Improving Policy and Practice for Adolescent Girls with Co-Occurring Disorders in the Juvenile Justice System

Prepared for the GAINS Center by

Laura Prescott

June 1998

Available from:
The GAINS Center
262 Delaware Avenue
Delmar, New York, 12054
Phone: (800) 311-GAIN
Fax: (518) 439-7612
E-Mail: gains@pra-inc.com
Website: www.pra-inc.com/gains
# TABLE OF CONTENTS

Introduction ........................................................................................................... 1

Female Adolescents with Co-Occurring Disorders in the Juvenile Justice System .... 3

Critical Issues ........................................................................................................ 5

Policy & Practice Recommendations ...................................................................... 11

I. Gender-Specific Programs & Practices ............................................................... 12

II. Gender-Specific, Culturally Sensitive Crisis Intervention Protocols & Procedures 16

III. Training & Dissemination .................................................................................. 17

IV. Research & Evaluation ...................................................................................... 19

Conclusion .............................................................................................................. 21

Appendix A ................................................................................................................ 23

References ............................................................................................................... 26
INTRODUCTION

While attention has begun to focus on the mental health and substance recovery needs of youth in the juvenile justice system in general, little emphasis has been given to the gender-specific needs of adolescent girls. In an effort to reverse this trend, the National GAINS Center for People with Co-Occurring Disorders in the Justice System convened a meeting in December 1997, facilitating dialogue with local, state, and national experts across multiple disciplines. The goals were to stimulate a broader understanding of major areas of concern as they affect the lives and health of adolescent females with co-occurring disorders and to provoke new recommendations for future impact on both policy and practice levels.

In an effort to provide an overview of existing prevalence rates, trends, characteristics, risk factors and future challenges for discussion, the National GAINS Center distributed their report, *Adolescent Girls with Co-Occurring Disorders in the Juvenile Justice System* (Prescott, 1997). The following section provides a summary of that report followed by a presentation of critical issues as they emerged from our collaborative efforts in December. Finally, the last section discusses specific recommendations for enhancing our joint efforts in supporting gender-specific, culturally and developmentally sensitive policy and practice.
FEMALE ADOLESCENTS WITH CO-OCCURRING DISORDERS IN THE JUVENILE JUSTICE SYSTEM

General prevalence statistics indicate that adolescent females are coming into contact with the juvenile justice system in increasing numbers for all types of offenses. In 1993, adolescent females accounted for nearly one-fourth of all those arrested under the age of 18 (Poe-Yamagata & Butts, 1996). Even though the extent of female involvement varies by offense, the largest percentage of adolescent girls are arrested for status offenses, and of those, more than half are specifically arrested for running away from home (Federal Bureau of Investigation, 1996). Additionally, Calhoun and colleagues (1993) report that female convictions related to gang activity, sexual misconduct and drug offenses quadrupled between 1987 and 1992. Like their adult female counterparts, juvenile girls are most often arrested for non-violent, drug-related crimes and are entering the system with serious medical and psychological needs related to high-risk sexual behavior, substance abuse and violence (Veysey, 1997; Girls Inc., 1996; Poe-Yamagata & Butts, 1996). And even though girls still represent a minority of those arrested for violent crimes, there appears to be a serious increase in these types of offenses over time (Poe-Yamagata, 1996; Girls Inc., 1996).

Researchers have noted the complex and often interrelated risk factors contributing to adolescent female involvement in the juvenile justice system. However, many indicate that the high prevalence of physical, sexual and emotional abuse/victimization in the lives of adolescent girls could be the most significant underlying etiology of high-risk behaviors leading to delinquency (Calhoun et al., 1993; MacVicar & Dillon, 1980; James & Meyerding; 1977; Bracey, 1983; Chesney-Lind, 1987; National Institute of Mental Health, 1977; Youth Policy and Law Center, 1982). Abuse has been correlated with increased truancy, running away, substance use/abuse, risky sexual behavior, eating disorders, low self-esteem, prostitution, and violence. Other risk factors include difficulty in school (often compounded by undetected learning disabilities, pregnancy and other health concerns), and gang-related activities (Girls Inc., 1996). With limited access to resources to meet their needs, many female juveniles express their distress by running away, becoming truant, engaging in high-risk sexual behavior, using substances and self-injuring. Calhoun and colleagues (1993) note, “among juvenile girls identified as delinquent by court,
over 75 percent have been sexually abused and in attempting to mitigate that abuse by running away, they are often labeled as delinquent."

