

Juvenile Justice Resource Series

Addressing the Mental Health Needs of Youth in Contact With the Juvenile Justice System in System of Care

An Overview and Summary of Key Issues



***Addressing the Mental Health Needs of Youth in Contact
With the Juvenile Justice System in
System of Care Communities:***

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**Joseph J. Cocozza, Ph.D.
Kathleen R. Skowrya
Jennie L. Shufelt, M.S.**

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About the Technical Assistance Partnership for Child and Family Mental Health

The Technical Assistance Partnership for Child and Family Mental Health (TA Partnership) provides technical assistance to system of care communities that are currently funded to operate the Comprehensive Community Mental Health Services for Children and Their Families Program. The mission of the TA Partnership is "helping communities build systems of care to meet the mental health needs of children, youth, and families."

This technical assistance center operates under contract from the federal Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

The TA Partnership is a collaboration between two mission-driven organizations:

- The American Institutes for Research — committed to improving the lives of families and communities through the translation of research into best practice and policy, and
- The National Federation of Families for Children's Mental Health — dedicated to effective family leadership and advocacy to improve the quality of life of children with mental health needs and their families.

The TA Partnership includes family members and professionals with extensive practice experience employed by either the American Institutes for Research or the National Federation of Families for Children's Mental Health. Through this partnership, we model the family-professional relationships that are essential to our work. For more information on the TA Partnership, visit the Web site at <http://www.tapartnership.org>.

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Forward

Each year, more than 2 million children, youth, and young adults formally come into contact with the juvenile justice system, while millions more are at risk of involvement with the system for myriad reasons (Puzzanchera, 2009; Puzzanchera & Kang, 2010). Of those children, youth, and young adults, a large number (65–70 percent) have at least one diagnosable mental health need, and 20–25 percent have serious emotional issues (Shufelt & Coccozza, 2006; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002). System of care communities focusing on meeting the mental health and related needs of this population through comprehensive community-based services and supports have the opportunity to not only develop an understanding around the unique challenges this population presents, but also to decide how best to overcome those challenges through planned and thoughtful programs, strong interagency collaboration, and sustained funding.

The Technical Assistance Partnership for Child and Family Mental Health (TA Partnership) recognizes the many challenges system of care communities face in working to better meet the needs of all of the children, youth, and young adults they serve. In an effort to help these communities meet the unique needs of young people involved or at risk of involvement with the juvenile justice system, the TA Partnership is releasing a resource series focused on this population. The TA Partnership has contracted with the National Center for Mental Health and Juvenile Justice (NCMHJJ) to produce this resource series, which contains three briefs. Each brief examines a unique aspect of serving this population within system of care communities.

The first brief, *Addressing the Mental Health Needs of Youth in Contact With the Juvenile Justice System in System of Care Communities*, provides an overview of the challenges many system of care communities face in working with children, youth, and young adults involved or at risk of involvement with the juvenile justice system and provides concrete examples of how some communities have overcome these challenges. The second brief, *Successfully Collaborating With the Juvenile Justice System: Benefits, Challenges, and Key Strategies*, takes a closer look at the importance of true collaboration between community-based child-serving agencies in providing a comprehensive array of services and supports and fostering positive outcomes for this population. Finally, the third brief, *Systems of Care Programs That Serve Youth Involved With the Juvenile Justice System: Funding and Sustainability*, explores ways in which communities can financially sustain the efforts they have in place to meet the needs of this population after the Substance Abuse and Mental Health Services Administration (SAMHSA) funding period has ended.

We hope that this resource series will support the planning and implementation of effective services, policies, and practices that improve outcomes for children, youth, and young adults involved or at risk of involvement with the juvenile justice system as well as their families.

Addressing the Mental Health Needs of Youth in Contact With the Juvenile Justice System in System of Care Communities: An Overview and Summary of Key Issues

Background

More than 2 million youth are arrested every year in the United States; more than 600,000 are processed through juvenile detention centers; and more than 93,000 are placed in secure juvenile correctional facilities (Snyder & Sickmund, 2006). The majority of these youth—65 to 70 percent—have a diagnosable mental health disorder (Shufelt and Coccozza, 2006; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). The mental health needs of these youth are often severe and complex. According to a recent study by the National Center for Mental Health and Juvenile Justice (NCMHJJ), 27 percent of youth in detention, correctional, and community-based placements experience disorders so severe that their ability to function is highly impaired. Furthermore, youth in the study often met criteria for multiple disorders. Of those youth who met criteria for at least one mental health disorder, more than 60 percent met criteria for three or more diagnoses, and nearly 61 percent had a co-occurring substance use disorder (Skowrya & Coccozza, 2007).

