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Judges' Perceptions of Screening, Assessment, Prevention, and Treatment for Substance Use, Mental Health, and HIV among Juveniles on Community Supervision: Results of a National Survey

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Abstract

Juvenile Justice-Translational Research on Interventions for Adolescents in the Legal System (JJ-TRIALS) National Survey was funded in part to describe the current status of screening, assessment, prevention and treatment for substance use, mental health, and HIV for youth on community supervision within the US juvenile justice system. Surveys were administered to community supervision agencies and their primary behavioral healthcare providers, as well as the juvenile or family court judge with the largest caseload of youth on community supervision. This article presents the findings from the judges' survey. Survey results indicated juvenile and family court judges were open to innovations for improving the court's performance, rated their relationships with collaborators highly, and appreciated the impact of screening, assessment, prevention, and treatment on judicial practices.

Keywords

Juvenile Justice System; Juvenile/Family Court; Community Supervision; Substance Use Disorders; Mental Health Disorders; HIV; Screening and Assessment; Behavioral Healthcare Interventions; Comorbidity

Until the 19th century, the legal system of the United States treated juvenile and adult law-breakers alike (Fox, 1970). In the late 1800s, however, the country's evolving perceptions of adolescence as a developmental stage distinct from adulthood resulted in critical legal reforms, such as age-segregated correctional institutions for youth (Scott & Steinberg, 2008). Other meaningful, systemic changes appeared at the end of the 19th century when the Progressive Movement fostered the creation of a dedicated juvenile court (Rothman, 1978). Nonetheless, in the latter decades of the 20th century, the passage of harsh sentencing laws

and other “get tough” legislation shifted the focus of the juvenile justice system away from a rehabilitative social welfare model toward a more punitive, just-desserts model for youthful offenders (Feld, 1993).

To counteract this approach to punishment, the Juvenile Justice and Delinquency Prevention Act, originally passed in 1974 and amended in 1980, 1992, and 2002, focused on both preventing youth from formally entering the legal system and treating them for the underlying problems that fostered their engagement in delinquent and criminal behavior (Finklea, 2012). In its basic tenets (core protections), the Juvenile Justice and Delinquency Prevention Act mandated the separation of incarcerated juveniles from adults, the deinstitutionalization of juvenile and status offenders, the privilege of treatment over detention for juvenile justice system-involved youth, and the reduction of disproportionate minority representation in the juvenile justice system (Kelly, 2014).

The current study examined the attitudes and perceptions of juvenile and family court judges regarding a wide variety of issues pertaining to the juvenile justice system and community supervision practices in the United States. In particular, the study investigated both the needs of youth in the system as well as services available to them either directly or indirectly through referral to address substance use, mental health and HIV risk.

Juvenile Justice System-Involved Youth

Substance use disorders

Substance use disorders are the most common types of problems among juvenile justice - involved youth, affecting more than 50% of males and 47% of females (Dennis et al., 2009; Shufelt & Cocozza, 2006; Teplin et al., 2002, 2006). Substance use is one of the most consistent predictors of continued serious offending among juveniles (Dembo, Wareham, & Schmeidler, 2007). Among the 2.4 million youth arrested in 2000, 1.9 million (79%) reported substance use problems, were arrested for drug offenses, or were under the influence of drugs at the time of their arrest (National Center on Addiction and Substance Abuse, 2004). Among youth further into the juvenile justice system, other studies have reported rates of substance use disorders of 45% to 65% (e.g., Shufelt & Cocozza, 2006; Teplin et al., 2002; Wasserman et al., 2002).

Mental health disorders

Compared with their non-juvenile justice involved counterparts, a higher proportion of juvenile justice involved preteens and adolescents are plagued by emerging or full-blown psychiatric symptoms that demand clinical assessment and treatment (Grisso, 2004). A national study, for example, found that between 50% and 75% of juveniles in detention suffered from mental illness (Shufelt & Cocozza, 2006). In addition, conservative estimates suggest that 10% of juvenile detainees have recently contemplated suicide, while another 10% have actually attempted suicide during their lifetimes (Abram et al., 2008).

