental health problems comes from adolescent studies. One study of youth entering non-residential juvenile justice settings (e.g., probation) estimated that 45% of boys and 50% of girls met diagnostic criteria for a mental health disorder (Wasserman, McReynolds, Ko, Katz, & Carpenter, 2005). Studies of residential juvenile justice facilities show higher rates of 65–70% (Shufelt & Coccozza, 2006; Teplin et al., 2002; Wasserman et al., 2002). Even when behavioral disorders (e.g., substance abuse, conduct disorder) were not considered, 46% of youth in residential justice settings met criteria for a mental health disorder (Shufelt & Coccozza, 2006).

Like non-justice-involved youth who have a mental health condition, comorbidity rates are high for justice-involved youth. An estimated 79% of youth with one mental health disorder also meet criteria for at least one other disorder, and more than 60% meet criteria for a substance use disorder (Shufelt & Coccozza, 2006). Co-occurring conditions predict worse outcomes; for example, youth with co-occurring behavioral problems and emotional problems are at elevated risk for recidivism (Cottle, Lee, & Heibrun, 2001; Hoeve, McReynolds, & Wasserman, 2013) and committing violent offenses during young adulthood (Copeland, Miller-Johnson, Keeler, Angold, & Costello, 2007). Thus, juvenile justice programs are responsible for the care of a large number of youth who have complex mental health needs (Coccozza & Skowyra, 2000).

Successful transitions to adulthood often depend on financial and emotional support from families beyond adolescence (IOM & NRC, 2014; Settersten, Furstenberg, & Rumbaut, 2008), an advantage many justice-involved youth do not have. For example, justice-involved youth also have high rates of involvement with the child welfare system, indicating family disruption and discord. Over 60% of “serious offenders” in juvenile detention had a history of child welfare involvement due to maltreatment (Langrehr, 2011). In one study, approximately 16% of youth who had a history of placement in foster care come into contact with the justice system during adolescence (Ryan & Testa, 2005). In the National Survey of Child and Adolescent Well-being, 16% of young adults with a history of child welfare contact during adolescence had been arrested in the previous year, and approximately 45% were assessed to be at risk for some type of mental health problem (Southerland, Casanueva, & Ringeisen, 2009). It is important to note that, in many states, youth cannot be concurrently involved in child welfare and juvenile justice; thus, research usually focuses on either past child welfare involvement of justice involved individuals or subsequent justice system

involvement of child welfare youth. Studies on the overlap between child welfare and juvenile justice involvement highlight the lack of “natural” supports for youth involved with these systems as they transition to adulthood.

5. Critical issues facing justice-involved transition age youth with mental health problems

Involvement with multiple systems is the rule rather than the exception for youth in the juvenile justice system, particularly those with mental health problems. For example, at least one in five youth involved in community-based mental health systems also has juvenile justice involvement (Cauffman, Scholle, Mulvey, & Kelleher, 2005; Rosenblatt, Rosenblatt, & Biggs, 2000; Vander Stoep, Evens, & Taub, 1997). Table 1 provides an overview of the service systems with which justice-involved youth typically interact, as well as key issues related to each system. As noted in a recent report from the Institute of Medicine and National Research Council, current policies and programs for this age group are often fragmented, inadequately coordinated, and not designed for their specific developmental needs (IOM & NRC, 2014). Navigating these separate systems can be incredibly challenging for a young person facing multiple psychosocial problems.

Interacting with multiple providers can be overwhelming to youth, particularly due to the lack of seamless interplay between systems (Davis, Green, & Hoffman, 2009) and youths’ lack of past experience with adult-oriented systems (e.g., vocational rehabilitation). Poor communication means that goal setting and interventions across agencies can be at odds with one another. In a study of collaboration between child welfare and juvenile justice, two factors predicted successful coordination of mental health services: (a) having a single agency held accountable for the youth’s well-being (i.e., either child welfare or juvenile justice) and (b) interagency sharing of administrative data (Chuang & Wells, 2010). Thus, effective coordination of care and agency accountability is necessary to ensure youth do not fall through the cracks.