Despite the increasing numbers of adolescent females coming in contact with the juvenile justice system, a dearth of information exists regarding who they are as they traverse various educational, health, child welfare, mental health, and substance abuse systems. This is reflected in the lack of large-scale epidemiological studies on the prevalence of mental health and substance abuse concerns impacting the lives of female juveniles. In one of the few studies available, Timmons-Mitchell et al. (1997) found that 84 percent of the female juveniles surveyed evidenced mental health needs compared to only 27 percent of the males. Other studies indicated significantly high percentages (60 - 87 percent) of juvenile female adolescents needing substance abuse treatment as well (Girls Inc., 1996; American Correctional Association, 1990; Myers et al., 1990).

Overall, research comparing differential experiences of adolescent girls and boys in the general population show that girls have higher rates of depression throughout adolescence than boys (Alfgood-Mertern, et al., 1990; Davis, Schoen, et al., 1997; Chwast, 1961; Ostov, et al., 1989; Rutter, 1986; Miller, Trapani, et al., 1995). Other significant gender differences reveal that female adolescents attempt suicide more often, frequently self-mutilate (Miller, 1994; Egan, 1997; Applewhite & Joseph, 1994) experience lower self-esteem (Davis et al., 1997; American Association of University Women, 1991; Davis et al., 1991; Rosenthal, 1981) and have lower rates of educational retention. Further, girls are at greater risk than males for physical and sexual abuse, repeated violent victimization, and while less likely than males to engage in violent behavior, girls are more likely to assault people known to them than strangers (Girls Inc., 1996).

As indicated earlier, researchers, administrators, clinicians, policymakers and juvenile justice personnel are only beginning to understand the extensive challenges confronting adolescent girls with emotional, behavioral and substance abuse difficulties who come in contact with the justice system. In order to increase and strengthen our developing field of knowledge, national experts were drawn from leading programs (see Appendix A) to provide guidance through shared practical experience on ways to assist these young women and those attempting to prepare them for a more positive future.
CRITICAL ISSUES

Many complex issues face adolescent girls today as they traverse various substance abuse, mental health and juvenile justice systems. However, several fundamental themes emerge to enhance our understanding of the most critical aspects of female-specific experiences. First, adolescent females in contact with the juvenile justice system who experience complicated mental health, substance abuse, and primary health care needs do not fare well in systems designed for boys. Anecdotal evidence and current research both suggest that there are profound differences between male and female adolescents in gender socialization, environmental stressors, and development.

In addition, many of these young women present complicated clinical profiles as a result of the pervasive violence in their lives. The predominance of abuse, subsequent posttraumatic stress, depression, suicidality, low self-esteem, self-injury, and substance abuse is frequently compounded by poverty, poor scholastic retention and relatively few community resources. This information strongly suggests that gender-specific differences in behavior lead adolescent females into the juvenile justice system. And finally, juvenile justice management policies and crisis protocols designed for males easily re-stimulate pre-existing conditions (such as posttraumatic stress) in females, creating high risks for decompensation and rapid trauma-response cycles.

Adolescent Girls Are Not Yet Adult Women

While there are many parallels between the experiences of adult women with mental health and substance abuse disorders in correctional systems and adolescent girls involved with juvenile justice systems, there are essential maturational and developmental differences between them. Unlike adult women, adolescent girls often find themselves in a number of double binds that are particular to both their age and minority status as females. For instance, the same decisions encouraged as healthy choices for adult women (leaving a violent home) can constitute “delinquent” behavior in adolescent girls resulting in juvenile justice involvement. By virtue of their age alone (unless emancipated) adolescent girls are denied the right to extricate themselves from environments that jeopardize their health and access to alternative resources in order to gain support to maintain safety and well-being in the community.
Female adolescents with co-occurring disorders in the justice system are frequently oldest children, sexualized at an early age, and carry a disproportionate level of familial responsibility as caretakers for siblings and/or parents. And even though these young women are socialized as adults and many of their needs closely resemble those of adult women, they remain children with needs that are age- and gender-specific.

The Role of Abuse, Violence & Other Gender-Specific Losses Are Not Addressed

Adolescent girls with mental health and substance abuse issues in contact with the juvenile justice system experience multi-layered and cumulative losses over time that are different than those experienced by their male counterparts. An example of gender-specific distress is reflected in the high proportion of "chronic" and "extensive" physical and sexual abuse in the lives of these young women. As the issues of abuse, loss, resultant grief, and rage are not addressed, there is a fairly clear continuum along which many girls progress leading to behaviors that are frequently viewed as "uncontrollable" and "unmanageable" by school, welfare, family and juvenile court personnel. There appears to be clear, causal relationships between behavior (for example: chronic running away, breaking and entering, sexual promiscuity, drug use and depression) and unmediated, gender-specific loss over time. Some of the important losses specifically affecting adolescent females with co-occurring disorders in contact with the justice system have been described as follows:

- Loss of role as caretakers
- Loss of self-esteem, self-worth
- Loss of educational and vocational opportunities
- Loss of health
- Loss of childhood
- Loss of control over their bodies
- Loss of home and sense of permanence
- Loss of belief, trust, faith and hope
- Loss of credibility once labeled
When Girls Respond to Distress, Their Behavior is Misinterpreted as Further Evidence of “Delinquency”

Gender and cultural bias across multiple systems (juvenile justice, mental health, substance abuse, primary health, educational and familial care) can lead to negative characterization of adolescent girls. These biases often add extra barriers preventing the problems female adolescents with substance abuse and mental health conditions experience from being recognized. In this way, their behaviors are de-contextualized and recast as symptoms of pathology, “anti-social acting out,” “manipulative,” “attention-seeking,” “trouble-making,” “deviant,” and “delinquent.” These labels not only erode pre-existing low self-esteem and mobilize shame, but serve to compound difficulties reintegrating into community settings upon release. The labels obfuscate the underlying etiology of behavior intensifying the experience of alienation from school, peers, family, and themselves.

As coping mechanisms are re-defined as “anti-social” in juvenile systems, “relapse” in substance systems and “symptoms of pathology” in mental health systems, adolescent girls are often disqualified from receiving services all together. Misinterpretation of distress and lack of available community alternatives can lead to punitive interventions and restrictive dispositions. And once confined in juvenile settings, clinical referrals and other responses to more subtle signs of distress are frequently delayed becoming secondary to those displaying more highly visible behaviors considered high-risk and potentially dangerous. Because the perception of acuity is based on behaviors typically displayed by males, adolescent females often find their signals of distress ignored, punished, and misinterpreted.

Policies & Procedures of Confinement Exacerbate Pre-Existing Conditions

Norms, rules, regulations, and protocols of confinement have been often characterized as conditions that negatively impact adolescent girls and frequently exacerbate pre-existing emotional distress. Particular risks for adolescent females in these environments are intensified by cultural isolation, lack of parity in specialized service delivery and sexual double standards encountered in restricted settings. Pathways to emotional health are made more arduous when conditions of confinement, crisis intervention protocols, and policies governing behavioral management often provoke female trauma-
response cycles. While intended to decrease agitation and control behavior, standard intervention strategies employed in restricted settings (such as seclusion, forced disrobing, four-point spread-eagle restraint) frequently have the unintended effect of causing increased stress, escalating behavior, thereby undermining the outcomes justice management systems are attempting to achieve.

The following examples illustrate the kinds of protocols and procedures that directly recreate environmental stressors causing adolescent females to decompensate prior to detention. While girls are not allowed to comfort each other through physical contact, male staff are often allowed to touch them. In addition, adolescent girls are regularly denied access to items they need and are sometimes encouraged to barter sexual favors for commodities.

Discipline methods intensify the gender disparity as well. Girls are isolated in cells during lock downs, commonly watched by male staff when on suicide precautions and given medication against their will. There is a growing concern about the overprescription of psychotropic medication to control female behavior that appears confusing or disturbing in restricted and punitive settings. Female adolescents with substance abuse and mental health issues are particularly vulnerable to being overmedicated because the gender-specific and cultural cues are frequently misunderstood, and alternative placements are lacking.

Standard crisis protocols often require groups of men to surround and subdue adolescent girls in very physical and forceful ways. Methods of restraint and containment, disrobing, and body searches have acutely sexual overtones that strongly convey implied messages: that girls do not have a right to their own bodies, that male intrusion is acceptable, and that violent responses to female behavior is normal.

Cultural & Linguistic Barriers Create Additional Burdens for Adolescent Females In Distress

Viewing adolescent girls within their own context is complicated when a specific ethnic culture is different from the norm. However, variable and conflicting systemic responses serve to undermine the original context within which girls express themselves. For example, mental health programs often interpret the advent of hearing voices as a symptom of pathology and will attempt to intervene through the use of medications. This response may conflict with a familial interpretation of the same phenomena.
that may view hearing voices as a spiritual event to be mediated by a shaman. The chasm between these interpretations, and subsequent differential responses creates additional burdens for adolescent girls who may not be part of dominant culture. The tension is magnified for young women who are the oldest and first-generation members of their families who may carry the specific responsibility for cultural and linguistic mediation between their families and larger social norms. Misunderstanding important cultural cues and responses can create environments of distrust, undermining future alliances between natural support systems (families) and various professional services being offered.

**Alternative Services for Adolescent Girls are Lacking**

Even where there are treatment, vocational, educational, and primary health care provisions for men in the correctional system, there is an abysmal dearth of services for women. Key policymakers, administrators and service providers from many states have identified the lack of available clinical community services and non-secure residential placements for girls as a major contributing factor in the unnecessary retention of adolescent females in juvenile settings. One state reports that approximately 40 percent of the adolescents in the juvenile system could be referred for community placement, but services are not available. Others report that some female adolescents with alcohol- and drug-related problems are retained for up to a year in juvenile hall prior to placement. Because non-secure placements have declined at least 25 percent over the last 10 years, fewer mental health, group home, and foster care placements exist.