HIV-risk behaviors

Juvenile justice system-involved youth are at elevated risk for HIV due to high rates of risky sexual behaviors, substance use and other psychiatric disorders, and sexually transmitted diseases (Donenberg et al., 2015; Gates et al., 2016; Teplin et al., 2013). In a sample of 10,352 adolescents and young adults in juvenile justice settings (Dennis et al., 2009), several HIV-risk behaviors were common in the past 90 days, including frequent sexual activity (67%), multiple sex partners (31%), unprotected sex (27%), victimization (20%), and needle use (2%). Rates of these behaviors were similar among young adults or had increased with age (e.g., McClelland et al., 2002).

Co-occurring disorders/problems

Juvenile offenders typically face a wide range of co-occurring problems, including a history of substance use and other psychiatric disorders, learning disabilities and academic failure, and trauma and neglect. In a sample of 10,352 adolescents and young adults in juvenile justice settings (Dennis et al., 2009), approximately 80% had three or more of eight major clinical problems. Another study found similarly high comorbidity rates of substance use, behavioral disorders, and psychiatric disorders among juvenile offenders (86% for female offenders and 85% for male offenders) (Karnik et al., 2009). Combinations of these problems suggest a poor prognosis for recovery and complicate diagnosis, treatment, and case management services (Abram et al., 2004; Grella, Hser, Joshi, & Rounds-Bryant, 2001).

Criminological risk assessment

Risk assessment practices are common in the field of juvenile corrections, especially in probation (Baird et al., 2013; Loung & Wormith, 2011). The primary purpose of risk assessment is to predict the likelihood of various youth outcomes while on community supervision, such as subsequent police contacts, arrests, and adjudications (Vincent, Guy, & Grisso, 2012). Examples of risk assessment tools for juveniles include the Youth Assessment and Screening Instrument (YASI), (Orbis Partners, 2011), the Youthful Level of Service/Case Management Inventory (YLS/CMI) (Olver & Stockdale, 2012), the Positive Achievement Change Tool (PACT), (Baglivio, 2009), the Structured Assessment of Violence Risk in Youth (SAVRY) (Meyers & Schmidt, 2008), and the Beck Youth Inventories-Second Edition (BYI-II) (Palmer & Binks, 2008).

Behavioral health screening and clinical assessment

Screening in juvenile justice system, detention, and community supervision settings generally involves a brief evaluation in order to detect emergent or probable problems that require further examination and possible treatment in different clinical and service domains (Belenko et al., 2017). Juveniles are usually screened in the earliest stages of contact within the juvenile justice system and are typically re-screened at periodic intervals while in detention or on community supervision (Grisso & Underwood, 2003).

Screening is not intended to diagnose behavioral health problems, nor is it tantamount to a professional evaluation (Grisso, Vincent, & Seagrave, 2005). For example, if screening identifies potential problems among youth, they are then fully assessed with reliable and

valid instruments, preferably administered by trained professionals with expertise in substance use and other psychiatric disorders (Grisso & Underwood, 2003). In short, assessment entails an in-depth evaluation of youth whose screening results indicate the likelihood of a diagnosable disorder (Desai et al., 2006).

Substance use and HIV prevention

Early drug use relates to a variety of other harmful behaviors, including delinquent and criminal activity, and other behavioral health problems (CASA, 2011; Mulvey, Schubert, & Chassin, 2010). Hence, prevention among youth is the key to alleviating the harms of adolescent substance use. Programs to prevent drug use among adolescents are designed generally to enhance protective factors (e.g., parental support) and diminish risk factors (e.g., antisocial attitudes) (National Institute on Drug Abuse, 2014).

Numerous evidence-based interventions and best practices for HIV prevention have been identified in systematic reviews and published in compendia (e.g., Centers for Disease Control, 2014). Nonetheless, few programs have been developed expressly for juvenile justice involved youth, which is troubling in light of their elevated risk for HIV and other STDs (Marshall, Crepaz, & O'Leary, 2010). Similar to those found in the field of substance use prevention, promising models to lower the risk of HIV among juvenile justice involved youth also incorporate interventions that bolster protective factors and reduce risk factors, such as problems related to mental health, substance use and trauma (Gates et al., 2016).

Substance use and mental health treatment

The serious behavioral health afflictions of juvenile justice involved youth can be alleviated with proper evidence-based services (Grisso, Vincent, & Seagrave, 2005). Indeed, studies have demonstrated the feasibility of implementing evidence-based assessment tools and interventions as well as the effectiveness of evidence-based substance use and mental health treatment among youth in the juvenile justice system (Skowrya & Coccozza, 2007). Nevertheless, the availability of such interventions fails to meet the demand for services, and rates of engagement and retention in substance use and mental health programs in the juvenile justice system are correspondingly low (Welty et al., 2016).

