Office of Research and Policy Analysis

A NUTSHELL SUMMARY OF A BLUE PRINT FOR CHANGE

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For the
Law and Justice Interim Committee
November 30, 2007

Published By
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This paper summarizes *A Blue Print for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System,* prepared by Kathleen R. Skowyra and Joseph J. Cocozza, PhD for the National Center for Mental Health and Juvenile Justice, U.S. Department of Justice, 2007

Purpose

Pursuant to HJR 26, the legislature has asked the Law and Justice Interim Committee to examine mental health diversion alternatives for mentally ill youth who become involved with the juvenile justice system. This paper launches this examination with a nutshell summary of a report produced from what is considered the most comprehensive study conducted to date on the mental health needs of justice-involved youth aimed at developing a comprehensive model to address these needs in an effective and strategic manner.

The study and report

The alarming number of youth in the juvenile justice system with identified mental health needs is straining juvenile justice systems nationwide. The executive director of the Coalition for Juvenile Justice[1] called mental health its number one issue. In 2000, the Federal Office of Justice and Delinquency Prevention under the U.S. Department of Justice commissioned a four-year study to assess the scope of the issue and develop a comprehensive blue print for change. This paper summarizes the report produced by the study, which is entitled *A Blue Print for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System*, published in 2007.

[1] The Coalition for Juvenile Justice (CJJ) is a national nonprofit association representing governor-appointed advisory groups on juvenile justice from the U.S. states, territories and the District of Columbia. The CJJ's website states that its principal mission is "to build safe communities one child at a time by ensuring that all children and families are treated fairly and given the resources and support to be positive and productive contributors to society."

The landscape

How big are the mountains?

Overall, 70.4 percent of the youth in the study were diagnosed with at least one mental health disorder. Among males, disruptive disorders were the most prevalent. Among females, anxiety disorders were most prevalent. Substance use disorders were the next most prevalent for both males and females.

Of the youth diagnosed with at least one mental health disorder, 79.1 percent had at least one other mental health diagnoses and 58.5 percent of the males and 65.6 percent of the females also met the criteria for a substance use disorder. Minority youth were also found to be over-represented in the mentally ill youth population.

An estimated 17 to 27 percent of the justice-involved mentally ill youth meet the criteria for a serious mental illness severe enough to require immediate and significant treatment.

How rough is the terrain?

Mental health and juvenile justice do not mix well. They are very different systems with very different goals and approaches. The goal of a mental health system is recovery, which involves a non-linear, non-adversarial process of carefully managing illness and gradually changing behavior over time. The justice system is linear and adversarial and looking for more immediate results. Mental health providers are not and should not become corrections officials and corrections officials are not and should not become mental health providers. Nevertheless, these two systems must learn to work together to appropriately manage justice-involved mentally ill youth.

Building blocks

Acknowledging the challenges, the report presents a blue print for change based on the following building blocks:

- underlying principles;
- cornerstones;
- critical intervention points; and
- program examples.

Principles

The nine underlying principles are outlined in Attachment A.

Cornerstones

The following cornerstones must be laid when developing any type of program to successfully manage mentally ill justice-involved youth:

- **collaboration** and interagency and multi-jurisdictional partnerships;
- **identification** of the target population;
- **diversion** of the youth from further penetration into the juvenile justice system; and
- **treatment** because diversion is only meaningful if it is a diversion to treatment.

Critical intervention points

A youth's mental health status and needs must be considered at each point within the juvenile justice system where critical decisions are made about how a youth will be handled. Traditional approaches will only exacerbate the problem behavior. The critical intervention points (and the key decisions makers at these points) at which mental health status and needs must be considered and intervention provided as appropriate are as follows:

- initial contact and referral (law enforcement officers);
- intake (juvenile probation officers);
- detention centers (administrators);
- judicial processes (county attorneys, public defenders, and judges);
- secure placements (administrators);
- probation (probation officers);
- re-entry (juvenile parole officers).

Recommendations and examples

Initial contact

Local law enforcement, mental health providers, and schools should collaborate, receive cross training, and implement procedures so that when a law enforcement officer or a school official

makes initial contact with a youth who may be acting out because of a mental illness, the aid of mental health providers can be enlisted.

Colorado has developed a statewide multi-jurisdictional Crisis Intervention initiative. A state-level agency helps local communities develop crisis intervention services by providing technical assistance, training, and staff support to communities throughout the state. Initial start-up and the first four years of the initiative's operation was funded through federal grant programs and on-going funding is being provided by blending state and local resources.

Intake

When a youth is referred to juvenile probation, the intake officer acts as a gatekeeper and has a great deal of discretion and control with respect to how a youth will be handled. Intake officers should receive mental health training and use standardized screening and assessment tools to facilitate early identification and intervention for mentally ill youth. Intake should also involve gathering information from schools, families, and mental health providers. Diversion strategies can then be developed to link the youth to needed services and provide for the youth to fulfill a treatment plan as an alternative to further court processing.

