RESOLVED, That the American Bar Association urges federal, tribal, state, territorial, local and municipal governments to enact legislation relating to youth in the juvenile justice system with co-occurring mental health and substance abuse disorders that increases:
   (a) Grants for services for youth with such disorders that evaluate the effectiveness of prevention and treatment programs;
   (b) Funding for local access to health care for such youth and their families; and
   (c) Collaboration among agencies involved in juvenile justice, mental health and substance abuse treatment in providing effective forms of locally-accessed and institutional treatment models.

FURTHER RESOLVED, That the American Bar Association urges federal, tribal, state, territorial, local and municipal governments to review privacy regulations with a view toward facilitating more effective treatment, and avoiding further involvement with the juvenile justice system. Such review should strive for fairness in considering youth privacy and informed cooperation between agencies, youth and families in integrated prevention and diversion out of the juvenile justice system and into treatment whenever possible, and strive for responsible and fair sharing of information among treating agencies for youth with co-occurring disorders.
REPORT

The problem of youth with both drug problems and mental health problems has been with us for many decades. Despite a growing recognition of many thousands of these youth within the juvenile justice system, models for successful treatment of both issues have been slow to develop. The reasons are to be found in the structure of the dual systems designed to treat each issue. Treatment of both issues could be successful if the models were more extensively studied and youth who do not need to be in the juvenile justice system at all were diverted within a treatment model that is local and has been shown to be successful.

Identifying and Understanding the Problem

Commencing with the Carter administration, the study of effective provision of mental health services has increasingly shed light on persons suffering from mental illness and one or more substance disorders. Since that time, awareness of the prevalence of such cases has increased through more detailed study in the 1980s and 1990s. These surveys estimated that a sizeable portion of the U.S. population, around five to seven million adults and youth, experienced co-occurring psychiatric and substance disorders. These studies indicated that about 20% of the adult U.S. population had a diagnosable psychiatric disorder and about 15% of that group had a co-occurring substance abuse disorder. At one time described as a “dual diagnosis” the more accurate term of “co-occurring disorder” (“COD”) indicates a person who has conditions that meet DSM-IV criteria for at least one mental health and one substance use disorder.

In 1992 Congress created the Substance Abuse and Mental Health Services Administration abbreviated as SAMHSA. Congress called on SAMHSA to report on the scope of co-occurring

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1 See Executive Order 11973 creating the President’s Commission on Mental Health, seeking a report to the President “recommending how the mental health needs of the Nation can be met and identifying the relative priority of those needs.”

2 Five major universities and the NIMH undertook a more comprehensive study, the Epidemiologic Catchment Area Study, from 1980 to 1985, administering a diagnostic interview to over 20,000 respondents in community and institutional settings.
http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/6153

3 In the early 1990s, the William T. Grant foundation funded a collaborative survey of 8,000 individuals between the ages of 15 to 54. This survey, the National Comorbidity Study (“NCS”), carried out through the University of Michigan’s Institute for Social Research, expanded focus on the co-occurrence of mental disorders and substance use, including type of substance, frequency, history and the problems resulting from drug use.
http://www.icpsr.umich.edu/icpsrweb/SAMHDA/studies/6693

4 Substance Abuse and Mental Health Services Administration. “SAMHSA’s Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders.”
http://www.samhsa.gov/reports/congress2002/chap1ucod.htm

5 The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition is published by the American Psychiatric Association, and is abbreviated as “DSM-IV”. It provides diagnostic guidance for mental health professionals (psychiatrists and other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, and counselors). The new DSM-V is scheduled for release in May 2013.
http://www.psychiatry.org/practice/dsm
disorders, current treatment approaches, best practice models, and prevention efforts. November 2012 marked the tenth anniversary of that agency’s 2002 report to Congress, which included its recommendations for the prevention and treatment of CODs. That report estimated that for youth in contact with the justice system in 2000, two-thirds, or about 670,000 youth, had co-occurring disorders.