**Tension Exists Between Mandates to Provide Public Safety and Rehabilitation**

As public pressure mounts to ensure legislative mandates and public policies focus on decreasing violence, juvenile justice systems are increasingly encouraged to rely on sanction and punitive measures to ensure public safety. Cross-system collaboration becomes more difficult when safety and decreasing dangerousness are perceived in opposition to mandates for the provision for mental health, substance abuse, primary health treatment, and rehabilitation. The shift in public perception, pressure, legislative mandates, and policy development has particularly deleterious potential for provoking negative outcomes for adolescent girls.
Unlike adolescent males, females represent the small minority of those presently adjudicated and incarcerated for violent offenses in juvenile justice systems. Research and anecdotal evidence indicates that these young women are most likely the victims of multiple forms of violence over time, resulting in status offenses, and drug-related crimes that put them at risk for other types of assault. Adolescent girls are entering the juvenile justice system with far more complex mental health, substance abuse, primary health, vocational, and educational concerns than their male counterparts. And the current political environment, coupled with an increase in funding for the construction of new detention and restricted facilities has meant decreasing availability of publicly funded treatment options. The increased focus on punitive sanctions instead of rehabilitation and the lack of community options has disproportionately impacted adolescent females in the juvenile justice system by further narrowing possibilities for needed intervention and diversion alternatives.
While there were many critical issues pertaining to adolescent females with mental health and substance abuse needs in the juvenile justice system, there are also a number of dynamic recommendations for improving programming, practices and policy. The following policy and practice suggestions fall into four general categories:

I. Gender-Specific Programs & Practices;
II. Gender-Specific, Culturally Sensitive Crisis Intervention Protocols & Procedures
III. Training & Dissemination
IV. Research & Evaluation
I. GENDER-SPECIFIC PROGRAMS & PRACTICES

Create Gender-Specific Programs & Practices Based on Normative Female Development

Using strength-based approaches rather than deficit-based models in all substance abuse and mental health practices serving adolescent girls in contact with the justice system acknowledges, reinforces, and supports their abilities. Focusing on the skills adolescent girls have cultivated in order to survive re-frames their behavior as normative, adaptive responses, increases self-esteem and further obviates the negative effects of labeling. There is a need for model programs that are supported by policies valuing female experiences, building on relational models known to be effective with adolescent girls, and addressing all of the interrelated needs of these young women. Current research emerging from the field of female adolescent development could be modified when creating innovative programs, intakes, referral methods, and crisis intervention protocols.

Design Strength-Based Assessments That Determine Levels of Distress for Adolescent Females

Innovative assessments have been designed by programs in collaboration with court personnel and community service agencies concerned with the mental health and substance abuse needs of adolescent girls in contact with juvenile systems. These assessments could be the basis for developing strength-based model assessment forms that are gender-specific, and culturally and developmentally sensitive. Because shame and distrust often prohibit young women from disclosing personal information, interviews and assessments performed by women in private may facilitate this process. Many girls come into and are diverted out of the juvenile justice system at variable points in time. Therefore, multiple assessments and increased flexibility in measuring long-term outcomes provide the most comprehensive picture of immanent needs and enduring strengths as they change. Recommendations for assessment areas include asking adolescent girls:

- What coping mechanisms, skills, and strengths have they used to mediate crisis in the past?
- How do they understand the current issues? What is most pressing for them at the moment?
- What people (familial, peer, extended relations, teachers) or institutional supports can they identify in the community that are helpful or could be helpful to them?
What concerns do they have about any of the following: current substance use, primary health concerns, levels of violence (specifically physical and sexual abuse), self-injury, eating disorders, safety, startle-reactions, levels of depression, parenting concerns?

Are there learning disabilities? Are there areas in school they like? Do they have any particular interests? What could be done to support these? Are there any vocational goals? What could be done to support these?

Have there been recent deaths, illnesses or other losses, among peers, family? Have they been able to talk to anyone about these? How do they feel about themselves? Is anyone encouraging them at this particular time? (measurements of self-esteem), etc.

**Provide Small, Single-Sex Dialogue Groups For Adolescent Girls**

Adolescent girls, particularly those with multiple vulnerabilities, are often reluctant to seek assistance or have relatively little access to mental health and substance abuse information and treatment. Small, single-sex therapy groups have been successfully used to facilitate discussions pertaining to female health care, physical and sexual abuse, school performance, depression, and substance abuse. The dialogue within groups provides a safe way for girls to explore issues of immediate concern, develop trust, and minimize shame. Those working with adolescent girls relate the severity of damaged self-esteem and resulting isolation seen in these young women, particularly those with emotional, mental health and substance abuse concerns. Young women engaging in high-risk behaviors frequently do not have anyone to approach for assistance and frequently become withdrawn, depressed and self-injurious. Small group interaction and relational approaches have been useful in modeling positive female relationships and facilitating the development of peer support systems for girls in the community and in juvenile detention settings.