Current Study

The juvenile justice system always has limited resources for screening, assessment, prevention, and treatment services for youth with behavioral health problems, such as substance use and mental health disorders, and enhanced risk for HIV (Pajer, Kelleher, Gupta, Rolls, & Gardner, 2007; Shelton, 2005). Historically, the primary mission of the juvenile justice system has been the incapacitation and punishment of juvenile offenders and the protection of public safety. Adherent to this mission, the system continues to be deficient as a primary provider of child and adolescent behavioral healthcare services (Coccozza, Loughran, Denney, & Espinosa, 2005; Thomas, Gourley, & Mele, 2005). Without appropriate diagnosis and treatment as juveniles, youth in the juvenile justice system are likely to follow a trajectory into adult criminality and incarceration (Osterlind, Koller, & Morris, 2007).

In 2013, the National Institute on Drug Abuse (NIDA) responded to the challenges of juvenile justice system-involved youth by funding the Juvenile Justice-Translational Research on Interventions for Adolescents in the Legal System (JJ-TRIALS) cooperative agreement. This research program was designed, in part, to investigate the nature and extent of behavioral health services in juvenile community supervision agencies by surveying a nationally representative sample of counties in the United States.

To explore the broad landscape of behavioral health services for juvenile justice system-involved youth, parallel surveys were administered to large samples of three populations: juvenile community supervision agencies; behavioral healthcare providers treating youth from community supervision agencies; and juvenile and family court judges monitoring youth from these agencies. The first wave of the survey was conducted between April 2014 and March 2015. A second survey of the same three groups is planned for 2017.

The current study presents the findings from the judges' survey, which was conducted to assess juvenile and family court judges' perceptions regarding the assessment and treatment of youth under community supervision. The survey examined three separate service domains: substance use, mental health, and HIV. The present investigation is the only project to date that used a representative national sample from all counties and focused on judges' views related to behavioral healthcare services for youth on community supervision.

Method

Overview of Sampling and Weighting Process

A nationally representative sample of 20 states was selected for the study based on the number of adolescents ages 10 to 19 as documented in the 2010 census. The five largest states were sampled with certainty, and the other 15 with probabilities proportionate to the number of youth in those states. Within each state, a representative sample of eight to 14 counties was selected based on the number of youth, again with the largest one or two counties sampled with certainty, and the remaining counties sampled with probabilities proportionate to the number of youth in those counties.

As noted above, within each sampled county, surveys were administered to juvenile community supervision agencies, the primary behavioral healthcare providers utilized by those agencies, and the juvenile or family court judge responsible for the largest number of youth on community supervision. Of the 198 juvenile and family court judges sent surveys, 179 (90%) completed and returned them. All the survey data were weighted and adjusted for nonresponse in order to represent the estimated 3,165 juvenile and family court judges with the largest caseloads of youth on community supervision, across 3,143 U.S. counties.

Judges' Survey Administration and Content

Each state was assigned a survey coach who worked with key stakeholders to identify the most appropriate agency and staff person at the county level for participation in each type of survey. Stakeholders were also asked to introduce the study to potential respondents. Survey coaches then delivered a PowerPoint presentation to respondents that described the survey goals and data-collection process. Survey coaches also mailed the survey and scheduled a

survey orientation call with those who had agreed to participate in the study. At the end of the call, participants and coaches agreed on a completion date for the survey. Coaches contacted participants each week to answer any questions and obtain an update on the survey completion process.

The juvenile and family court judges' survey contained questions in several content areas: professional identities; demographic characteristics; experiences and assignments (e.g., juvenile court, peer court, and family drug court); training in substance use, mental health, and HIV; collaborations, relationships, and coordination with service providers (substance use, mental health, and HIV); and perceptions of the prevailing climate and working relationships in the county's juvenile justice system. Judges were also asked to prioritize several issues affecting the juvenile justice system and the processing of juvenile offenders, and to rate the usefulness of screening and assessment tools in terms of improving decision-making with respect to substance use, mental health, and HIV. Finally, judges were asked to indicate their needs for additional professional training.

Results

Judges' Descriptors

Demographic characteristics—Nearly all (98%) of the judges were white and 80% were men. In terms of age, 50% were 60 or older, 40% 50 to 59, and 12% 40 to 49.