With the passage of time, research has documented the over-representation of adolescents with CODs in the juvenile justice system, and identified effective interventions, but the work on how to overcome barriers to effective treatment is far from complete. Research published in 2005, focusing on juveniles with CODs in detention centers, found that between 52% and 73% of the juveniles subject to a diagnostic interview in detention had co-occurring disorders. That report stressed the need for routine assessment at various entry points to the juvenile justice system, and that service providers be able to treat both mental health and substance abuse issues. Another, larger-sampled survey estimated that on a given day approximately 12,000 youth in detention had both a major mental disorder and a substance abuse disorder.

The current resolutions relating to youth with co-occurring disorders are intended to build on prior policy efforts made by the Criminal Justice Section, including increased use of problem-solving courts to deal with criminally-involved persons with mental illness and addiction issues (2001), dealing with diversion from the criminal justice system of adults and juveniles with mental illness and emotional disorders (2004), and equal and uniform access to therapeutic courts, and access to drug treatment and counseling in sentencing such persons.

**Detention and Placements Disrupt Treatment**

In their respective criminal and juvenile systems, adult and adolescent populations’ need for integrated mental health and substance abuse treatment has not been adequately met while

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6 SAMHSA’s Report was required under Section 3406 of the Children's Health Act of 2000 (Public Law 106-310), an amendment to Section 503A of the Public Health Service Act, codified at 42 U.S.C. 290aa-2. The report summarized (a) the manner in which individuals with co-occurring disorders are receiving treatment, including the most up-to-date information available on the number of children and adults with co-occurring disorders, and the manner in which Federal Block Grant funds are used to serve these individuals; (b) practices for preventing substance abuse disorders among individuals who have a mental illness and are at risk of having or acquiring a substance abuse disorder; (c) evidence-based practices for treating individuals with co-occurring disorders and recommendations for implementing such practices; and (d) improvements necessary to ensure that individuals with co-occurring disorders receive the services they need.


incarcerated or placed outside the home. Because persons with mental illness are much more likely to be arrested and jailed for minor or non-violent crime, jail and prison can become a convenient but harsh means to force treatment of adults with CODs after entry into the criminal justice system. The overall impact of this approach on adults is disruption of any prior community-based services and poor re-engagement with treatment upon reentry into the community. Deciding to place a juvenile in a restrictive setting, away from family, done because of a lack of locally-accessed treatment is an even harsher remedy, as it disconnects a child who is still developing from any positive supports in the community.

SAMHSA’s report in 2002 offered the following three recommendations for justice-involved youth with co-occurring disorders: (a) providing integrated and coordinated treatment addressing both disorders, (b) diversion whenever possible, and (c) community-based (i.e., locally-accessed) treatment with a multidisciplinary approach.

“Youth” is a loosely defined term in federal statutes, but the most relevant definition for the purpose of this policy recommendation is “an individual under 21 years of age”, which is the definition to determine eligibility for grants and programs for coordinated services for children, youth and families, in the Public Health and Welfare title of the U.S. Code. Various ages meet this definition in state statutes, but state law is important in determining the age for which some protection is given to justice-involved youth due to age.

Focusing on youth raises the question of whether youth should have a separate policy focus or should policy efforts be aimed at the larger group of criminally-involved persons with co-occurring disorders. Focusing specifically on youth is important for a number of reasons. First, youth are given legal protection from the full brunt of the criminal justice system – given an opportunity for treatment and supervision as primary means of correcting delinquent behavior. Justice-involved youth are a demographic that often “ages out” of that protection and ages into the criminal justice system. Second, with respect to issues of mental illness and substance abuse, youth with co-occurring disorders require a specialized approach due to their dependence on


15 See also 42 U.S.C.A. 5732a(3)“Homeless Youth” is defined as a youth not less than 16 years old, but less than 21 years; 42 U.S.C.A 5732a(4)”Runaway Youth” is defined as a youth not less than 18 years old.

16 42 U.S.C.A. 12302(6) and 12376(2).
other adults – parents, guardians or agency officials – who are required to care for them. This key distinction plays out differently for youth, from what types of diversion will be most successful to efforts made in treatment and upon reentry from an out-of-home placement. For youth facing the complexities of co-occurring disorders, the separate focus would be helpful in avoiding mis-adapting the approaches used for the adult population to youth with a significantly different set of issues.