**Adapt Trauma-Based Treatment Models**

Trauma-based treatment models known to be successful with women with co-occurring disorders in correctional settings need to be adapted for female adolescents in similar settings. One community program specializing in addressing the needs of women who are homeless, diagnosed with co-occurring disorders and have extensive histories of abuse, presented preliminary findings of a study they are currently conducting. The directors of that program compared retention rates of women in a correction setting attending groups based on a trauma intervention model to those attending a traditional mental
health groups based on the Therapeutic Community (T.C.) model. After a year and a half, the data indicates that 80 percent of the women participating in the trauma-based model stayed, compared to only 12 percent of those participating in the T.C. model.

This information suggests that treatment retention is predicated on service delivery that meets gender-specific needs of the women involved. Even when women perceive participation in treatment as potentially beneficial in reducing sentencing in correctional settings, they tend to drop out when the programming is not relevant for them. Adolescent girls involved with the juvenile justice system reiterate similar information. They state that their needs are different than those of their male counterparts. In one mobile assessment and intervention treatment program, clinical personnel found a direct relationship between the ability of female adolescents to establish trust and the length of time successfully maintained in the community.

**Support Mobile Assessment, Intervention & Treatment in Community Settings**

Many adolescent girls with prior juvenile justice contact are poor and have little access to mental health and substance abuse services outside their immediate surroundings. Because these girls are highly vulnerable to re-engaging in activities that put them at risk for re-involvement in the juvenile justice system, providers must be willing to mobilize services and develop their capacity to do outreach in neighborhoods where girls live. Youth centers, schools, community health care clinics, and local “hang-outs” have been used to make contact with adolescent females known to be at risk for decompensation and to intervene in ways that assist them in preventing future recidivism. Neighborhood environments provide a way to avoid stigmatizing adolescent girls who are in need of services. In an effort to reduce recidivism and prevent further decompensation, some programs use social workers to follow up with more intensive individual intervention with adolescent girls in the community.

Without support for setting standards that include providing immediate, mobile and direct support in neighborhoods where the girls live, work and attend school, there is an increased likelihood of recidivism. Mobile, integrated services are more cost-effective, efficient and humane than detention. In order to continue with this type of service provision, policymakers must prioritize this method of intervention and treatment for future funding allocation.
Increase Alternative, Single-Sex, Residential Placements in Community

In order to prevent recidivism and decrease retraumatization, integrated services are most successful when combined with creative residential options in the community. To successfully achieve this, strategies are required to ensure that the allocation of state-level funding is directed toward alternative single-sex, residential construction in the community. Increasing the availability of single-sex community alternatives specifically for female juveniles with co-occurring disorders are needed in addition to the following:

- foster-care placements
- alternatives for adolescents running from abusive homes
- a network of “safe homes” for temporary placement
- alternative drop-in sites located centrally in communities

Develop Interventions with Family Members & Other Natural Community Supports

While alternative community residential placements need to be developed, adolescent girls with co-occurring disorders often return to their families even though their family members most frequently refer them to the juvenile justice system. The implied message suggested to adolescent females is that they do not “fit” anywhere and the continual referrals from one system to another erodes self-esteem and trust. Research and anecdotal evidence suggests that physically and sexually violent family settings are strongly associated with adolescent substance use and other high-risk behaviors previously described. Therefore, it is necessary to develop practical and concentrated efforts in working with family members with the same intensity as the adolescent girls themselves. Similarly, there is a need to explore the possibilities of supporting multigenerational and extended family placements for young women who are not able to return to families of origin.
II. GENDER-SPECIFIC, CULTURALLY SENSITIVE CRISIS INTERVENTION PROTOCOLS & PROCEDURES

Improve Protocols & Procedures in All Restricted Environments to Mitigate Retraumatization

The issues of retraumatization are central to developing effective alternative crisis intervention protocols and procedures in restricted environments. In order to obviate decompensation, flashbacks, rage-reactions, self-injury, and further relapse, all intervention procedures and protocols must assume adolescent females have histories of physical and sexual abuse. The high concentration of known physical and sexual abuse survivors in mental health settings has driven some state mental health departments to explore alternatives to current restraint and seclusion practices. Future policy and practices could build on restraint and seclusion reduction protocols and clinical guidelines developed for adult females with abuse histories in restricted facilities. More specific recommendations include:

- Presence of female staff at all health screens; Alternatively, policies have been developed to defer health screens to community female physicians and/or to contact with female physicians or practitioners to come to the facility on certain days to provide Pap smears, breast exams, pelvic exams, assessments for HIV, STDs and gather other information that is potentially difficult for young adolescent females.