Professional experience—The judges overall were very experienced; 55% had worked in the juvenile justice field for more than 21 years, 30% had worked in the field for between 11 and 20 years; and 16% were employed in the field from one to ten years. Nearly 70% had been in their current position for 11 or more years. The majority of participants had held positions in the court system before becoming juvenile or family court judges. Specifically, 71% had been defense attorneys or public defenders, while 67% were former prosecutors or state's attorneys. In addition, 20% had been judges (in other than a juvenile justice system court), magistrates or other judicial officers, and 2% had been probation officers. The remaining 32% had served only in other miscellaneous positions.

As expected, nearly all (99%) of the judges had been involved with juvenile courts in the past year. The remaining 1% of judges had been recently assigned to the juvenile court. Large percentages of the judges were also involved with the criminal (84%), civil (82%), and family (81%) courts in the past year. Smaller percentages had been involved with mental health courts (14%), juvenile drug courts (9%), and other specialized courts (34%) in the past year.

Cases on docket—Although all of the judges obviously had juvenile community supervision cases on their caseloads, the percentages of such cases varied. Specifically, 72% indicated that between "1% and 25% of their caseloads" were youth on community supervision; 5% indicated that between "26% and 49% of their caseloads" included youth on community supervision; and 23% indicated that between "50% and 100% of their caseloads" were filled with youth on community supervision. Judges also varied in the percentage of their cases with current or prior involvement in the child welfare system.

Specifically, 47% reported between “0% and 25% of their cases,” 37% reported between “50% and 100% of their cases,” and 16% reported between “26% and 49% of their cases.”

Past-year training—Judges were asked to report the number of hours of training they had received in the past year in three major areas of behavioral health: substance use, mental health, and HIV. By far, the highest percentage of judges indicated having participated in substance use training; specifically, 43% reported receiving five or more hours of such training in the past year. Nearly one-third (32%) reported receiving between two and four hours of substance abuse training, 5% reported receiving one hour of training, and 20% reported receiving no training.

In the area of mental health, 23% reported receiving five or more hours of training and 38% reported receiving no mental health training. The overwhelming majority of judges (96%) reported receiving no HIV training, with the remaining 4% indicating either one hour (3%) or between two and four hours (1%) of HIV training.

Impact of Behavioral Health Services on Judicial Outcomes

Judges were asked to rate the extent to which they agreed that various behavioral health services lead to better judicial outcomes such as more balanced judicial decisions, less crime in the community, less recidivism by youth on community supervision, appropriate punishment of youth on community supervision, fair treatment of youth on community supervision, a more efficient justice process, and youth desistence from delinquency and criminal behavior. Figures 1 and 2 present these results.

Criminological risk assessment—Nearly 60% of judges agreed that risk assessment tools lead to more balanced judicial dispositions, half (50%) agreed that risk assessment tools lead to fairer treatment of youth, and nearly half (49%) agreed that such tools lead to a more efficient justice process and the appropriate punishment of youth on community supervision (48%). In contrast, only 22% agreed that risk assessment tools lead youth to desist from delinquency and criminal behavior, while 17% agreed that such tools lead to less crime in the community (Figure 1).

Standardized screening—A majority of judges agreed that using short standardized screeners to determine the need for substance use, mental health, and HIV- risk services leads to more balanced judicial dispositions (66%), fair treatment of youth on community supervision (60%), and a more efficient judicial process (61%). Much lower percentages of judges agreed that short standardized screeners lead to less recidivism among youth on community supervision (35%), youth desistence from delinquency and criminal behavior (32%), and less crime in the community (25%) (Figure 1).

Clinical assessment—A majority of the judges also agreed that using more formal clinical assessment tools to determine the need for substance use, mental health and HIV- risk services leads to more balanced judicial dispositions (75%), less recidivism (62%), fair treatment of youth on community supervision (70%), more appropriate punishments (64%), and a more efficient justice process (63%). Lower percentages agreed that clinical

assessment tools lead to youth desistance from delinquency and criminal behavior (47%) and less crime in the community (36%) (Figure 1).