The “Window of Opportunity”

Of special concern for juvenile justice practitioners is the potential for preventing the development of CODs while youth are in cognitive development stages suitable for intervention. In the last fifteen years, study of the timing of COD development in adolescents points to the presence of specific risk factors17, including family history, environmental factors, personal and environmental factors, and traumatic events. There is also a tendency for mental health problems to develop years before substance abuse problems.18 Treatment of adolescents with mental health problems should address these risk factors with a view toward preventing substance abuse disorders in youth, and integrating youth and family engagement in these efforts. A specific focus of research has been the role of trauma and co-occurring disorders.19 The findings of such research should be applied to screening, diversion and treatment models, and funding for similar research on youth with CODs should be increased.20 Current research also suggests that the earlier that intervention occurs to deal with the risk factors leading to CODs, the less likely youth are to become involved in the juvenile justice system.

Youth with CODs tend to have higher rates of polysubstance abuse, delinquent and criminal activity and out-of-home placements.21 With the above factors present in their lives, it is not surprising that these youth are likely to be unsuccessful in treatment.22 Once these disorders co-

20 Hendrickson, Elizabeth, “Trauma and Co-Occurring Disorders among Youth”, Children's Hospital Los Angeles, 2009 http://www.aodpolicy.org/Docs/Trauma_and_COD_Among_Youth.pdf
occur, the likelihood of successful treatment becomes bleak, and the cost of that failure is high for the youth and for the community, in terms of human potential and in terms of dollars.

**Determining Effective Treatment of CODs in Youth**

SAMHSA’s report to the Congress in 2002 noted the scarcity of data on best practices in treating adolescents with CODs, citing a 1993 report of its Center for Substance Abuse Treatment (“CSAT”). Communities have and continue to attempt to deal with the unmet needs of these youth. There has been some study of innovative programs which attempt to deal with CODs in youth.\(^{23}\) Despite efforts to evaluate treatment models based on various types of group and family therapy, this research has been difficult to interpret, in part due to a focus on non-COD groups, the lower rates of participation of adolescents in treatment, and large dropout rates by adolescents with ADHD and conduct disorders.\(^{24}\) CSAT’s mission is to support efforts to provide multiple treatment modalities, evaluate treatment effectiveness, and use evaluation results to enhance treatment and recovery approaches.\(^{25}\) Coordination of this mission should involve all federal, state and local agencies involved with juvenile justice, mental health and children’s health. Increased federal funding applied to this effort would help communities evaluate programs and determine which programs they can fund at the state and local level – that determination should reduce the cost of treating these youth, since locally accessed treatment would be less costly than treatment away from the community.\(^ {26}\)

In order to provide integrated treatment of young people with CODs at risk of entering the juvenile justice system, effective locally-accessed treatment should be developed that avoids the costly and potentially detrimental effect of removing a juvenile from family and community to provide access to more comprehensive treatment in a more restrictive setting. In order to prevent unnecessary confinement where community safety is not threatened, diversion efforts should be expanded at various points of access to the juvenile justice system: at school, at initial intake, and through any other community-based agencies or partnerships. Useful models for screening these cases as early as possible for youth at risk of entering the juvenile justice system have been developed and should be promoted for use by schools, police, probation, prosecutors, and other systems that deal with youth.\(^ {27}\)

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Current Barriers to Integration

Our sub-committee contacted various agencies involved in studying this issue or in treating juveniles with CODs, to seek their input. We also consulted with those involved in juvenile justice at the state and local level. It is worth noting that efforts have been made to develop solutions to this problem. Dr. Joseph Cocozza, director of the National Center for Juvenile Justice and Mental Health has been studying this area of juvenile justice for many years, and has over the years identified many promising programs designed to develop effective solutions and minimize barriers to success.28

However, serious policy and funding issues remain as barriers to successful treatment of youth with CODs. Discussions with state-level juvenile justice agencies revealed that the dual systems designed to treat mental health and substance abuse remain difficult to coordinate. This is true even after these agencies have entered into formal agreements to collaborate on this issue. Of states with more success in treating CODs in youth, joint administration of the effort had some success. Although mental health and substance abuse treatment systems have separate rules protecting client privacy, these rules are often raised by practitioners as an excuse for poor communication and failed integration of treatment. Ideally, both mental health and substance abuse should be treated by a single provider, if that provider has received training to treat adolescents for mental health and substance abuse disorders.