6. Issues specific to detained and incarcerated transition age youth and reentry

Among youth processed and adjudicated delinquent by the juvenile justice system in 2009, 27% were placed in residential settings, 60% were placed on probation, and 13% received other sanctions (Knoll & Sickmund, 2012). Thus, incarcerated youth make up a significant minority (27%) of the juvenile justice population. Many of the estimated 200,000 juveniles and young adults ages 24 and under returning from incarceration each year will face reentry during their transition to adulthood (Mears & Travis, 2004). One study found that only 31% of youth were engaged in either school or work 12 months after release from correctional facilities (Bullis, Yovanoff, Mueller, & Havel, 2002). This is likely in part due to low high school completion rates and lack of work experience during time spent in a locked facility. The situation is compounded by the return to former neighborhoods and peer groups that may foster criminal behavior. Reentry programs have been primarily developed and studied

with adult populations; thus, little is known about their effectiveness with youth (Farrington, Loeber, & Howell, 2012).

Following reentry, transition age youth display low rates of engagement with community-based services such as mental health treatment and vocational rehabilitation. In one study, only 35% of juvenile offenders had been engaged in such services during the 6 months following reentry (Chung, Schubert, & Mulvey, 2007). Primary barriers include insufficient healthcare coverage, inability to navigate multiple systems, and, for some, lack of service providers in their communities. Transition age youth often qualify only for adult-oriented care that is not suited to their developmental needs. Upon reentry, transition age youth often face the perception and reality of having “fallen behind” same-age peers and hopelessness about their ability to catch up.

Although detained and incarcerated youth could be considered a “captive audience,” the justice system is currently not well equipped to provide effective mental health treatment to the large numbers who require it (U.S. Department of Justice, 2005). One large-scale study found that only about 15% of youth with a significant mental health problem received treatment while detained (Teplin, Abram, McClelland, Washburn, & Pikus, 2005). The involvement of family members in mental health interventions, a key factor in successful treatment, is rarely available to incarcerated youth, limiting both treatment effectiveness and maintenance of gains. Many treatments in correctional facilities are delivered in a group format, aggregating delinquent peers – a strategy shown to have iatrogenic effects on group members due to “deviance training” or the learning of new delinquent behaviors from deviant peers (Dishion, McCord, & Poulin, 1999; Mathys, Hyde, Shaw, & Born, 2013). There is also a lack of continuity of care for these youth as they transition from treatment providers in detention centers to those in their communities. Finally, after release, youth face the same barriers to mental health treatment as many of their peers, including availability of providers in their neighborhoods, transportation problems, and healthcare coverage, among others.

7. Evidence-based and promising practices and policies

There is little information on evidence-based practices and policies specifically for justice-involved transition age youth with mental health problems (Hoffman, Heflinger, Athay, & Davis, 2009; IOM & NRC, 2014). Most of what is known is extrapolated from studies with adult or adolescent justice-involved populations. A variety of treatments have been well validated to target delinquency among justice-involved adolescents (e.g., Multisystemic Therapy, Multidimensional Treatment Foster Care; for review, see Henggeler & Sheidow, 2012), but far fewer are specifically designed to meet the unique developmental needs of transition age youth or to address mental health problems among justice-involved youth. Evidence-based treatments for adolescents can be adapted for use with transition age youth; however, they often rely heavily on parental involvement, an approach that may be less effective or feasible with transition age youth, who may be either living independently, with peers, or otherwise disengaged from their family of origin. Thus, we summarize what may be applicable to transition age youth while identifying areas in need of further investigation.