Substance use and HIV prevention—Substantial percentages of judges (nearly 70% or higher) agreed that providing substance use prevention can positively affect judicial practices and community supervision outcomes. For example, 90% and 89%, respectively, agreed that substance use prevention leads to less crime in the community and less recidivism among youth on community supervision. In addition, approximately 70% agreed that substance use prevention leads to a more efficient justice process, fair treatment of youth on community supervision, and more appropriate punishment of youth on community supervision. In stark contrast, 10% or fewer of the judges agreed that providing effective HIV-risk prevention services affected any of the juvenile justice system or community outcomes listed in the survey except for youth desistance from delinquency and criminal behavior (12% agreement) (Figure 2).

Substance use and mental health treatment—Judges' views of the effectiveness of both substance use and mental health treatment were highly favorable. More than 9 out of 10 judges agreed that providing effective substance use treatment leads to less recidivism among youth on community supervision, less crime in the community, and youth desistance from delinquency and criminal behavior. Similarly, more than 8 out of 10 judges agreed that providing mental health treatment leads to less crime in the community, more appropriate punishment of youth on community supervision, less recidivism among youth on community supervision, and youth desistance from delinquency and criminal behavior (Figure 2).

Screening and Assessment Ratings

Judges were also asked to rate their agreement with several statements about the effects of screening and assessment on juvenile justice system outcomes. Nearly three-fourths (74%) of the judges agreed that clinical assessment tools are necessary to determine the severity of juvenile justice clients' mental health problems, while far fewer (57%) thought that such tools were necessary in determining the severity of juvenile justice clients' substance use problems (Table 1). Only 41% agreed that the use of standardized clinical assessments was the best way to ensure that delinquent youth were appropriately placed in treatment. Half of the judges (50%) agreed that juvenile justice staff should not conduct clinical assessments, while a larger percentage (76%) felt that only trained clinicians should perform clinical assessments.

Overall, judges' opinions concerning standardized clinical assessments were positive. Specifically, only 25% felt that such tools take too long to administer, while even smaller percentages felt that standardized clinical assessments provide only "paperwork" for service providers (7%), are not worth the effort due to the limited availability of resources (5%), and usually indicate that all juvenile offenders have similar needs (5%). Half (51%) of the judges had mixed opinions or were unsure about the value of screeners to identify who might need further standardized clinical assessment. Among those judges who had an opinion, 38% agreed with the statement that screening was the best way to identify youth who need standardized clinical assessment, while 11% disagreed with that statement.

Coordination, Climate, and Priorities

High percentages of judges rated their relationships as excellent to very good with community supervision agencies (91%), local police departments (85%), and other juvenile courts (76%). In contrast, they rated their relationships with state police departments (73%) and local/state child welfare agencies (70%) somewhat less favorably (but still positively). An average of 7% of judges rated as fair to poor their relationships with local/state child welfare agencies, local schools/school systems, and mental health service providers. The vast majority (9 out of 10) of judges indicated that they had no relationship with HIV prevention providers (Table 2).

Large percentages of judges agreed to be open and willing to try new ideas related to youth on community supervision (100%) and to promote different ideas even if they conflicted with established policies or practices (94%) (Table 3). The overwhelming majority of judges (92%) believed that the court and key service providers can freely discuss system-related difficulties or problems with youth on community supervision. They also indicated that they shared the goals that needed to be achieved in order to help youth on community supervision (84%), and that all court and key service providers were involved in discussions regarding the best ways to help youth on community supervision and their families (78%). Nevertheless, only 60% agreed that the court and key service providers met periodically to discuss what was working in an effort to improve outcomes for youth on community supervision.

Less than 60% agreed that the juvenile court system had specific plans to achieve its goals, and less than 40% agreed that the juvenile court system had well-defined performance outcomes for achieving its goals. However, large percentages (91%) of judges felt that they have opportunities to attend trainings and pursue other avenues for developing their skills and capacities; they also believed in the value of learning new knowledge and skills in the areas of substance use, mental health, and HIV as a means to improve their job performance. In addition, large percentages of the juvenile justice/family court judges agreed that other judges in their jurisdictions integrated new knowledge and techniques into their work (88%), viewed attendance in training as a priority (77%), and stayed current with new techniques related to their judicial practices (75%).

Table 4 presents judges' views about actual and desired priorities in their juvenile justice court systems. As shown, 60% or more of the judges selected as high or very high the following actual priorities in their jurisdictions: effective prosecution of juvenile offenders (80%), staff development and training (65%), effective juvenile defense counsel (64%), policymaker support for rehabilitation (63%), and appropriate services for young offenders (61%). Sharply lower percentages of judges endorsed the following as actual priorities in their jurisdictions: (reductions in) disproportionate minority contact (21%), gender-responsive services (19%), resources for non-English speakers (17%), and culturally relevant services (15%).