Many youth with mental health needs end up in the juvenile justice system not because of the seriousness of their offenses but because of their need for mental health treatment that is otherwise unavailable to them in the community (Skowrya & Coccozza, 2007; Casey Strategic Consulting Group, 2003). During a survey by the National Alliance on Mental Illness (NAMI, 1999), 36 percent of parents reported that their children were placed in the juvenile justice system because mental health services were unavailable in the community. In a similar manner, a U.S. General Accounting Office report found that, in 2001, parents placed almost 13,000 children in the child welfare or juvenile justice systems in an effort to access mental health treatment (U.S. General Accounting Office, 2003). The undesirable trend of parents' turning to the juvenile justice system as a last resort for treatment was confirmed during a series of focus groups convened in 2004 by NCMHJJ and the Federation of Families for Children's Mental Health (Osher & Shufelt, 2006). Furthermore, a 2004 study of juvenile detention facilities across the country found that two-thirds of facilities reported holding youth because they needed mental health treatment that was not available in the community (U.S. House of Representatives, 2004).

The unfortunate irony of using the juvenile justice system to access mental health care is that the mental health services within the juvenile justice system are frequently inadequate or completely unavailable. Investigations by the U.S. Department of Justice into the conditions of confinement in juvenile detention and correctional facilities have documented consistent and pervasive failures in the provision of adequate mental health services to youth in their care (U.S. Department of Justice, 2005). Similarly, a 2004 study of 698 detention centers found that a quarter of all facilities provided poor or no mental health treatment to youth, and more than 50 percent had inadequate levels of staff training (U.S. House of Representatives, 2004). This is particularly troubling for youth of color, who are overrepresented in the juvenile justice system (Drakeford & Garfinkel, 2000), underrepresented in outpatient mental health treatment (U.S. Department of Health and Human Services, 2001), and more likely than white youth to

have their mental health problems identified through the juvenile justice system (National Mental Health Association, 2004).

For youth with serious and complex mental health needs, involvement with the juvenile justice system can have profound and devastating effects. Placement in juvenile justice facilities can exacerbate a youth's mental health symptoms and, among those youth with a history of traumatic experiences, can trigger memories and reactions to previous traumatic experiences (Mahoney, Ford, Ko, & Siegfried, 2004). Involvement with the juvenile justice system can also be detrimental to a youth's family. Families may feel increasingly anxious and concerned about the safety and well-being of their children, powerless to help their children or manage their treatment, and resentful and angry over the unavailability of other services that might have prevented the involvement of their child with the juvenile justice system (Osher & Hunt, 2002). Families often report feeling "dismayed and bitterly disappointed with the care and treatment their children . . . received" while involved with the juvenile justice system (Osher & Shufelt, 2006).

The Role of Systems of Care

The multitude of communities across the country that receive funding through the Comprehensive Community Mental Health Services Program for Children and Their Families, commonly referred to as the "system of care initiative," have a significant opportunity to change the stories of youth in their community who have mental health needs and have become involved with the juvenile justice system. For those communities that take on this challenge, the success of their effort will require the following:

1. *Recognition that youth with mental health needs are more often than not found outside the traditional children's mental health system.* Youth with mental health needs are now seen in multiple systems and contexts beyond the traditional mental health setting, including the juvenile justice, child welfare, education, and health care systems. The President's New Freedom Commission Report on Mental Health recognized this trend and called for a "fundamental transformation" of the nation's mental health system into a system that can face this reality and provide access to mental health services *in these various contexts* (The President's New Freedom Commission on Mental Health, 2003). We now know that the vast majority of youth in the juvenile justice system have mental health needs. The system of care initiative, at its core, encourages the formation of multiagency partnerships to provide a wraparound strengths-based approach to mental health care that is driven by the needs of youth and their family. Therefore, systems of care are ideally positioned to embrace such a transformation.
2. *Commitment to enter into meaningful partnerships with the juvenile justice system to jointly examine the extent of overrepresentation of youth with mental health needs in the juvenile justice system at key stages of processing, and to develop joint ways to respond.* These partnerships are not always easy. However, this issue cannot be solved by any single agency or system, and collaboration is critical. A multisystem planning committee is vital to building consensus around a select number of priority issues (e.g., reducing school-based referrals to the police, providing preadjudicatory mental health diversion services to juvenile probationers, strengthening aftercare planning for youth coming home), and such a committee allows a community to strategically select its

target group and its focus. Starting small and building on achieved success creates a foundation for future and potentially more ambitious collaborations.