7.1. Multisystemic therapy

Multisystemic Therapy (MST) is a well-established, intensive, community-based treatment for delinquent behavior among justice-involved adolescents (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009). Two adaptations of MST are reviewed. First, MST was adapted for justice-involved transition age youth with serious mental health conditions (i.e., Multisystemic Therapy for Emerging Adults [MST-EA]). MST-EA integrates MST principles, evidence-based mental health treatments, and psychiatric support for medication monitoring. In addition, MST-EA therapists target concerns specific to transition age youth (e.g., educational/vocational goals, independent housing). A pilot study of MST-EA found reduced recidivism, mental health symptoms, and association with antisocial peers (Davis, Sheidow, & McCart, 2014), but additional research is needed. Second, Family Integrated Transitions (FIT) is an MST adaptation for youth with co-occurring mental health and substance use disorders transitioning home following incarceration (Trupin, Kerns, Walker, DeRoberts, & Stewart, 2011). FIT combines MST, dialectical behavior therapy, parent training, and motivational enhancement implemented 2–3 months prior to release through 4–6 months post-release. A pilot study found reductions in felony (but not overall) recidivism among 12- to 19-year-olds (Trupin et al., 2011). However, FIT was designed for adolescents rather than transition age youth. Thus, there is a strong emphasis on parental involvement, which differs from MST-EA and may be less developmentally appropriate for transition age youth.

7.2. Foster care

Youth aging out of the foster care system are at particularly high risk for criminal justice involvement. However, recent studies have shown that extending foster care beyond age 18 can reduce arrests during young adulthood (Lee, Courtney, & Hook, 2012; Lee, Courtney, & Tajima, 2014). Thus, two specific policies and programs related to foster care are relevant for transition age youth. The first is the John H. Chafee Foster Care Independent Living Program, which promotes successful transition to independent living for youth up to age 21. Funds can be used for housing, educational/vocational training, and mental health treatment (Foster & Gifford, 2005). One pitfall is that many states have had difficulty providing comprehensive and well-coordinated services under this program due to limitations in available federal funds (Collins, 2004; Davison & Burris, 2014). A second resource is Multidimensional Treatment Foster Care (MTFC), a home-based family treatment provided as an alternative to group homes and residential settings (Chamberlain, 2003). MTFC utilizes specialized foster homes where caregivers are trained to manage delinquent behaviors until youth can transition back to their families. MTFC also provides individual and family therapy, educational programming, and psychiatric care and is effective in reducing delinquent behaviors, justice system contacts, substance use, depression, and teen pregnancy (Chamberlain, Leve, & DeGarmo, 2007; Kerr, DeGarmo, Leve, & Chamberlain, 2014; Smith, Chamberlain, & Eddy, 2010). Though only evaluated with adolescents, MTFC may prove to be useful if adapted for transition age youth, especially given the push to extend foster care services through the transition age and the focus of MTFC on transitioning youth from foster care back to their communities.

7.3. Wraparound services

Wraparound services use a system of care philosophy, emphasizing maintenance of youth in the least restrictive environment through intensive coordination of multiple services (Bruns et al., 2004). The Connections program in Washington state is one of the most rigorously studied wraparound programs for youth up to age 18 with mental health problems (Pullman et al., 2006). Each family is assigned to a team of professionals, including a mental health care coordinator, a probation counselor, a family assistance specialist for emotional support and practical assistance, and a juvenile services associate for mentoring and aid with the treatment plan. Youth in this program were less likely to recidivate in general and have felony offenses in particular, and they served less detention time than comparison youth (Pullman et al., 2006). Similar programs have also shown promise in reducing recidivism (Anderson, Wright, Kooreman, Mohr, & Russell, 2003; Kamradt, 2000), though one program produced positive effects on educational outcomes and police contacts but not on arrests or incarceration (Carney & Buttell, 2003). However, the comparative effectiveness of the wraparound approaches compared to case management for reduction of mental health symptoms has not been established (see Bruns et al., 2015). Moreover, evaluations have not focused on older transition age youth (i.e., over age 17).