Judges revealed major discrepancies between the actual and desired priorities (Table 4). Differences of 33 percentage points or higher (desired versus actual) were found regarding public support for rehabilitation (78% versus 28%), culturally relevant services (56% versus

15%), capacity of the juvenile justice system to measure performance and evaluate services (72% versus 33%), effective juvenile defense counsel (99% versus 64%), and gender-responsive services (53% versus 19%).

Crime Reduction Remedies

All or nearly all of the judges agreed that the best ways to reduce crime among youth on community supervision are needs-based treatment (100%) and effective treatment for substance use (98%) and mental health (99%) problems (Table 5). Decreasing percentages of judges agreed that the best ways to reduce crime are jobs (84%), educational programs (74%), crime-related interventions (65%), and HIV-prevention and education initiatives (13%).

Training and Educational Needs

More than 70% of judges agreed that they needed additional training and education in the areas of mental health treatment (78%), substance use treatment (77%), the effect of trauma and psychiatric disorders on delinquency (76%), and substance use prevention (73%) (Table 6). Two-thirds or more of the judges agreed that they needed additional training in the areas of family engagement (69%), the understanding and use of standardized risk and recidivism measures (68%), the monitoring of program performance (67%), the effects of adolescent development on assessment, prevention, and treatment, and judicial communication with youth (66%). Less than 50% agreed that they needed additional training and education on the effects of environmental factors on choice of interventions (49%), increasing rapport with youth (46%), and HIV-risk prevention (43%). Only 28% of the respondents agreed that they lacked access to the training and development programs needed for their judicial practices.

Discussion

Judicial Leadership

Juvenile and family court judges are arguably the most important actors in the juvenile justice system, uniquely positioned and qualified to parse and weigh the varying and often conflicting perspectives and recommendations brought to the bench apropos troubled youth and their families (Rubin, 1979). With increasing numbers of youth entering the juvenile justice system with serious mental health and substance use problems, judges are increasingly called upon to exercise therapeutic jurisprudence in their daily practices, thereby serving the protective interests of both the youth and the communities in which they reside and striking a difficult balance between various competing interests in the juvenile justice system and public sphere (Miller, 2013). From their unique vantage point on the bench, judges can assess how the juvenile justice system works as a collective enterprise. Furthermore, their position of power and influence affords them a platform to convene broad-based coalitions to improve the juvenile justice system by, for example, placing more emphasis on rehabilitation and gender-responsive services. We recommend that judges lead discussions with key juvenile justice stakeholders about desired and actual outcomes in their respective juvenile courts, which will suggest strategies to reduce the disparities between aspirations and actual performance.

Judicial leadership within collaborative and cohesive court teams can effectuate systemic changes that ultimately improve outcomes for young people and their families (Miller, 2013). The role of the juvenile/family court judge is an admixture of juridical practices, administrative expertise, interpersonal savvy, and broad-based advocacy. Juvenile and family court judges' decisions set standards within the community and service systems that interface with the court (Rubin, 2012). Judicial activism can also set the stage for more behavioral healthcare resources and greater interconnectivities between treatment and the juvenile justice system.

Participants were open to new ideas, innovations, and discussions with juvenile justice system stakeholders for the sake of improving the court's performance. Judges rated highly their relationships with key collaborators, such as community supervision agencies, the police, and other juvenile justice system courts. Not so highly rated were judges' perceived relationships with child welfare agencies, schools, and mental health providers, as well as the court's ability to identify and measure performance indicators. We recommend joint conferences and trainings that will foster greater understandings and closer working relationships among the various systems and institutions that touch the lives of juvenile/family court-involved youth.

Screening and Assessment

Judges clearly appreciated the impact of screening and assessment on judicial practices, but to varying degrees depending on different types of assessments and their effects on different outcomes. With regard to generating more favorable outcomes, judges rated clinical assessment tools higher than standardized screenings and criminological risk assessment instruments, which they rated the lowest among the three types of evaluations. Overall, judges were most likely to agree that assessment tools lead to more balanced judicial dispositions, fair treatment of youth on community supervision, and a more efficient justice process; conversely, they were least likely to agree that assessment tools lead to youth desistance from delinquency and criminal behavior and less crime in the community. Standardized screening and clinical assessments provide judges with reliable information regarding a youth's behavioral health problems and allow them to compare such information with data from previous cases. Similarly, they are likely to value evidenced-based practices because they can expect that such services have met a certain touchtone of quality and effectiveness.