A county diversion program in Kentucky targets first-time status offenders in grades 6 through 8 who have mental health and substance abuse problems. A court-designated worker screens the youth and shares the results with a Family Intervention Resource Services Team (FIRST). A FIRST case manager meets with the youth's family and develops a family service plan that links the youth to a range of community services. The case manager reports to the court on how the case is progressing and if the youth meets the established goals, the youth's case is closed.

Detention

Youth with a mental illness who become involved in the justice system should not be inappropriately warehoused in youth detention centers because they have nowhere else to go. Furthermore, while the mentally ill youth in detention should receive treatment, a mental health treatment system should not be built within detention centers. Rather, detention centers should establish linkages with community-based treatment providers who can serve youth while they are in detention.

Bernalilo County in New Mexico has developed an intake process that identifies a youth with mental health needs and diverts the youth to a community mental health clinic fully funded by Medicaid. Additionally, through a collaborative agreement, the clinic's staff can provide services in the detention center.

Illinois has developed a statewide approach to provide mental health juvenile justice liaisons who identify the most seriously mentally ill youth in detention centers. When a youth has been identified as meeting certain criteria, a liaison works with mental health providers, families, and advocates to develop a treatment plan that will links the youth to needed services for a least 6 months. The liaison informs the court so that the court may release the youth from the detention center. The program is funded through the state's Department of Human Services.

Judicial processing

It is critical that judges have sufficient information about a youth's mental health treatment history and current needs in order to make informed decisions about the disposition of a case and the future of the involved youth. Ideally, the information should be gathered through intake evaluations and judges should have the resources to order clinical assessments. Some jurisdictions have established specialty courts to handle cases in which the youth meets a specified criteria.

A treatment court in Summit County, Ohio serves court-involved youth ages 12 to 17 who have a major affective disorder, severe post-traumatic stress disorder, psychotic disorders, or a co-occurring substance abuse disorder and who agree to participate in the treatment court. Youth who have committed a serious felony offense are ineligible. A comprehensive assessment is done, the youth is linked with community-based services, and a treatment plan is developed. Upon successful completion of the treatment plan, charges are dismissed and the youth's record is cleared.

Dispositional alternatives

Traditional state juvenile correctional facilities have been criticized as sterile and inappropriate for providing rehabilitation. Additionally, large congregate care facilities, such as training schools or boot camps have not proven especially effective at reducing recidivism. Critics of these facilities and programs argue for community-based programs in settings where a youth can learn and apply social and other skills in contact with their families, schools, and communities.

Secure placement

There is increasing concern about the mental health care and treatment provided in youth correctional facilities. Recent investigations by the U.S. Department of Justice has documented the failure of many of these facilities to meet even the most basic mental health needs of youth in their care.

Some states, such as Ohio, Texas, and Florida, have created centralized intake programs and corrections-based mental health service delivery systems consisting of specialized treatment institutions for youth with mental health needs.

Probation

Probation offers and opportunity to link youth with evidence-based treatment programs, such as Functional Family Therapy, Multi-Systemic Therapy, and Multi-Dimensional Treatment Foster Care.

In Connecticut, for example, the court services division provides funding to each of the state's judicial districts for Multi-Systemic Therapy "slots". These slots are available to youth adjudicated delinquent, placed on probation, and meeting certain risk and need criteria.

Re-entry

Juvenile re-entry is defined as programs, services, and supports intended to assist youth in the transition from residential placement back into the community. It is best accomplished through collaborative arrangements with community service providers that ensure the supervised delivery of mental health treatment while the youth is in transition. A lack of access to mental health treatment and supervised medication management reduces the likelihood of a successful transition.

Washington state developed a re-entry program specifically designed for juvenile offenders between 11 and 17 years of age with an Axis I mental health disorder and a co-occurring substance abuse disorder. The program, called Family Integrated Treatment Project, is a family-centered approach designed to improve the youth's psycho-social functioning and to promote the parent's capacity to supervise the youth.

Conclusion

This paper has attempted to summarize in a nutshell the results of a four-year study and a

comprehensive report that offers many more details about findings and conclusions. The full report also offers descriptions of many more programs across the nation that may serve as inspiration for developing similar programs in Montana. These are provided at Attachment B. The key themes repeated throughout the report are:

- mental health and juvenile justice need to bridge their differences and learn to collaborate;
- interagency and multi-jurisdictional planning groups and task forces are needed in order to plan and implement change;
- cross-training is essential at all levels;
- standardized and effective screening and assessment tools are a must in order to identify target populations and provide appropriate treatment and services;
- mental health records and information must be shared between agencies and jurisdictions;
- diversion does not work unless there are effective treatment programs;
- treatment programs should use evidenced-based practices; and
- families should be involved and kept informed every step of the way.
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