7.4. Diversion programs

Diversion programs provide alternatives to formal justice system sanctions, typically for first-time offenders, and often provide treatment in lieu of punishment (see Chapin & Griffin, 2005 for a review). One meta-analysis did not find significant reductions in recidivism, even for diversion programs that specifically targeted mental health needs (Schwalbe, Gearing, MacKenzie, Brewer, & Ibrahim, 2012). However, when evidence-based interventions for adolescent delinquent behaviors (e.g., MST, Functional Family Therapy) were included in diversion plans, results were promising. Similar to these findings, preliminary results from Ohio's Behavioral Health Juvenile Justice program suggest that a diversion program that provides evidence- and community-based behavioral health treatment is effective in improving both delinquency and behavioral health outcomes (Kretschmar, Butcher, Flannery, & Singer, 2014). Thus, diversion programs may be effective when evidence-based treatments are available in youth's communities. Further, diversion programs reduce time in locked settings, a contributor to developmental delays (Chung et al., 2005). For these reasons, diversion programs should be tailored to meet the needs of transition age youth with mental health problems and examined as alternatives to formal sanctions.

7.5. Reentry and aftercare programs

Reentry and aftercare programs are initiated either during the transition from incarceration to the community or soon after reentry and aim to reduce recidivism through provision and coordination of services. Some treatments, such as Multisystemic Therapy, can be utilized for reentry services, but some programs are specifically tailored to this transition. In a meta-analysis of specific reentry programs for justice-involved adolescents and young adults (but not specifically youth with mental health needs), a small but positive effect on recidivism was identified (James, Stams, Asscher, De Roo, & van der Laan, 2013). Results suggested a

particular benefit for older youth, and two of the reviewed programs were designed specifically for transition age youth. The Boston Reentry Initiative (BRI) involved individualized transition plans (e.g., acquisition of housing and employment, mental health treatment) and frequent contact with a mentor (Braga, Piehl, & Hureau, 2009). BRI lowered re-arrest rates for young adults with violent criminal histories. The second program, Lifeskills'95, also incorporated developmentally appropriate services, including job and educational resources, skills training, and substance use services. Lifeskills'95 was superior to usual services for recidivism, employment, substance abuse, and family relationship outcomes (Josi & Sechrest, 1999).

Another promising reintegration program is Multidimensional Family Therapy–Detention to Community (MDFT-DTC) (Liddle, Dakof, Henderson, & Rowe, 2011). MDFT is a family-based intervention originally designed for adolescent substance use. The DTC adaptation extended MDFT to justice-involved youth with substance abuse and related emotional or behavioral disorders. In a pilot study, MDFT-DTC showed promise with regards to feasibility, implementation, and treatment engagement (Liddle et al., 2011). However, like other family-based interventions that rely predominantly on family therapy and parenting techniques, MDFT-DTC cannot be fully delivered in the absence of involved caregivers, which may inhibit its application with transition age youth.

7.6. Coordination of care programs

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

8. Domain-specific services

There are also some effective programs developed within specific domains relevant to justice-involved transition age youth. None of these interventions alone are likely to be sufficient to ensure a successful transition to adulthood for justice-involved youth, and coordination and individualization of such services are needed to ensure effectiveness. However, they represent potential building blocks of successful programs for this age group.

8.1. Mental health treatment

Little is known about the effectiveness of evidence-based mental health treatments in justice settings, and such treatments are rarely available to justice-involved youth (see Sukhodolsky & Ruchkin, 2006 for a review). Although this may reflect barriers to disseminating evidence-based treatments in general, the justice system presents unique challenges. For example, by definition, justice-involved youth with mental health diagnoses have multiple

psychosocial problems, and evidence-based treatments designed for single disorders are often insufficient. The Comprehensive Community Mental Health Services (CCMHS) for Children and Their Families Program, administered by SAMHSA and the U.S. Department of Health and Human Services, aims to address this problem among youth (up to age 21) with mental health problems through coordinating systems of care (SAMHSA, 2010). In a large-scale evaluation, CCMHS improved functional impairment, school performance, mental health service utilization, arrest rates, and delinquency (SAMHSA, 2010). Importantly, 57% of these youth had conduct problems, lending support for CCMHS's potential for justice-involved youth. Evaluations of communities implementing CCMHS have shown increased availability of evidence-based mental health services and improved service delivery systems.