3. *Use of system of care funding to create more community-based, evidence-based mental health treatment capacity for youth in contact (or at risk of contact) with the juvenile justice system.* This targeted capacity-building effort could be used to accomplish the following:
 - a. Prevent involvement with the juvenile justice system by providing services for youth that are accessible by parents, schools, and police
 - b. Create more diversion opportunities for youth with mental health needs so that they can be safely and appropriately diverted from the juvenile justice system and into community-based mental health treatment
 - c. Create aftercare services for youth with mental health needs who are transitioning out of juvenile justice system placement and back to their homes and communities

Challenges to System of Care–Juvenile Justice Partnerships

The juvenile justice system has been identified as a “critically important component” in the system of care initiative (System of Care Evaluation Brief, 2000). The Substance Abuse and Mental Health Services Administration (SAMHSA) has gone so far as to encourage the prioritization of youth in the juvenile justice system. Additionally, they require applicants to demonstrate substantial planning, support, and input from a variety of state and local stakeholders, including representatives from juvenile justice when developing their programs. Despite the declaration that at-risk youth or youth involved in the juvenile justice system represent a priority population for the system of care communities, the focus on serving these youth varies widely and has not been a priority for many sites.

Data from a national cross-site evaluation of the system of care program indicates that only about 15 percent of all referrals in the system of care sites come from the juvenile justice system. Juvenile justice referrals ranged from 0 to 83 percent across the sites, with half the funded sites receiving fewer than 5 percent of their referrals from juvenile justice (Cocozza, 2004). This suggests that, for the most part, youth in contact with the juvenile justice system remain underserved within many system of care communities. In some cases, this is due to the presence of competing priorities and limitations on resources. In others, it is due to a number of barriers and challenges associated with such partnerships. Under any circumstance, this kind of effort can be difficult. Some of the most common barriers to partnership between the juvenile justice system and systems of care are discussed below.

Difficulties Associated With Collaboration. Critical to the establishment of any partnership is some degree of trust between the involved systems (Skowrya & Cocozza, 2007). A lack of a collaborative history between the mental health and juvenile justice systems can make it hard for these two systems to trust each other. Collaboration can be challenging for a number of reasons. The juvenile justice and mental health systems have very different goals (rehabilitation and the implementation of sanctions versus treatment), philosophies (families in some way are responsible for their children’s misbehavior versus family-driven care), and language (holding youth accountable versus strength-based treatment planning). Separate funding streams and

accountability measures make blending or braiding funding difficult. Uncertainty about the limits and appropriateness of information sharing, and perceptions that the “other” agency is attempting to avoid responsibility often complicate collaborative relationships.

Complexity of Needs. Youth in contact with the justice system commonly present with multiple and complex needs. Many of these youth have multiple mental health disorders and/or co-occurring substance use disorders (Shufelt & Coccozza, 2006). In addition, these youth are likely to have educational, developmental, and behavioral challenges. Coupled with the fact that these youth have come into contact with the juvenile justice system as a result of delinquent behaviors, many community mental health service providers perceive these youth as dangerous or violent, and are unwilling to accept and treat them. Reluctance on the part of community service providers to engage these youth results in even fewer service options.

Public/Political Support. Many youth in the juvenile justice system have complex mental health needs that are best addressed through diversion to community mental health services (Skowyra & Coccozza, 2007). A significant portion of these youth have committed minor, nonviolent offenses, and had it not been for the lack of access to community services, they would not be in the juvenile justice system in the first place. Unfortunately, the service needs of youth in the juvenile justice system are often not a high priority for policymakers, despite the significant potential for cost-savings by reducing institutional placement costs. Without strong advocacy and community awareness efforts, programs that serve these youth are often cut during times of fiscal shortfalls. This uncertainty and lack of prioritization can be a significant challenge to communities looking to establish a stable and sustainable system of care.

Lack of Treatment Capacity. The reality for most system of care sites is that the need for mental health services far outstrips the capacity of the community to provide services, because of a lack of qualified providers, inadequate funding, or other barriers. As a result, these communities must make difficult decisions about which populations of youth to prioritize. Unfortunately, because of the often limited political and public support for serving youth involved with the juvenile justice system, and the challenges associated with collaboration, lack of service capacity often results in the prioritization of other youth populations.

