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JUVENILE JUSTICE POLICY BRIEF SERIES

Mental Health Issues in California's Juvenile Justice System

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The Berkeley Center for Criminal Justice (BCCJ) works to enhance public safety and foster a fair and accountable justice system through research, analysis, and collaboration.

About this Series

The *Juvenile Justice Policy Brief Series* was developed with support from The California Endowment to address the critical issues facing California's juvenile justice system today. This series provides research and recommendations for policymakers, local officials, and practitioners confronting the inadequacies of the juvenile justice system.

The following policy briefs are included in this series:

- Mental Health Issues in California's Juvenile Justice System
- Gender Responsiveness and Equity in California's Juvenile Justice System
- Reducing Racial and Ethnic Disparities in California's Juvenile Justice System

Juvenile Justice Advisory Board

This project was guided by a diverse group of key leaders from across California. The advisory board convened to identify topics and related issues, provide consultation, and review the policy briefs.

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Youth with mental health issues pose numerous challenges to California's juvenile justice system. Despite significant resources dedicated to the provision of mental health services, California's juvenile justice system has been unable to adequately meet the needs of this population. Youth diagnosed with mental illness have been steadily increasing in the juvenile justice system for nearly a decade, as have the numbers of youth receiving treatment (California Department of Corrections and Rehabilitation, 2005). This trend, taken together with independent reports and media accounts documenting the failures of the juvenile justice system, underscores the urgent need for change.

One of the difficulties in meeting the needs of youth with mental health issues is highlighted by the tensions inherent in the juvenile justice system itself. The system must respond to delinquent behavior based upon competing mandates and priorities, including the desire to rehabilitate juvenile offenders and treat any potential pathologies believed to have caused them to engage in delinquent behavior, as well as the need to hold them accountable for their behavior and protect public safety. Balancing these competing priorities is an ongoing challenge for probation staff and practitioners. The critical nature of that challenge is especially heightened when the youth has mental health issues.

How systems of care respond to this population's needs significantly impacts probation, mental health service providers, the courts, community-based organizations, and most importantly, the youth themselves and their families. By making the case for universal mental health definitions, screening and assessment, outcomes-based programs, and collaboration, this policy brief offers research-based recommendations on how juvenile justice and other systems of care can better meet the needs of youth with mental health issues. The overarching goal of these recommendations is to enhance the provision of mental health treatment in California's juvenile justice system by improving the infrastructure that supports service delivery.[1]

[1] This brief does not cover all of the topics related to improving mental health provision within California's juvenile justice system. The important issues of whether a youth is competent to stand trial, the degree to which mental health treatment is culturally appropriate or gender responsive, the debate surrounding the over- or under-medication of youth, as well as the issues arising from youth with co-occurring mental health and substance abuse issues, are mentioned briefly but are not addressed directly. The omission of the latter issues from the larger conversation does not imply that they should be any less of a priority—only that they fall outside of the scope of this paper.

Currently, California has no statutory specifications defining the criteria for a mental health problem, disorder, or illness with corresponding treatment options that take into account the severity of the condition, the youth's receptivity to treatment, and his or her location within a system of care. While mental health practitioners rely on definitions and treatment options set forth in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV),[2] there is little consistency in the juvenile justice system and across all systems serving youth in identifying mental health disorders and determining the most appropriate treatment options based on the severity of their DSM-IV diagnoses.

The absence of universal, functional mental health definitions that match youth with appropriate mental health services impedes overall efforts toward improving the provision of those services within the juvenile justice system. Without this mechanism, the state juvenile justice system and county probation departments—as well as other agencies serving children and youth—all use different criteria to direct youth to treatment and estimate the prevalence of youth with mental health issues.

Inconsistent criteria generate inaccurate aggregate numbers, affecting the utility of county and statewide data and inhibiting the ability to speak accurately about the nature and prevalence of mental health issues in the state. It is critical that policy decisions be based on accurate data to ensure that limited resources are used effectively.

> "Youth with mental health issues are our biggest challenge. Delinquency we know; mental health we don't."
>
> *—Jerry Powers, Chief Probation Officer, Stanislaus County; Past-President, Chief Probation Officers of California*

BUILDING THE CASE

Subjective Mental Health Definitions and Prevalence Rates

According to widely accepted estimates, 40 to 70 percent of youth in the California juvenile justice system have some mental health disorder or illness. The number of youth with mental illness severe enough to significantly impair their ability to function has been estimated at approximately 15 to 25 percent (Skowyra and Cocozza, 2007; Shufelt and Cocozza, 2006; Teplin et al., 2005; Arredondo et al., 2001; Center for Healthy Communities, as cited in the State Commission on Juvenile Justice, 2009). While the high percentage of youth with mental health disorders is alarming, of equal concern is the fact that the estimates are so imprecise. The high end of each estimate is nearly double the low end, which raises questions regarding the underlying numbers, and which youth are counted as having a mental health issue.

