Juvenile Justice & Behavioral Health Diversion: Using the System of Care Framework to Build on and Sustain System Reform

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Why integrate JJ in Systems of Care?

Merging Care with Control Brief I: Why Engage Juvenile Justice in System of Care

The Issue

Adolescence is a period of developmental transition, characterized by changes in family, school, peers, self-concept, and general physical development (Bergman & Scott, 2001). Although most youth successfully navigate this developmental period, incidents of rule breaking and behavioral problems are common and can result in involvement with law enforcement. Further, youth with untreated or undiagnosed mental health needs may engage in behaviors that are viewed as delinquency. It has become common knowledge that youth with mental health needs are disproportionately represented within the juvenile justice system.

Consequently, private foundations, federal agencies and state and local stakeholders have joined together to address juvenile justice and mental health reform. At the forefront of recent juvenile justice reform efforts are the Annie E. Casey Foundation’s Juvenile Detention Alternatives Initiative and the John D. and Catherine T. MacArthur Foundation’s Models for Change. Recognizing the unique challenges presented by youth with mental health needs involved with or at risk of involvement in the juvenile justice system, the John D. and Catherine T. MacArthur Foundation extended their Models for Change efforts by creating the Mental Health and Juvenile Justice Action Network coordinated by the National Center for Mental Health and Juvenile Justice (NCMJJ). The Action Network initially targeted four states (Rhode Island, Oregon, Pennsylvania, and Washington) and eventually expanded to include four additional states (Colorado, Connecticut, Ohio, and Texas), all focusing on efforts to address both policies and practices for mental health and juvenile justice reform. This collaboration resulted in the development of the Mental Health and Juvenile Justice Collaborative for Change. The Collaborative for Change is a resource center coordinated by NCMJJ to share information on mental health reforms and to provide guidance for effectively implementing these reforms in communities and states throughout the country (for more information go to ncmjj.org).
Rate: In the last decade—much higher rates of psychiatric disorders among juvenile justice youth.

Prevalence: Studies indicate prevalence rates anywhere from 50% to 75% (Wasserman, et al., 2010) with 20% to 25% having serious emotional disorders (Cocozza et al., 2000).

Variance: Studies differ due to the intercept point within the juvenile justice system from which samples were drawn (Wasserman et al., 2005).

Institutions: Teplin et al., (2012) postulated of the 92,854 youth in JJ institutions, 55,000 suffer from one or more psychiatric disorder.
JJ System as a form of Mental Health Care

• Survey of juvenile detention facilities fond that two-thirds reported holding youth in detention because they were waiting mental health care (US House of Representatives, 2004).

• National Alliance on Mental Illnesses (NAMI; 1999) found over 36% of families surveyed had their child arrested or detained because of the need for mental health services.

• U.S General Accounting Office (2001) reported that approximately 13,000 youth in juvenile justice system were referred by families to access mental health care.
JJ System Processing

• Most youth arrested are processed by a local juvenile court resulting in some form of supervision within their community (Puzzacheria, 2013).

• Youth with mental health challenges are more likely to be unsuccessful under supervision and more likely to be removed from the home through the use of violation of probation (Espinosa et. al., 2013).

• Those with identified mental health disorders are typically required to participate in treatment as a condition of their probation.

• Some mental health workers fall prey to the “treater-turned monitor” syndrome where services result in some form of coercion (Solomon et. al., 2002).
Outcomes for Youth with MH Challenges in the JJ System

- Rates of re-arrest for juvenile offenders who have returned range from 40% (Taylorn et. al., 2009), 65% (Benda, Corwyn, & Toombs, 2001) to as high as 85% (Trulson et al., 2005).
- *Can exacerbate a youth’s mental health symptoms* especially when the environment within the facility stimulates or triggers a youth’s *memory and/or reaction to a traumatic experience* (Mahoney, et al., 2004).
- Youth reactions to traumatic pasts *could result in behaviors that causes additional sanctions* by the system and further system involvement (Espinosa, et al., 2013).
Pathways Study

• ALL youth referred to local JPDs during January 1, 2007 – December 31, 2014 (N = 337,022)

• Matched to all youth who received service from public mental health system (DSHS)

• 15% of the youth in the sample were served by both local juvenile probation and the public mental health systems (n = 50,553)

• Limited final sample to youth formally processed for delinquency or status offenses (n = 271,427)