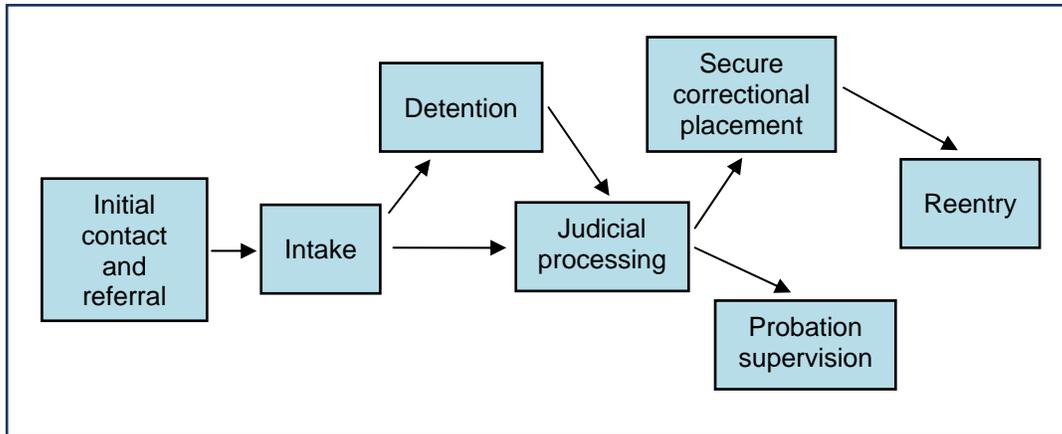
Opportunities for Partnership

While certainly more the exception than the rule, it is possible to create strong partnerships between the juvenile justice system and systems of care. It has been done in a small number of sites—Wraparound Milwaukee, Central Massachusetts Communities of Care, the Dawn Project in Indianapolis, IN, and Project Hope in Rhode Island are all examples of instances where such partnerships have worked exceptionally well. Arguably, the first step in undertaking a collaboration with the juvenile justice system is *understanding* the juvenile justice system, and the key opportunities for system of care collaboration. The juvenile justice system can be complicated and difficult to understand, thus frustrating efforts by the mental health system to meaningfully connect.

In 2007, NCMHJJ released its “Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System” (Skowyra & Coccozza, 2007). This technical assistance document, prepared for the Office of Juvenile Justice and Delinquency Prevention (OJJDP), provides a framework for

examining the juvenile justice system in its entirety and offers recommendations and guidelines for improving collaboration, identification, diversion, and treatment for youth with mental health needs who are involved with the system. A key component of the Blueprint is the identification of Critical Intervention Points (Figure 1), which are discrete processing points in the juvenile justice continuum that can be used as a framework for thinking about where opportunities for enhanced collaboration between the juvenile justice and mental health systems exist.

Figure 1. Critical Intervention Points



The following sections describe each critical intervention point in the continuum and provide examples of existing collaborative initiatives that target youth at this particular intervention point. Some examples are of juvenile justice/system of care collaboratives; others are of innovative programs or strategies that have been developed to improve the response to youth with mental health needs. Both types of examples provide illustrations of how mental health collaboration, identification, diversion, and treatment can be improved at key juvenile justice processing points.

Initial Contact and Referral. When a youth is suspected of committing an offense, the police are often the first to intervene. Law enforcement officers respond to calls from schools, parents, the concerned public, and victims of a suspected offense. When responding to a call involving youth with mental health needs, law enforcement officers typically have discretion about how best to respond. Common responses include: informal “adjustment,” either on site or at the station house; diversion of youth from formal processing based on certain conditions; or filing of a formal complaint or charges. Increasingly, law enforcement departments are partnering with community mental health agencies to assist police responding to crises involving individuals with mental health needs, by co-responding with police officers, co-training police on how to respond to youth experiencing some type of mental health crisis, or providing a place for law enforcement officers to take youth in need of mental health evaluation and services. System of care communities can partner with law enforcement on such efforts, to ensure that youth in a mental health crisis receive immediate and effective crisis services.

Program Example:

Central Massachusetts Communities of Care (CMCC) accepts referrals from various points within the juvenile justice system, including the police. The goal of CMCC is to

“decrease and prevent youth with serious emotional disturbance from becoming involved with the courts and to reduce the seriousness and duration of juvenile justice involvement” (Wenz-Gross & DuBrino, 2008). CMCC operates two Family Centers that provide a range of services from prevention to intervention, as well as evidence-based practices, such as Trauma-focused Cognitive Behavioral Therapy and Positive Behavioral Interventions and Support.