SAMHSA has also funded demonstration projects for transition age youth. In 2002, the Partnerships for Youth Transition program funded five sites to develop transition support systems for youth (up to age 24) with serious emotional disturbance. This cross-site evaluation showed moderate improvements in employment and education outcomes, but mixed results for justice system involvement and substance use (Haber, Karpur, Deschenes, & Clark, 2008). Another program, the Emerging Adult Initiative, emphasized greater system change and policy work and funded seven sites in 2009. This program is still underway, but a preliminary report suggests positive results (SAMHSA, 2013). In 2014, SAMHSA funded 17 sites with their Now is the Time – Healthy Transitions program. This is similar to the Emerging Adult Initiative, but with a stronger emphasis on outreach to unidentified or unserved transition-age youth with or at risk of serious mental health conditions. These projects may develop into resources for transition age youth in the juvenile justice system.

8.2. Substance abuse treatment

There are a handful of substance use treatments with a strong evidence base for adolescents and/or adults. These include family-based treatments (including MST and MDFT), contingency management, motivational interviewing, and cognitive behavioral approaches, as well as treatments combining these approaches (see Hogue, Henderson, Ozechowski, & Robbins, 2014 for a review). Less is known about the effectiveness of these treatments for transition age youth, particularly those with co-occurring mental health problems (Sheidow, McCart, Zajac, & Davis, 2012). For example, although family involvement is an important predictor of positive treatment outcomes in adolescent samples, it is less clear how to involve families of transition age youth in developmentally appropriate ways.

8.3. Educational and vocational supports

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

A few evidence-based interventions have been developed to support secondary education for youth with psychiatric disabilities (Rogers, Kash-MacDonald, & Maru, 2010). For example, Check and Connect aims to increase educational engagement through monitoring of academic performance, building of problem-solving skills, and provision of a trained mentor who partners with the family, school, and community. This intervention has been shown to improve academic performance and reduce disciplinary referrals and drop out (Maynard, Kjellstrand, & Thompson, 2014; Sinclair, Christensen, & Thurlow, 2005). Jump On Board for Success (JOBS) provides developmentally tailored wraparound services focused on career development (Clark, Pschorr, Wells, Curtis, & Tighe, 2004). JOBS coordinates wraparound care and supported employment for youth (16 to 22) with serious emotional disturbance involved with the juvenile justice system or adult corrections. The program improved engagement in school and/or employment from 23% at baseline to 96% at graduation. RENEW (Rehabilitation, Empowerment, Natural Supports, Education, and Work) was developed for youth with emotional and behavioral disorders to provide an individualized and comprehensive planning and support process focused on high school completion, career development, employment, and post-high school activities such as independent living, education and training, and community inclusion (Hagner, Cheney, & Malloy, 1999). A pilot study found promising effects on employment and graduation rates, and a larger trial is currently underway. Finally, Individualized Placement and Support (IPS) is an evidence-based employment intervention for adults with mental illness. Across four studies, individuals receiving IPS had almost double the employment rate and about triple the number of weeks employed compared to controls (Bond, Drake, & Becker, 2012). However, young adults in IPS were not employed for most weeks and averaged fewer than 20 work hours per week.

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

The National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) funds two research and training centers relevant to transition age youth: focusing on (a) educational and vocational supports for transition age youth with serious mental health concerns (<http://labs.umassmed.edu/transitionsRTC/>), and (b) successful transitions for youth with mental health conditions (<http://www.pathwaysrtc.pdx.edu/>). These centers have developed multiple interventions for this age group, including MST-EA described previously. For example, the Supported Employment and Supported Education for Emerging Adults program is a vocational support program for youth (16 to 21), adapted from the Individual Placement and Support model described above, that provides

educational and vocational services in coordination with clinical services (Ellison et al., 2015). This model is augmented by same-age peers who provide vocational mentorship. The Better Futures Program coordinates care through individualized coaching, peer support, and connection to community resources to support postsecondary education among transition age youth with mental health conditions in foster care (Geenen et al., 2015). Evaluations of these programs are underway.