Judges agreed that clinical assessments are necessary to determine the nature and extent of mental health and substance use problems, and that such assessments are best done by trained clinicians. However, fewer (41%) indicated that standardized clinical assessments are the best mechanism for placing youth in treatment programs. We recommend that judges review current screening and assessment tools used by practitioners in their court systems in order to identify ways in which such instruments can be improved to be more user-friendly and useful in terms of better informing judges' decisions on a variety of case-specific matters.

Prevention and Treatment

Judges were particularly mindful of the importance of substance use and mental health treatment. On all measures, three-quarters or more of the judges agreed that such treatment leads to better outcomes for the court, youth, and community. They also saw the value of substance use prevention. Few judges, however, saw much value in the prevention of HIV-risk behaviors.

Training

Continuing education and training are essential components in the preparation of judges for handling complex juvenile justice system cases. The current study shows that judges highly value training and are up to speed on the nature and extent of drug problems (70% or more received two or more hours of training regarding substance use disorders). However, they are not so well versed with respect to psychiatric problems (50% received two or more hours of training regarding mental disorders) and not at all well versed with respect to HIV (only 4% received one or more hours of training regarding HIV). Judges were eager to learn more about substance use and other psychiatric disorders as well as family dynamics, adolescent development, and the pernicious effects of trauma on youth.

The high prevalence of mental health and substance use problems among juvenile justice system-involved youth increases their risk of contracting HIV, which can have life-altering and even deadly consequences. Thus, further judicial training in these areas is clearly recommended and warranted. The more knowledgeable judges are on the topic of HIV, the more informed their judicial decision-making will be in terms of offering prevention and treatment services for at-risk youth. We also recommend that judges continue to share information about their behavioral healthcare training needs and priorities, which can be used in setting agendas for future educational sessions.

In conclusion, based on a large national sample of juvenile and family court jurisdictions, the current study demonstrated that judges are keenly aware of the range of behavioral health services for delinquent and juvenile offenders. Although not a panacea, judges recognized that screening, clinical assessment, prevention, and treatment services for substance use and mental health problems are key to reducing recidivism and crime in the community. They would also like the juvenile justice system to return to its original mandate, namely to serve as a vehicle for the rehabilitation and reintegration of troubled youth.

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Figure 1.
Judges' Views on Criminological and Behavioral Health Screening and Assessments

Figure 2.
Judges' Views on Prevention and Treatment Services

Table 1

Beliefs about Screening and Assessment Practices (weighted average)

	<u>Judges' Agreement Levels</u>		
	Agree	Mixed	Disagree
Clinical assessments should only be done by trained clinicians.	76%	19%	5%
Scored standardized clinical assessment tools are necessary to determine the severity of juvenile offender mental health problem.	74%	22%	4%
Scored standardized clinical assessment tools are necessary to determine the severity of juvenile offender substance use problem.	57%	19%	24%
Juvenile Justice staff should not do standardized clinical assessments.	50%	34%	16%
The best way to ensure that delinquent youth are appropriately placed in a treatment is through the use of standardized clinical assessments.	41%	38%	21%
A brief, scored screening tool at intake is the best way to identify youth on community supervision who need further formal standardized clinical assessment.	38%	51%	11%
Standardized clinical assessments take too long.	25%	53%	22%
The main purpose for formal clinical assessments is to provide the paperwork needed by service providers.	7%	40%	53%
Standardized clinical assessments are not worth the effort due to the limited availability of resources.	5%	47%	48%
Standardized clinical assessments usually indicate all juvenile offenders have similar needs.	5%	50%	45%

Table 2

Relationship between Court and External Partners (weighted average)

External Partner	Judges' Ratings			
	Excellent to Very Good	Good	Fair to Poor	No relationship
Community supervision agencies	91%	9%	0%	0%
Local police departments	85%	13%	1%	1%
Other Juvenile Courts	76%	12%	3%	9%
State police departments	73%	18%	3%	7%
Local/state child welfare agency	70%	23%	7%	0%
Local schools/school system	63%	29%	7%	1%
Substance abuse service providers	61%	35%	2%	1%
Mental health service providers	52%	41%	7%	1%
HIV prevention providers	4%	1%	5%	90%