Sometimes a school will refer youth to the police. Many schools do not want to make this referral, particularly for a youth who is suspected of having a mental health need of some sort. However, they are often left with very few options. A new response that has developed over the last few years involves the use of mental health responders who are assigned to specific school buildings and are available to respond to school-based incidents among youth with suspected mental health disorders, in lieu of a referral to the police. These mental health responders provide immediate crisis intervention, arrange for parents to be contacted and evaluations to be performed, make referrals for treatment planning and service provision, and provide case management services.

Program Example:

Mobile Urgent Treatment Teams (MUTT), Wisconsin, created as an offshoot of Wraparound Milwaukee, provide mobile crisis response services to schools in the Milwaukee School District. These teams provide a range of crisis-intervention and treatment-planning services to youth, and work with schools on safety plans that will allow youth to stay in school while they receive mental health treatment for the behavioral health issue that brought them to the attention of the MUTT. This model has been replicated in other states participating in the John D. and Catherine T. MacArthur Foundation’s Models for Change Mental Health/Juvenile Justice Action Network, including Connecticut, which is implementing a high-fidelity wraparound responder model in two middle schools, as well as Washington State, which is using Three Rivers Wraparound as its mental health responder for youth in middle schools in Benton and Franklin counties.

Intake. “Intake” generally refers to the process that occurs after a formal referral by law enforcement, during which an assessment process is initiated to determine whether a case should be dismissed, handled informally, or referred to juvenile court for formal intervention. While the general function of intake is consistent, its structure varies significantly across jurisdictions. Intake may be the responsibility of probation, juvenile court, the prosecutor’s office, a state juvenile justice agency, or a centralized intake center, known as a “juvenile assessment center.” Because of the nature of intake, and the discretionary decisions made at this time, intake represents a significant opportunity to identify mental health needs among youth and to divert and/or refer youth for community-based treatment. By working with intake units to provide assessment services and diversion opportunities, system of care sites can ensure that the mental health needs of youth are identified early and that youth are diverted (when appropriate) in the early stages of the juvenile justice processing continuum, before youth and their families experience many of the negative effects of system contact.

Program Example:

Beaver County System of Care: Optimizing Resources, Education and Support (BC-SCORES), Pennsylvania, serves youth between the ages of 10 and 21 in Beaver County, PA, who have mental health and co-occurring substance use disorders and who are involved with the juvenile justice system. Referrals come from the Juvenile Services Division, which is responsible for juvenile court intake and probation supervision. Services provided through BC-SCORES include case management, Multi-Systemic Therapy (MST), family-based therapies, individual psychotherapy, medication management, and a range of support services. Family coordinators are available to help families understand and access available resources.

Program Example:

Special Needs Diversionary Program (SNDP), Texas, is a probation-based collaborative program targeting youth who meet specific mental health diagnostic criteria. SNDP serves as both a diversion program and a reentry program for youth released from secure care. Colocated Probation/Licensed Practitioners of the Healing Arts (LPHA) teams of four provide joint case management, service coordination, and supervision to caseloads of anywhere from 12 to 15 youth. After an initial MAYSI-2 screen and a clinical assessment and family interview, treatment plans are developed and services are provided using a wraparound philosophy.

Detention. The most common use of secure detention facilities is as a short-term “holding” facility for youth while they await adjudication. However, some states also use detention as a holding facility for youth awaiting disposition or placement after adjudication, and a few use detention facilities as a postadjudication placement. Because of the short length of stay common in detention facilities (approximately 15 days), and their preadjudicatory, temporary nature, as well as overcrowding and staff shortages, many of these facilities fall short of providing quality mental health care. Given the fact that these facilities often represent a youth’s first separation from his or her parents or caregivers, and can result in interruptions in medication and therapeutic services, mental health assessment and treatment for youth in detention is particularly critical. System of care sites can provide assistance by partnering with detention to provide community-based mental health assessment and services to youth.

Program Example:

The Illinois Mental Health/Juvenile Justice Initiative (MHJJI) was created in 2000 as a way to target youth in juvenile detention who have the most serious of disorders. Funds are provided to the community mental health agency to support “system liaisons” who serve as care coordinators to identify youth in detention appropriate for MHJJI, conduct eligibility assessments and develop care plans, seek approval from the court to release the youth from detention to participate in the program, and link the youth and their families to services for 6 months. Once the plan is in place, services are provided on the basis of a wraparound model.