- Presence of female staff that are known to the adolescent during crisis intervention;

- Developing policies that emphasize protocols for the least restrictive intervention during the onset of crisis, followed by more restrictive interventions thereafter;

- Develop alternatives to restraints that mirror sexual abuse;

- Direct questioning by women staff during the intake and evaluation process regarding abuse history, types of prior restraint, and reactions to prior restraint;

- Providing information about protocols at initial intake so that adolescent girls know what to expect, thereby mitigating some of the feeling of being “out of control”;

- Provide uniforms that are opaque to assure privacy;

- Use female staff during close observation procedures;

- Provide opportunities for peer support, group interaction and processing after crisis;

- Develop uniform reporting mechanisms that work with selected oversight bodies when intrusive methods (handcuffs during transport, restraints, forced medication, body searches) are employed to control behavior in crisis intervention.
III. TRAINING & DISSEMINATION

*Develop Strong Cross-System Collaboration In Gender-Specific Issues*

Educational systems are one of the most potentially consistent community resources for girls to acquire important skills, and scholastic retention is closely associated with long-term, positive outcomes. Therefore, establishing linkages with teachers, school guidance personnel, nurses, and board members is an essential part of maintaining transitional success in the community. School systems are a natural place to begin cross-system collaboration efforts with educational personnel and information dissemination with adolescent girls. Training curriculums known to be successful with women with co-occurring disorders who are at-risk could be adapted for girls at various developmental stages. Successful curriculums have included health information (including parenting, STDs, HIV and other risks), violence (battering, incest, physical abuse), alcohol and drug abuse, mental health issues (particularly depression, anxiety, eating disorders, self-injury and posttraumatic stress).

Cross-system collaboration and training must include representatives from all those involved in the lives of adolescent females in the juvenile justice system. Members from other groups include: judges, prosecutors, juvenile justice personnel, mental health and substance abuse clinicians, primary health care physicians, police, policymakers, vocational rehabilitation, child welfare and victim services personnel, family members, and clergy.

*Develop Written Material For Training*

There is currently a lack of written material outlining some basic issues regarding gender-specific services, treatment needs, etiologies of behavior, and suggestions for policy and practice implementation in juvenile justice and community settings. Brief informational data sheets drawn from available literature on female development, anecdotal information provided by adolescent girls, and preliminary research findings are needed to address gender-specific differences in:

- the role of self-esteem in substance use, mental health problems and delinquent behaviors;
- effects of retraumatization on recidivism rates;
• levels of abuse and its interrelationship with substance use, truancy, poor school performance, increased contact with the juvenile justice and mental health systems;
• characteristics of female-specific expressions of distress, strength, and resistance;
• differences between gender-specific and stereotypic female behavior.

In order to disseminate information to the broadest possible constituency and promote effective systems change, those working with adolescent girls require data sheets with rationales specifically addressing the recommendations made in this document. The following practices reflect some important components in the provision of quality services for adolescent girls with mental health and substance abuse needs in contact with the juvenile justice system: requiring a female presence at health care screens; integrating mental health, substance abuse and victim services; promoting vocational and educational rehabilitation; focusing on individualized, flexible treatment; understanding the effects of retraumatization; and utilizing single-sex therapeutic groups and residential placements.

Collaborate with Other Systems to Promote Systems Change

Other strategies for collaboration include supporting and expanding the endeavors of agencies already engaged in informational sharing and dissemination on relevant topic areas, such as the National Council for Negro Women, and the Center for Women's Policy Research. Additional strategies for collecting nationwide data include: requesting reports on gender-specific plans for intake, referral, retention, and disposition from agencies in each state responsible for collecting information on the status of adolescent females; identifying which states received challenge grants for public policy development related to gender-specific services; and requesting preliminary data they may have regarding outcomes.
IV. RESEARCH & EVALUATION

Expand Research Agendas to Include Longitudinal Outcome Data

Understanding the impact of interrelated stressors in the lives of adolescent females with co-occurring disorders who are involved in the juvenile justice system provides opportunities to advance the evolution of gender-specific and age-appropriate interventions and treatment. Therefore, research agendas must be expanded to include gender-specific longitudinal data that measures risk factors influencing the onset of offenses, delinquency, and etiologies of violent behavior.