8.4. Healthcare

The justice system provides many youth with their first access to much-needed healthcare (Golzar, Hunt, & Anoshiravani, 2006; Rogers, Pumariega, Atkins, & Cuffe, 2006). This is particularly important given high rates of sexually transmitted infections in this population. For example, transition age youth have the highest incidence of HIV and the poorest adherence to medication regimens (MacDonell, Naar-King, Murphy, Parsons, & Harper, 2010; Metsch et al., 2008). Young adults with chronic conditions also frequently face barriers to care including decreased parental involvement, a shift from pediatric to adult settings, and the loss of healthcare coverage (MacDonell et al., 2010). Incarcerated youth also present with significant health needs (Bradley & Kalfs, 2003; Feinstein et al., 1998). One study found that the majority of juvenile correctional facilities provided health screenings at admission, crisis management, and access to psychotropic medication management, but only 68% provided outpatient psychotherapy and fewer provided other types of mental health services (Pajer, Kelleher, Gupta, Rolls, & Gardner, 2007). Despite high rates of medication management, reentry planning is needed to ensure continued healthcare access after discharge. This is particularly important for those whose health care coverage will potentially shift due to attaining adult status (IOM & NRC, 2014).

8.5. Housing and transportation

Obtaining and maintaining independent housing is a significant challenge for many transition age youth. For low-income youth, housing subsidies are in short supply and have long waitlists. One solution is for juvenile justice or mental health agencies to develop collaborations with public housing agencies to allow rapid access to housing options and assistance (Koyanagi & Alfano, 2013). Transportation can pose a similar challenge. Youth must be mobile to access needed services to attend multiple weekly appointments, and service providers might not be located in close proximity to one another. Youth often lack the financial resources to have independent transportation and rely on family members, friends, or public transportation. This barrier is more pronounced in rural areas where there are greater distances between providers and public transportation is not available. There is a lack of programs to address these problems.

8.6. Pregnancy and parenting

High rates of risky sexual behaviors also put justice-involved females at risk for pregnancy and early parenthood. In a study of female adolescents (ages 13–17) involved in both the juvenile justice and child welfare systems, between 22% and 30% reported a pregnancy during their lifetime (Kerr et al., 2009). This number undoubtedly increases as youth reach transition age, with a larger number of young women becoming parents. Researchers have recognized the need for gender-specific programming in the juvenile justice system to

address needs related to pregnancy and parenting (Bloom, Owen, Deschenes, & Rosenbaum, 2002), but evidence-based programs are not currently available.

For young mothers and fathers, parenting can be an overwhelming task, and intensive services are often necessary to ensure support for the youth and her child. One such program is the Nurse-Family Partnership (NFP), an evidence-based home visitation program that provides services during and following pregnancy for low-income, first-time mothers (Olds, 2006). NFP has been shown to improve parent-child interactions, maternal well-being, and vocational outcomes, and reduce risk for subsequent pregnancies. An augmentation of NFP for mothers with mental health problems (i.e., depression, partner violence) has been developed but has not yet been evaluated (Boris et al., 2006). Although not specifically evaluated with justice-involved mothers, NFP has the potential to be a helpful tool for this group.

9. Policy and practice recommendations

Current policies and programs are not sufficient in addressing the needs of justice-involved transition age youth with mental health problems. The following policy recommendations are consistent with those put forth for transition age youth with serious mental health conditions (Davis et al., 2009). An overarching recommendation is that federal policies, including IDEA and the Chafee Act, are fully implemented in the juvenile justice system (see Gagnon & Richards, 2008; Koyanagi & Alfano, 2013). Most policies relevant to juvenile justice are at the state rather than federal level; however, two federal programs provide funding that can be used by juvenile justice programs: federal block grants and Title V Local Community Prevention Incentive Grants. Federal block grants currently only fund programs up to age 18, precluding their use for older youth in juvenile justice systems. It is recommended that federal block grants, as well as other federal policies that set upper age limits of 18 for “child” programs, extend the upper age limit minimally to age 21, and ideally to age 25. The Title V Local Community Prevention Incentive Grants program is not age restrictive but is highly competitive, making it difficult for many local programs to secure funding.