• Of youth placed out-of-home (Non-Secure, Post Adjudication Secure, State Care)
<table>
<thead>
<tr>
<th>Pathways Demographics</th>
<th>Girls</th>
<th>Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race - Black</td>
<td>22%</td>
<td>22%</td>
</tr>
<tr>
<td>Ethnicity - Hispanic</td>
<td>46%</td>
<td>47%</td>
</tr>
<tr>
<td>Mean Age at Referral</td>
<td>15.34</td>
<td>15.39</td>
</tr>
<tr>
<td>Mean Age at Onset</td>
<td>14.97</td>
<td>14.78</td>
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<tr>
<td>Mental Health Need</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAYS1-2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Warnings (Total #)</td>
<td>47%</td>
<td>22%</td>
</tr>
<tr>
<td>Drug</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Angry</td>
<td>11%</td>
<td>6%</td>
</tr>
<tr>
<td>Depressed</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>Somatic</td>
<td>8%</td>
<td>4%</td>
</tr>
<tr>
<td>Suicide</td>
<td>17%</td>
<td>7%</td>
</tr>
<tr>
<td>Trauma Score – MAYS1-2</td>
<td>1.21</td>
<td>1.05</td>
</tr>
<tr>
<td>Behavioral Health Referral –JPD</td>
<td>16%</td>
<td>20%</td>
</tr>
<tr>
<td>Contact with Public Mental Health (DSHS)</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Prior referrals - mean (s.d.)</td>
<td>.59 (1.43)</td>
<td>1.00 (1.99)</td>
</tr>
<tr>
<td>Prior offense history – mean (s.d.)</td>
<td>.76 (1.46)</td>
<td>1.36 (2.04)</td>
</tr>
<tr>
<td>Prior probated dispositions - mean (s.d.)</td>
<td>.16 (.56)</td>
<td>.33 (.84)</td>
</tr>
<tr>
<td>Prior facility composite</td>
<td></td>
<td></td>
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</tbody>
</table>
Thoughts?
How do we do this?

- No less than an equal partner.
- Ensure that **key judicial leadership and probation line staff** are active members in the planning and implementation process.
- Capitalize on catalyst events
- Leverage resources for shared outcomes.
A Developmental Approach

National Research Council (2014) plan *sets forth seven hallmarks* of a developmental approach to juvenile justice reform.

1. Accountability without Criminalization
2. Alternatives to Justice System Involvement
3. Individualized Response Based on Assessment of Needs and Risks
4. Confinement Only When Necessary for Public Safety
5. A Genuine Commitment to Fairness
6. Sensitivity to Disparate Treatment
7. Family Engagement
Catalyst Mechanisms

• Opportunities to “kick” off system reform efforts

• Critical for system builders to be constantly scanning the environment to identify what those opportunities are

- Legislative Mandates (new or existing)
- Study Findings (needs assessments, research, or evaluation)
- Judicial Decisions—Class Action Lawsuits
- Charismatic/Powerful Leader
- Outside Funding Sources (federal, foundations)
- Funding Changes
- Local “Scandals” and Other Tragedies
- Coverage of Successes

• Name a few Catalyst items for JJ and MH
The Sequential Intercept Model
(Munetz & Griffin, 2006)

- **Initial contact (law enforcement)** – Initial contact with law enforcement.
- **Intake** – The point in which a youth is either arrested by law enforcement or when an offense is ‘formalized’
- **Detention** – The point in which a youth is placed in a secure detention setting pending future court processing.
- **Judicial Processing** – The point when a juvenile court conducts an adjudication hearing and the court prepares to dispose of the case.
- **Disposition** – The point in which a youth’s case receives a formal court decision. This occurs after adjudication and can include everything from community supervision to incarceration.
- **Re-Entry** – This is the point where the youth is released from a juvenile justice placement and returned to the community.
**Intake Intercept:** Developing JJ Diversion by Integrating Behavioral Health Screening in JJ with Community System of Care
Behavioral Health Screening in JJ

• Virtually non-existent 15 year ago, now exists in almost half (24) of U.S. states as a mandated structure for youth in detention,
• Only 13 states mandate a screening process at probation, and
• Almost every state requires screening at corrections (Wachter, 2015).

• Examples of validated mental health screening tools:
  • Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2)
  • Global Appraisal of Individual Needs – Short Screener (GAIN-SS)
Strengthening Connections

• Youth and caregivers have identified the time period immediately following detention as critical time to access treatment and supports (Aalsma et al., 2014).
• Than 30% of youth identified needing services when screened actually received them, and
• Almost half boys and 1/3 of girls continued to have one or more psychiatric disorders with impairment five years after detention (Teplin, 2012).
Risk Assessment in Juvenile Justice

• Strong recognition for the need to assess risk and criminogenic needs

• Evidence that mental health needs are not the strongest predictors of continued offending (Guebert & Oliver, 2014, Schubert et al., 2011).

• Treating the mental health issues without treating the criminogenic needs is ineffective (Guebert & Oliver, 2014).

• Generally consider static and dynamic factors to determine a youth’s level of intervention required to protect public safety and help reduce risk in the future (Vincent et al., 2012)
Integrate JJ BH Screening & Assessment to SOC

- Check to see what behavioral health screening in JJ is?
- Decide on an intercept point
- Cross-system education about screening and assessment methods
- Balance Risk Needs of JJ and Treatment Needs of MH
- Development of a service matrix
- Examine eligibility and enrollment criteria to streamline effort
Thoughts?

Thank You!

Erin & Jill