Table 3

County Climate (weighted average)

	Judges' Agreement Levels		
	Agree	Mixed	Disagree
I am open and willing to try new ideas or ways of doing things related to youth under community supervision	100%	0%	0%
I feel comfortable promoting different ideas or suggestions, even if they conflict with established policy or practice.	94%	5%	1%
I believe that the court and key service providers can have open discussions about system-related difficulties or problems with youth under community supervision.	92%	8%	0%
Opportunities are provided for Juvenile Justice and Family Court judges to attend training or other developmental opportunities	91%	5%	4%
Learning new knowledge and skills about substance use, HIV and mental health, and using it in my job, is highly valuable	91%	9%	0%
There is a shared understanding of the goals that need to be met in order to help youth under community supervision in this county	84%	8%	8%
There are discussions involving all of the court and key service providers about the best ways to help youth under community supervision and their families.	78%	8%	14%
The court and key service providers periodically meet and talk about what is working well and what is working poorly to improve outcomes for our youth under community supervision.	60%	19%	21%
We have specific plans in place for how to achieve our goals.	58%	28%	14%
We have well-defined performance outcomes in place for how to achieve our goals.	38%	35%	27%
Integrate new knowledge and techniques into their work to improve the ways in which services are provided.	88%	11%	1%
See attendance at training and development programs as a priority activity.	77%	21%	3%
Stay current with new techniques that relate to the job.	75%	24%	1%
Lack access to the training and development programs they need.	28%	14%	58%

Table 4

Juvenile Justice Priorities in the County (weighted average)

Percentage Scored as High to Very High Priority	National	
	Should be a Priority	Is a Priority
Effective juvenile defense counsel	99%	64%
Effective prosecution of juvenile offenders	98%	80%
Staff development and training	84%	65%
Developmentally appropriate services for young offenders	86%	61%
Alternatives to secure detention	81%	52%
Public support for rehabilitation of young offenders	78%	28%
System capacity to measure performance and/or evaluate programs and services	72%	33%
Policymaker support for rehabilitation of young offenders	73%	63%
Information technology	66%	40%
Culturally relevant services for young offenders	56%	15%
Gender responsive services for young offenders	53%	19%
Disproportionate minority contact	48%	21%
Resources for non-English speaking youth and families	46%	17%

Table 5

Best Ways to Reduce Crime (weighted average)

	<u>Judges' Agreement Levels</u>		
	Agree	Mixed	Disagree
Make sure that the treatment provided is matched to the youth needs.	100%	0%	0%
Make sure youth receive effective treatment for mental health problems while under community supervision.	99%	0%	1%
Make sure youth receive effective substance use prevention and treatment while they are under community supervision.	98%	2%	0%
Provide more jobs for youth.	84%	12%	3%
Provide more educational programs for youth.	74%	24%	2%
Provide more treatment to address problems that often contribute to crime.	65%	26%	9%
Make sure youth receive effective HIV prevention and treatment for services while they are under community supervision.	13%	44%	43%

Table 6

Need for Additional Experience and/or Training (weighted average)

	Judges' Agreement Levels		
	Agree	Mixed	Disagree
Effective mental health treatment	78%	6%	16%
Effective substance use treatment	77%	7%	16%
Impact of trauma and other mental health disorders on adolescent behavior	76%	15%	9%
Effective substance use prevention	73%	7%	20%
Increasing family engagement	69%	16%	15%
Understanding and using the results from standardized risk of recidivism measures	68%	21%	11%
Effectively monitoring program performance	67%	20%	12%
Adolescent development and its implications for assessment, prevention, treatment and judicial messages	66%	16%	18%
Ongoing organizational assessment and quality improvement for improving the design, delivery, and ultimate effectiveness of services for juvenile offenders	65%	26%	9%
Effectively monitoring youth progress	62%	21%	17%
Using performance monitoring to improve services	59%	27%	15%
Adolescent brain development and the impact of addiction	59%	22%	19%
Evidence based prevention and treatment for substance use, HIV risk behaviors and mental health	59%	24%	17%
Methods for integrating the results from formal screens and assessments with case planning and implementation	52%	31%	17%
Adolescent sensitivity to environmental influences which may impact the design of interventions	49%	39%	12%
Increasing rapport with youth	46%	21%	33%
Effective HIV risk behavior prevention	43%	36%	21%