Judicial Processing. Judicial processing encompasses two major steps that occur within juvenile court: adjudication and disposition. “Adjudication” refers to the process of conducting a hearing, considering evidence, and making a delinquency determination. If a youth is found delinquent during the adjudicatory process, a dispositional plan is developed. The dispositional plan is similar to sentencing within the adult system. This plan details the consequences of the youth’s

offense (e.g., probation, placement in a juvenile correctional facility, restitution). Development of the plan is based on a detailed history of the youth and assessment of available support systems and programs, and can include psychological evaluations and diagnostic testing. There are many opportunities within judicial processing for system of care sites to work with the courts. System of care sites can provide diagnostic and evaluation services, collaborate with the justice system to establish diversion options for youth with mental health needs, and establish community-based programs and services that can be incorporated in a dispositional plan.

Program Example:

Mental Health Diagnostic and Evaluation (D&E) Units, Jefferson County, Alabama, established through a system of care grant, serve youth through four D&E Units located in schools, child welfare, and the juvenile court. The juvenile court D&E Unit conducts assessments and develops individualized service plans for youth who meet criteria for serious emotional disturbances, have either experienced a previous separation from the family or significant functional impairments at home, and are at risk of placement. Referrals to the court D&E unit are made by both probation intake and the family court judge. This unit also provides a range of services, including medication management, crisis services, case management, and outpatient therapy.

Program Example:

Crossroads, Summit County, Ohio, is a specialized, postdispositional court for youth with mental health and co-occurring substance use disorders who meet specific diagnostic and juvenile justice criteria. The court's psychologist conducts assessments of youth, and treatment is provided primarily by specific community providers, although youth and families have the option of choosing their treatment providers. Some youth, whom the court's suitability committee deems most in need of home-based services, receive Integrated Co-Occurring Treatment (ICT). Crossroads probation officers serve as case managers and are responsible for the community supervision of youth. If a youth successfully completes treatment, his or her admitting charge and any related probation violations are expunged from their record.

Secure Correctional Placement. Placement in a secure juvenile correctional facility is the most restrictive disposition that a youth in the juvenile justice system can receive. Although all juvenile correctional facilities are designed to impose a sanction on the youth, protect the public, and provide some type of structured rehabilitative environment (Bilchik, 1998), the characteristics of these facilities vary significantly. Because of their secure nature and long-term custody of youth, these facilities are responsible for providing a range of services to youth. However, these facilities have been criticized as being sterile, inappropriate for rehabilitative programming, and fostering abuse and maltreatment (Greenwood, Model, Rydell, & Chiesa, 1996). There are real concerns about the quality and availability of mental health care for youth in correctional settings (Bosman, 2010), and a sense among mental health experts that it is preferable to treat youth with serious mental health disorders outside institutional settings in general and outside correctional settings in particular (Koppelman, 2005). Furthermore, these facilities frequently do not allow for youth to maintain connections with their families and ecological support systems, making it very difficult for the effects of any type of therapeutic intervention to be sustained. Despite these very real challenges and concerns, youth with mental health needs who end up in correctional placement should be afforded access to effective, evidence-based mental health treatment.

Program Example:

The Integrated Treatment Model (ITM), Washington, is an umbrella term for a combination of approaches used by Washington State’s Juvenile Rehabilitation Administration within the state’s residential programs and parole aftercare services. ITM combines a set of evidence-based cognitive behavioral therapy (CBT) approaches shown to reduce recidivism and improve clinical outcomes for troubled youth. The skills addressed in treatment reflect the clinical needs of the youth. All residential staff are trained in these principles and parole staff are trained in Functional Family Parole, which focuses on family and community reintegration. A preliminary evaluation of the ITM model indicates that it has had a positive impact on functioning and recidivism (Lucenko & Mancuso, 2009).

Probation Supervision. Probation supervision is the most common disposition within the juvenile justice system. Probation supervision is frequently accompanied by other court-imposed conditions, such as community service, restitution, or participation in community treatment services. For youth with mental health needs on probation supervision, this can be an important opportunity to provide needed mental health services. Partnerships with system of care sites can ensure that there are a range of services and programs available to meet the mental health needs of youth on probation supervision.

Program Example:

Harris County Systems of Hope, Texas, accepts referrals of adjudicated youth on probation that meet criteria for an Axis-I disorder according to the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) and have an IQ of at least 70. Assessments are completed by juvenile probation, and appropriate youth are sent to Systems of Hope. Once a referral is received, youth are either offered participation in a juvenile mental health court or wraparound services. A dedicated care team works with youth participating in the 6-month juvenile mental health court program.