Fair Information Sharing Practices

If the most successful means of preventing CODs, treating affected youth within the juvenile justice system, or safely diverting and treating such youth outside of the juvenile justice were determined, the current systems of treating each disorder require integration of treatment. Principles of fairness in allowing integration of case information are key to establishing trust between treating agencies, the youth and the family.29

Integration is needed to avoid psychological issues interfering with substance abuse treatment and vice versa. This involves sharing of information from both systems so that each provider can consider the interrelationship between the problems and avoid failure in either system because of a lack of understanding or failure to synthesize the information flowing through each treatment effort. According to agency input, failures occur in this area due to the perception among treatment providers that information cannot be shared between substance abuse and mental health treatment providers.


29 See Id.
In practice, perceived privacy barriers could be overcome with clearer collaboration among agencies who treat youth with CODs and between the agencies and the youth’s family. A cooperative, family-engaged approach to sharing information between mental health and substance abuse treatment is vital to allowing the youth and the youth’s family to emotionally invest in the treatment process. From the treatment provider’s perspective, input and feedback from the youth and family should lead to better decision-making among the various providers.  

Along the same lines, treatment agencies should fully and carefully assess the impact on privacy for the information that agencies are sharing. To ensure that the youth and family remain engaged and invested in the efforts, the agencies should provide a developmentally and culturally appropriate understanding of any privacy rights that the youth and family are waiving in allowing their information to be shared. Equally as important, the non-individualized data gathered during integrated treatment should be used to assess the effectiveness of the program and to allow aggregated measures of the types of programs that are successful.

Funding mechanisms are a difficult problem in that mental health services are generally covered by Medicaid, but substance abuse treatment is not, and the latter efforts in a community might have to close or cut staff if block funding or grants dry up. This requires families in a vulnerable economic demographic to pay out of pocket if private insurance is unavailable or does not cover the treatment, or to forego treatment altogether.

Allowing youth to pass through the juvenile justice system without properly addressing major issues that contribute to their problems benefits no one. The cost of failure to the youth is considerable, leading to further institutional contact and chronic conditions such as homelessness and health problems, in addition to the potential for continuing to suffer from CODs. The cost to the agencies and governments is also considerable, in that the efforts expended on the affected juveniles will not make much progress in avoiding future delinquency and criminal conduct or in creating a happier more productive member of our society.

Respectfully submitted,

William Shepherd, Chair
Criminal Justice Section
August 2013


31 Id.
1. **Summary of Resolution(s).**
   This resolution urges the development and implementation of legislation that provides for an increase in grants for services for youth with co-occurring mental health and substance abuse disorders who are involved with the juvenile justice system, increased funding to enhance local access to health care for these youth and their families, and increased collaboration among agencies involved in juvenile justice, mental health and substance abuse treatment. This resolution also urges governments to review privacy regulations with a view toward facilitating more effective treatment.

2. **Approval by Submitting Entity.**
   The proposed resolution was approved by the Criminal Justice Section Council at its Spring Meeting on May 12, 2013.

3. **Has this or a similar resolution been submitted to the House or Board previously?**
   This resolution is similar to resolution 116 passed by the House of Delegates during the 2004 ABA Midyear Meeting (urging Congress to enact legislation that would address the complex problem presented by the large number of adults with mental illness and juveniles with mental or emotional disorders who come into contact with the criminal and juvenile justice systems), resolution 117 passed by the House of Delegates during the 2007 ABA Annual Meeting (supporting the creation of problem solving courts, such as drug courts and mental health courts), and resolution 101F, passed by the House of Delegates during the 2012 ABA Midyear Meeting (encouraging access to problem solving courts, such as drug courts).