In general, we recommend that an extension of the positive youth development and developmentally appropriate framework of the most recent juvenile justice reform be maintained at the upper age limits of juvenile justice services (National Research Council, 2013). In addition, we offer nine specific suggestions to promote systemic reform:

9.1. Recommendation 1. Rehabilitation versus punishment

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

incorporating age-appropriate supports, including educational, vocational, mental health, and substance abuse interventions.

9.2. Recommendation 2. Mandatory transition planning in the juvenile justice system

Transition planning should be required for youth ages 16 or older in the juvenile justice system. It is already a requirement for youth who receive special education services and those in foster care (through the Fostering Connections Act), and the educational and child welfare systems have models for how to implement such planning. These plans should include provisions for transitions from child to adult systems of care (e.g., mental health) and also assess and plan for needs in key areas crucial to success in adulthood (e.g., education, vocation, independent living). Plans should be integrated with existing transition plans for youth in foster care and/or special education services. Stakeholders from key community agencies (e.g., mental health, child welfare, vocational rehabilitation, school districts) should have input in transition planning. Specifically, coordination with other systems should be attained through memoranda of understanding to achieve the commitment needed for ensuring appropriate services.

9.3. Recommendation 3. Coordination of care across service systems

There is a clear need for improvements in coordination of care among the many service systems involved with transition age youth in the juvenile justice system. Adult service systems, including adult mental health and vocational rehabilitation, must be included. Policies aimed at improving coordination of care should hold agencies accountable for outcomes to ensure youth are meeting the goals of each system. The most pervasively practiced model of coordination of care for youth with mental health conditions is the wraparound approach, though not all wraparound teams specialize in juvenile justice populations. Policies that support full implementation of wraparound, extend wraparound to age 21, and require relevant agency involvement in the oversight of services should facilitate care coordination. A practice model for coordination of care is Project Connect (described above), though it would require careful modification specific to transition age youth. If possible, service providers across systems should be condensed under one roof or in close physical vicinity. Increasing the convenience of attendance can significantly improve youth engagement. Alternatively, providers could be allowed to meet with youth in their homes or communities.

9.4. Recommendation 4. Access to evidence-based mental health treatments

One barrier to evidence-based mental health treatment is lack of health care coverage. Various Affordable Care Act (ACA) provisions increase availability of coverage for young adults but there are reasons to be skeptical about the effectiveness of such reforms for transition age youth with substantial mental health morbidity. Studies of health care reform in Massachusetts found increased enrollment for young adults in Medicaid and healthcare exchanges (Gettens, Mitra, Henry, & Himmelstein, 2011; Long, Yemane, & Stockley, 2010) but worse enrollment among adults with behavioral health problems (Capoccia, Croze, Cohen, & O'Brien, 2013). The effects of ACA on health care coverage should be monitored among vulnerable youth. In addition, improving coordination of care and linkage to services

are important but will only be effective if quality mental health services are available in young adults' communities.

9.5. Recommendation 5. Training for professionals who work with transition age youth

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

9.6. Recommendation 6. Additional research and program development

Additional work on mental health treatments and transition services is needed for transition age youth in juvenile justice settings. Current evidence-based programs for adolescents and adults can be adapted for this age group, but thorough efficacy evaluations are needed.

9.7 Recommendation 7. Assessment of a wider range of transition-related outcomes

The majority of existing programs have focused on outcomes related to recidivism and have neglected other important outcomes for this group, including mental health and vocational/educational outcomes. Assessments of these outcomes further into adulthood (i.e., up to 5 years after aging out of the juvenile justice system), are also needed.

9.8 Recommendation 8. Smaller caseloads

High caseloads preclude the individualized intensive services required for justice-involved youth with mental health problems. This problem is common to mental health, probation, child welfare, and vocational rehabilitation providers. Thus, the recommendation is to reduce caseloads for providers working with complex multi-problem youth.

9.9. Recommendation 9. Promotion of appropriate involvement of families

As youth transition to adulthood, they often require the support of their family; however, family involvement is likely to decrease as youth progress into adulthood. The aim should be to move youth progressively into "the driver's seat" while encouraging support from family members. In addition, mentors and other key members of the youth's social network can be leveraged to promote successful transitions to adulthood. This is likely to be a helpful framework across all service systems.