Reentry. Reentry is the final point in the juvenile justice processing continuum, and incorporates programs and services that assist youth transitioning from juvenile justice placement back into the community (Geis, 2003). An effective reentry program that involves collaboration between the juvenile justice and mental health systems begins well in advance of a youth’s release and ensures that the youth is linked with effective community-based services, which can be critical to his or her long-term success. Since one of the goals of reentry planning is to link youth with community mental health services that will be available after contact with the juvenile justice system ceases, reentry is a logical point in the juvenile justice system for a partnership with a system of care. System of care sites may be able to partner with correctional facilities to provide reentry planning and services to youth who will continue to need mental health care on their release. These efforts need to begin early—shortly after the youth enters the facility (“think exit at entry”)—and should, whenever possible, involve the youth, his or her family, and representatives from the community-based agencies that will be working with the youth on release from care.

Program Example:

Project Hope, Rhode Island, which began as a system of care site, is an aftercare program for youth diagnosed with a mental health disorder who are leaving the Rhode Island Training School (RITS). Reentry planning begins 90 to 120 days prior to a

youth's discharge from RITS, and is a coordinated effort between the RITS clinical social worker and Project Hope Family Service coordinators, who work together to plan for a youth's service needs and community safety concerns. Case managers oversee service plan implementation for 9 to 12 months postdischarge.

Conclusion

All too often, youth with mental health needs are unnecessarily referred to the juvenile justice system because community-based mental health services are unavailable to them. Many of these youth are in the juvenile justice system for relatively minor, nonviolent offenses and would be more appropriately served in community settings that allow them access to effective treatment, and give them the chance to stay connected to their families, schools, and communities. Unfortunately, the reality is that for many youth, these treatment options do not exist and referral to the juvenile justice system becomes their last and only resort.

System of care communities, in partnership with the juvenile justice system, have the potential to change this course. By helping create more community-based treatment capacity and establishing linkages between the community mental health system and the juvenile justice system at key points of opportunity, communities have the potential to make a great difference in the lives of many children and youth. While such partnerships must confront and address a number of unique challenges, these challenges are by no means insurmountable. With careful planning and open communication, these challenges can be avoided or overcome, and successful and sustainable systems of care can be built to serve youth with mental health needs in the juvenile justice system.

This resource series is intended to provide system of care sites with information, practical advice, and strategies for responding to the large numbers of youth with mental health needs in contact with the juvenile justice system. This series includes the following publications:

- "Addressing the Mental Health Needs of Youth in Contact With the Juvenile Justice System in System of Care Communities: An Overview and Summary of Key Issues"
- "Successfully Collaborating With the Juvenile Justice System: Benefits, Challenges, and Key Strategies"
- "System of Care Programs That Serve Justice-Involved Youth: Funding and Sustainability"

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Appendix A: Additional Resources

This appendix includes additional resources that may be helpful to system of care sites focused on youth in the juvenile justice system. Resources include important publications and reports, Web sites for national technical assistance organizations, and important federal agencies, and available trainings on relevant topics.

Trauma

1. NCMHJJ Annotated Bibliography on Trauma
<http://ncmhjj.com/pdfs/publications/Bibs/Trauma.pdf>
2. The National Child Traumatic Stress Network
www.nctsnet.org
3. Center for Mental Health Services National Center for Trauma-Informed Care
www.mentalhealth.samhsa.gov/nctic/default.asp
4. “Trauma Among Youth in the Juvenile Justice System: Critical Issues and New Directions”
http://ncmhjj.com/pdfs/Trauma_and_Youth.pdf

Family Engagement

1. National Federation of Families for Children’s Mental Health
www.ffcmh.org
2. “Involving Families of Youth Who are in Contact With the Juvenile Justice System”
<http://ncmhjj.com/pdfs/publications/Family.pdf>
3. “A Family Guide to Getting Involved With Correctional Education”
<http://www.neglected-delinquent.org/nd/resources/spotlight/familyGuide2008.asp>
4. “Working With Families of Children in the Juvenile Justice and Corrections Systems: A Guide for Education Program Leaders, Principals, and Building Administrators”
<http://www.neglected-delinquent.org/nd/resources/spotlight/spotlight200611a.asp>