Evaluate Efficacy of Alternative Approaches Over Time

Individual and programmatic “success” is most accurately measured incrementally and longitudinally, reflecting the evolutionary process of recovery itself. Evaluation instruments are needed to measure positive outcomes for both the adolescent girls and the systems serving them. This process requires combining information gathered, expanding research agendas that frame experiences of mental health and substance abuse within a female-specific context, and evaluating alternative approaches in model programs over time. In addition, those receiving grants for program development in the future should be required to submit reports on their process of integrated service delivery, gender-specific planning, and implementation in order to evaluate outcomes.

Create Partnerships With Female Adolescents To Assess & Evaluate Treatment Efficacy

Developing safe environments, establishing trust, and enhancing self-esteem, are possible when service provisions are flexible enough to incorporate individual needs, maximize participation, and create policies reflecting standards that assure the articulated needs of adolescent girls are a priority. Young women receiving services can play a central role in the process of assisting policy makers, administrators, and service providers in identifying relevant programmatic issues and proposing solutions. Forming focus groups with adolescent females provides unique opportunities to receive feedback regarding the efficacy of program efforts. This kind of collaboration promotes trust, extends confidence, and allows for evaluation on an ongoing basis.
Engaging key mental health, substance abuse, victim services, peer relations, vocational, educational and primary medical personnel, can be an initial step toward establishing common principles. These principles form a basis for promoting policies driving new and innovative alternatives by lending uniformity to previously fragmented systems or services. The standards provide groundwork for continuous quality improvement and oversight, mirroring the evolutionary process anticipated for the adolescent females being served.
CONCLUSION

As evidenced above, many challenges lie ahead for all who are concerned with the care and treatment of adolescent girls with complex mental health, substance abuse, and primary health needs who come in contact with the juvenile justice system. Other important endeavors may lie in developing pilot programs that bring together best practice and policy recommendations. Additional longitudinal research and evaluations are required to measure the impact of programming innovations on: reduced recidivism; decreased revictimization; increased overall health; educational retention; articulated sense of safety and well-being. Perhaps one of the most important measures of success will become clarified when adolescent girls with mental health and substance abuse concerns in contact with the juvenile justice today, speak to us in the future. Where will they be? And can we, as service providers, administrators, policymakers, educators, family members and juvenile justice personnel, remain flexible enough to continually challenge and expand our vision as girls, themselves, change and develop over time? Many people are actively creating practice innovations in an attempt to engage young adolescent females with multiple vulnerabilities as they enter juvenile justice systems with increasing prevalence. It is our hope that this document will support those efforts and inspire others to create safe environments for adolescent girls to put the pieces of their lives back together in an integrated fashion, to discover their potential as young women, and to emerge with new skills and insights.
APPENDIX A

Female Adolescents with Co-Occurring Disorders in the Juvenile Justice System
December 11-12, 1997

Participants

Linda Albrecht
11535 Green Court
Conifer, CO 80433
Phone: (303) 385-8198
FAX: (303) 385-6850

Maxine Harris, Ph.D.
Community Connections
801 Pennsylvania Avenue, S.E.
Suite 201
Washington, DC 20003
Phone: (202) 546-1512
FAX: (202) 544-5365

Mary Aushlander, M.S.W.
Box 230
East Dennis, MA 02641
Phone: (508) 385-8198
FAX: (508) 385-6850

Pasquale Huerta, L.C.S.W.
103 Loma Vista Court
Los Gatos, CA 95032
Phone: (408) 356-6844
FAX: (408) 229-8327

Marva Benjamin, M.S.W.
Director of Cultural Competence Initiative
National Technical Assistance Center for Children's Mental Health
3307 M Street, N.W., Suite 401
Washington, DC 20007
Phone: (202) 687-5000
FAX: (202) 687-8899

Marion Kelly
Virginia Department of Criminal Justice Services
805 East Broad Street
10th Floor
Richmond, VA 23219
Phone: (804) 225-4072
FAX: (804) 371-8981

Helen Bergman
Community Connections
801 Pennsylvania Avenue, S.E., Suite 201
Washington, DC 20003
Phone: (202) 546-1512
FAX: (202) 544-5365

Charlotte Mallon-Wenzel
Associate Director
Juvenile Court
1100 S. Hamilton Avenue
Chicago, IL 60612
Phone: (312) 226-1166
FAX: (312) 433-4441

Judy de Chabert, Divisional Director of Training Prototypes
5601 West Slawson Avenue, Suite 200
Culver City, CA 90230
Phone: (310) 641-7795
FAX: (310) 338-0915

Dusty Miller, Ph.D.
Professor of Psychology
Antioch New England Graduate School
Department of Clinical Psychology
40 Avon Street
Keene, NH 03431
Phone: (603) 357-3122
FAX: (603) 357-0718