10. Conclusion

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

involved with the juvenile justice system, providers and policymakers have the opportunity to impact large numbers of vulnerable youth through the implementation of effective programming.

Substantial changes in the juvenile justice and mental health systems are required to ensure successful transitions to adulthood. An overarching theme is the need for developmentally appropriate policies and interventions, taking into account factors that differentiate this age group from both adolescents and adults. A key to overcoming barriers to services is the effective coordination of the various systems that transition age youth must navigate, and providers must be well versed in the specific needs of this age group. Although policies and programs that support these principles are rare, initiatives have been developed that may serve as a springboard for continued policy and program development for this important population.

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Highlights

- We summarized the developmental and service needs of justice-involved transition age youth with mental health problems.
- Transition age youth are a unique subgroup within the juvenile justice system.
- There are high rates of mental health problems among this group.
- We highlighted areas in need of further research.
- We provided nine specific policy and practice recommendations for this group.

Figure 1.

Upper age of original juvenile court jurisdiction, 2013.

Source: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. (2013). *Statistical Briefing Book*.

Statistics retrieved from http://www.ojjdp.gov/ojstatbb/structure_process/qa04101.asp?qaDate=2013

Figure 2.

Extended age of juvenile court jurisdiction, 2013

Source: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. (2013). *Statistical Briefing Book*.

Statistics retrieved from: http://www.ojjdp.gov/ojstatbb/structure_process/qa04106.asp?qaDate=2013&text=

Table 1**Relevant Service Systems for Justice-Involved Transition Age Youth**

Service System	Key Features
Child Welfare	<ul style="list-style-type: none"> • Frequent current or historical involvement due to abuse or neglect • In severe cases, youth are removed from family of origin and placed with foster family or group home (Malmgren & Meisel, 2004)
Special Education	<ul style="list-style-type: none"> • Justice-involved youth have high rates of learning disabilities, cognitive delays, and/or emotional/behavioral problems that affect their ability to learn and tend to have intellectual functioning in the low-average to average range (Foley, 2001) • Also at-risk for school-related sanctions, including expulsion
Mental Health	<ul style="list-style-type: none"> • High rates of mental and behavioral health problems for this age group, including onset of severe mental illness (e.g., schizophrenia, bipolar; de Girolamo, Dagani, Purcell, Cocchi, & McGorry, 2012) • At age 18, youth may become ineligible for continued care in the child system and many fail to qualify for adult mental health services due to more stringent qualifying criteria • Youth sometimes face a change or loss in their health care coverage upon reaching an adult age (e.g., youth's legal guardian is unable or unwilling to continue carrying youth on insurance coverage) • Adult mental health providers rarely have specialized training on transition age youth • After youth reach 18, privacy law protections change in protecting health information (e.g., therapists fail to engage transition age youth's family members in mental health treatment; Osgood et al., 2010)
Vocational Rehabilitation	<ul style="list-style-type: none"> • Goals of vocational rehabilitation: creating individualized employment plans; job readiness through education and on-the-job training; assisting with job seeking, applications, and retention • Wide disparity in intensity, quality, and efficacy of state vocational rehabilitation agencies • Justice-involved youth face additional challenges, as they often lack basic skills necessary for employment (e.g., no workplace experience, interactions with authority figures have been punitive rather than professional, little time management and professionalism skills) • Long waitlists for vocational services and inflexible policies regarding appointment attendance can alienate transition age youth
Housing Authority	<ul style="list-style-type: none"> • Barriers to successful employment and self-sufficiency can lead to difficulty obtaining housing • Public housing applications often cannot be submitted until age 18. Waitlists can be long (e.g., in 2013, the average wait in Washington, DC was 28–39 years depending on number of bedrooms; Dvorak, 2013) • Youth who recidivate and receive a felony conviction can be denied public housing permanently. • Some housing authorities can deny public housing on the basis of disqualifying offenses committed by any family members, including juvenile offenders (Henning, 2004)