Screening and Assessment

1. National Youth Screening & Assistance Project NYSAP
<http://qa2-www.umassmed.edu/nysap/index.aspx>
2. NCMHJJ Annotated Bibliography: Screening and Assessment
<http://ncmhjj.com/pdfs/publications/Bibs/S&A.pdf>
3. “Youth With Mental Health Disorders in the Juvenile Justice System: Results From a Multi-State Prevalence Study”
<http://ncmhjj.com/pdfs/publications/PrevalenceRPB.pdf>
4. “Mental Health Screening Within Juvenile Justice: The Next Frontier”
http://ncmhjj.com/pdfs/MH_Screening.pdf

5. "Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System"
http://ncmhjj.com/pdfs/publications/Screening_And_Assessing_MHSUD.pdf

Gender

1. "Adolescent Girls With Mental Health Disorders Involved With the Juvenile Justice System"
http://ncmhjj.com/pdfs/Adol_girls.pdf
2. Office of Juvenile Justice and Delinquency Prevention Girls Study Group
<http://girlsstudygroup.rti.org/>

Diversion

1. "Juvenile Diversion: Programs for Justice-Involved Youth With Mental Health Disorders"
<http://ncmhjj.com/pdfs/publications/DiversionRPB.pdf>
2. Texas Special Needs Diversionary Program
<http://www.ncmhjj.com/Blueprint/programs/SpecialNeeds.shtml>
3. "Making Court the Last Resort: A New Focus for Supporting Families in Crisis"
<http://www.modelsforchange.net/publications/184>

Treatment

1. "Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth With Mental Health Needs in Contact With the Juvenile Justice System"
<http://ncmhjj.com/Blueprint/default.shtml>
2. "A Blueprint for Change: Improving the System Response to Youth with Mental Health Needs Involved with the Juvenile Justice System"
http://ncmhjj.com/Blueprint/pdfs/ProgramBrief_06_06.pdf
3. "Juvenile Mental Health Courts: An Emerging Strategy"
<http://ncmhjj.com/pdfs/publications/JuvenileMentalHealthCourts.pdf>
4. "Funding Mental Health Services for Youth in the Juvenile Justice System: Challenges and Opportunities"
http://ncmhjj.com/pdfs/publications/Funding_Mental_Health_Services.pdf
5. "Treatment in the Juvenile Justice System: Directions for Policy and Practice"
http://ncmhjj.com/resource_kit/pdfs/Treatment/Readings/TreatInJJSys.pdf
6. "Evidence-Based Practice in Child and Adolescent Mental Health Services"
http://ncmhjj.com/resource_kit/pdfs/Treatment/Readings/EBPChild.pdf

Additional Web Sites

1. Center for Mental Health Services
<http://www.mentalhealth.samhsa.gov/cmhs>
2. Center for Substance Abuse Prevention
<http://www.prevention.samhsa.gov>

3. Center for Substance Abuse Treatment
<http://www.csat.samhsa.gov>
4. Office of Juvenile Justice and Delinquency Prevention
<http://ojjdp.ncjrs.org>
5. National Alliance on Mental Illness
<http://www.nami.org>
6. National Federation of Families for Children's Mental Health
<http://www.ffcmh.org>
7. Office of Justice Programs
<http://www.ojp.usdoj.gov>
8. Substance Abuse and Mental Health Services Administration
<http://www.samhsa.gov>
9. American Probation and Parole Association
<http://www.appa-net.org>
10. Annie E. Casey Foundation
<http://www.aecf.org>
11. National Evaluation and Technical Assistance Center for the Education of Children and Youth Who Are Neglected, Delinquent or At-Risk
<http://www.neglected-delinquent.org>
12. National Technical Assistance Center for Children's Mental Health
http://www.gucchd.georgetown.edu/programs/ta_center/index.html
13. The John D. and Catherine T. MacArthur Foundation
<http://www.macfound.org>
14. Co-Occurring Center for Excellence
<http://www.coce.samhsa.gov>
15. Juvenile Law Center
<http://www.jlc.org>
16. National Partnership for Juvenile Services
<http://www.npjs.org/njda.html>
17. National Center for Juvenile Justice
<http://www.ncji.org>
18. Coalition for Juvenile Justice
<http://www.juvjustice.org>
19. Child Welfare League of America
<http://www.cwla.org>
20. Council of Juvenile Correctional Administrators
<http://www.cjca.net/default.aspx>
21. The REACH Institute
<http://www.thereachinstitute.org>

22. American Academy of Child and Adolescent Psychiatry
<http://www.aacap.org>
23. The National Council on Crime and Delinquency
<http://www.nccd-crc.org>
24. Judge David L. Bazelon Center for Mental Health Law
<http://www.bazelon.org>
25. The Council of State Governments
<http://www.csg.org>