Barbara Guthrie
Assistant Professor/Research Scientist
Department of Health Promotion/Risk Reduction
University of Michigan - Room 3247
400 North Ingalls Building
Ann Arbor, MI 48109-0482
Phone: (313) 936-7783
FAX: (313) 936-7788
Laura Prescott  
P.O. Box 266  
Worthington, MA 01098  
Phone: (413) 238-0478  
FAX: (413) 238-5915

Sue Sanchez  
Prototypes Women's Center  
152 North Dos Caminos  
Ventura, CA 93003  
Phone: (805) 641-2649  
FAX: (805) 641-2958

Brenda Smith, J.D.  
Senior Counsel  
Director of Women in Prison Project  
National Women's Law Center  
11 Dupont Circle, Suite 800  
Washington, DC 20036  
Phone: (202) 588-5180  
FAX: (202) 588-5185

Rose Soo Hoo, M.S.W.  
Department of Youth Services  
1211 East Alder Street  
Seattle, WA 98122  
Phone: (206) 205-9420  
FAX: (206) 205-9609

Lee Underwood, Psy.D.  
Director of Clinical Services  
Ohio Department of Youth Services  
51 North High Street  
Columbus, OH 43215  
Phone: (614) 466-0586  
FAX: (614) 752-9078

Federal Participants

Jutta Butler  
Systems Development & Integration Branch  
Center for Substance Abuse Treatment  
5515 Security Lane  
Rockwall II Building, Suite 740  
Rockville, MD 20852  
Phone: (301) 443-6503  
FAX: (301) 443-3543

Nicholas Demos  
Criminal Justice Systems Branch  
Center for Substance Abuse Treatment  
5515 Security Lane  
Rockwall II Building, Suite 740  
Rockville, MD 20852  
Phone: (301) 443-6533  
FAX: (301) 443-3543

Douglas Dodge  
Director  
Special Emphasis Division  
Office of Juvenile Justice and Delinquency Prevention  
810 7th Street, N.W. - 8th Floor  
Washington, DC 20531  
Phone: (202) 307-5914  
FAX: (202) 514-6382

Alvin Hall  
Community Corrections Division  
National Institute of Corrections  
500 1st Street, NW - 7th Floor  
Washington, DC 20534  
Phone: (202) 307-3106 Ext. 162  
FAX: (202) 307-3361

Maury Lieberman  
Chief  
Special Programs and Development Branch  
Center for Mental Health Services  
5600 Fishers Lane, Room 16C-17  
Rockville, MD 20857  
Phone: (301) 443-7790  
FAX: (301) 443-7912
Andie Moss  
Correctional Program Specialist  
National Institute of Corrections  
500 1st Street, N.W.  
Washington, DC 20534  
Phone: (202) 307-3106 x 140  
FAX: (202) 307-3361

Susan Salasin  
Prevention and Program Development Branch  
Center for Mental Health Services  
5600 Fishers Lane, Room 18C-07  
Rockville, MD 20857  
Phone: (301) 443-7790  
FAX: (301) 443-7912

Yolanda Shamwell, M.S.W.  
Acting Associate Administrator for Women's Services  
SAMHSA  
5600 Fishers Lane - Room 1399  
Rockville, MD 20857  
Phone: (301) 443-2868  
FAX: (301) 443-8964

Maggie Wilmore  
Team Leader  
Women and Children's Programs  
Center for Substance Abuse Treatment  
Rockwall II Building - 7th Floor  
5600 Fishers Lane  
Rockville, MD 20857  
Phone: (301) 443-8216  
FAX: (301) 443-3543

GAINS Center Staff

Collie Brown  
National GAINS Center  
Policy Research, Inc.  
262 Delaware Avenue  
Delmar, NY 12054  
Phone: (518) 439-7415 x 225  
FAX: (518) 439-7612

Joseph Cocozza, Ph.D.  
National GAINS Center  
Policy Research, Inc.  
262 Delaware Avenue  
Delmar, NY 12054  
Phone: (518) 439-7415  
FAX: (518) 439-7612

Robert Rich, Ph.D.  
Institute of Government and Public Affairs  
University of Illinois  
1007 West Nevada  
Urbana, IL 61801  
Phone: (217) 333-3340  
FAX: (217) 244-4817

Kathy Skowyra  
National GAINS Center  
Policy Research, Inc.  
262 Delaware Avenue  
Delmar, NY 12054  
Phone: (518) 439-7415 x 241  
FAX: (518) 439-7612

Henry Steadman, Ph.D.  
National GAINS Center  
Policy Research, Inc.  
262 Delaware Avenue  
Delmar, NY 12054  
Phone: (518) 439-7415  
FAX: (518) 439-7612

Bonita Veysey, Ph.D.  
Policy Research, Inc.  
262 Delaware Avenue  
Delmar, NY 12054  
Phone: (518) 439-7415 x 230  
FAX: (518) 439-7612
REFERENCES