4. **What existing Association policies are relevant to this Resolution and how would they be affected by its adoption?**
   This resolution builds upon prior policy, but uniquely and specifically addresses the need for increased, enhanced and more collaborative services to treat youth with co-occurring mental health and substance abuse disorders.

5. **What urgency exists which requires action at this meeting of the House?**
   We currently allow youth to pass through the juvenile justice system without properly addressing major issues that contribute to their problems. The cost of failure to the youth is considerable, leading to further institutional contact and chronic conditions such as homelessness and health problems, in addition to the potential for continuing to suffer from CODs. Youth’s unnecessary suffering and confinement can be limited by increasing and streamlining services. Moreover, research indicates there is potential to prevent the development of CODs while youth are in cognitive development stages suitable for intervention.

6. **Status of Legislation.** (If applicable)
   Not Applicable
7. Brief explanation regarding plans for implementation of the policy, if adopted by the House of Delegates.
The policy will be distributed to various criminal justice stakeholders in order to encourage and facilitate awareness and encourage necessary action to develop more collaborative and streamlined systems to treat youth with co-occurring mental health and substance abuse disorders who are involved with the juvenile justice system. The policy will also be featured on the Criminal Justice Section website and in Section publications.

8. Cost to the Association. (Both direct and indirect costs)
No cost to the Association is anticipated.

9. Disclosure of Interest. (If applicable)
None

10. Referrals.
At the same time this policy resolution is submitted to the ABA Policy Office for inclusion in the 2013 Annual Agenda Book for the House of Delegates, it is being circulated to the chairs and staff directors of the following ABA entities:

Standing Committees
Governmental Affairs
Gun Violence
Pro Bono and Public Service
Legal Aid and Indigent Defendants
Professionalism
Ethics and Professional Responsibility

Special Committees and Commissions
Commission on Civic Education in the Nation’s Schools
Center on Children and the Law
Commission on Disability Rights
Commission on Homelessness and Poverty
Center for Human Rights
Commission on Youth at Risk

Sections, Divisions
Family Law
Government and Public Sector Division
Health Law
Individual Rights and Responsibilities
Judicial Division
National Conference of Federal Trial Judges
National Conference of Specialized Court Judges
National Conference of State Trial Judges
Litigation
Judicial Division
113B

Senior Lawyers Division
State and Local Government Law
Tort Trial & Insurance Practice
Young Lawyers Division

11. **Contact Name and Address Information.** (Prior to the meeting. Please include name, address, telephone number and e-mail address)

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12. **Contact Name and Address Information.** (Who will present the report to the House? Please include name, address, telephone number, cell phone number and e-mail address.)

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EXECUTIVE SUMMARY

1. Summary of the Resolution
This resolution urges the development and implementation of legislation that provides for an increase in grants for services for youth with co-occurring mental health and substance abuse disorders who are involved with the juvenile justice system, increased funding to enhance local access to health care for these youth and their families, and increased collaboration among agencies involved in juvenile justice, mental health and substance abuse treatment. This resolution also urges governments to review privacy regulations with a view toward facilitating more effective treatment.

2. Summary of the Issue that the Resolution Addresses
Allowing youth to pass through the juvenile justice system without properly addressing major issues that contribute to their problems benefits no one. The system’s failure to treat youth with co-occurring mental health and substance abuse disorders, leads to the youth’s further institutional contact and chronic conditions such as homelessness and health problems, in addition to the potential for continuing to suffer from these co-occurring disorders. The cost to the agencies and governments is also considerable, in that the efforts expended on the affected juveniles will not make much progress in avoiding future delinquency and criminal conduct or in creating a happier more productive member of our society.

3. Please Explain How the Proposed Policy Position will address the issue
This resolution would help ensure that youth who do not need to be in the juvenile justice system are diverted through a successful treatment model.

4. Summary of Minority Views
None are known.