These percentages can be misleading because the populations they refer to can vary. Prevalence rates of youth with mental illness are difficult to estimate nationally as "some measures limit the definition to certain psychiatric diagnoses; others focus on the degree of impairment; while others use service utilization as an indication of severity" (Narrow et al., 1998). Inconsistent use of mental health assessment tools, unclear definitions of mental health disorders, and differences in the populations included in some evaluations (such as residential or nonresidential settings) are all partly responsible for this lack of clarity (Shufelt and Cocozza, 2006).

[2] DSM-IV is a reference published by the American Psychiatric Association that covers all mental health disorders for both children and adults.

The ambiguity in defining mental health disorders also complicates efforts to identify youth in an accurate and standardized way, so that youth can be placed in treatment modalities appropriate to their diagnoses. Prevalence rates for mental health disorders can vary depending on whether particular disorders—such as conduct or substance abuse disorders—are included or excluded from the definition (Grisso, 2007). As a result, it is impossible to separate which youth defined as having mental health issues meet criteria for serious psychiatric or cognitive disorders; substance abuse or co-occurring disorders; and conduct disorders, such as lying, stealing, fighting, and truancy. In fact, "there is no clear, objective, scientifically based formula to distinguish between the different levels of need or seriousness in order to determine which youth should receive services" (Skowyra and Cocozza, 2007). This becomes especially problematic in determining which youth need services and what level of treatment is most appropriate (Skowyra and Cocozza, 2007).

Philosophical Differences

One of the primary barriers to consensus around functional definitions is a philosophical debate over criteria for mental health diagnosis. At the core of the issue are competing beliefs regarding what constitutes a mental health diagnosis. Some believe that behavioral problems, such as conduct disorder and oppositional defiant disorder, underlie diagnosable illnesses and should be treated as mental health issues, while others are of the opinion that many behavioral problems are normal, non-diagnosable adolescent behavior. For those who contend that behavioral problems are diagnosable mental health issues, the following broad categories apply: oppositional defiant disorder, conduct disorder, attention deficit/hyperactivity disorder, major depression, bipolar disorder, and anxiety disorder. Others believe that behavioral disorders should be excluded in mental health diagnoses (Cohen and Pfeifer, 2008).

Implications of Unreliable Data

Data drive policy and are the basis for a multitude of critical decisions related to staffing and budgets. In order to make sound economic decisions, distribute resources effectively, and improve the system, agreement on the population intended to be served is needed. At present, there is little consistency across counties in data collection methods (Cohen and Pfeifer, 2008; Burrell and Bussiere, 2005). This is evidenced by the enormous variation in the way data on "open mental health cases" are reported annually to the California Department of Corrections and Rehabilitation. One county defined open mental health cases as "those youth taking psychotropic medications," while another defined it as "anyone who either takes psychotropic medications or is currently involved in the mental health system." Other counties defined open mental health cases to be any youth who has had "a mental health staff person become involved beyond initial assessment." As a result, there is enormous variance in the way youth receiving treatment are counted, and how open mental health cases are defined. In addition, staff in some counties rely on memory alone to recall information on youth to track their cases (Cohen and Pfeifer, 2008). The ambiguity in the underlying numbers may lead policymakers to erroneous conclusions, and ultimately to ill-informed policy decisions.

RECOMMENDATION

Develop universal, functional definitions of mental health to correlate DSM-IV diagnoses with appropriate levels of treatment.

Addressing inconsistencies in mental health data collection and reporting should be a top priority in the effort to improve the provision of mental health services within California's juvenile justice system. A first step is to define the population in an accurate and standardized way. Mental health experts, juvenile justice and court stakeholders,

and school officials should be tasked with the responsibility of linking existing DSM-IV diagnostic language to treatment options within the continuum, based on varying levels of severity, to be used within the juvenile justice system and other systems of care.[3]

The creation of universal, functional definitions of mental health would not replace diagnoses set forth by the DSM-IV, but rather link DSM-IV diagnoses with treatment options to be used across all agencies serving youth. Functional mental health definitions should include a range of DSM-IV diagnoses, where each diagnosis would have a corresponding menu of potential treatment options that take into account the severity of the youth's condition, as well as his or her receptivity to treatment and location within the juvenile justice continuum. Similarly, functional mental health definitions should also correspond to the various points on the continuum of care for all other systems serving children and youth with mental health issues. This would enable increased consistency in the identification, treatment, and placement of youth across systems.

To summarize, correlating DSM-IV diagnoses to appropriate treatment options based on youth's level of severity will:

- Allow for youth to be placed within an appropriate continuum of mental health treatment options and matched with the corresponding level of care
- Help standardize mental health treatment across all agencies serving children and youth
- Mitigate ambiguity relating to the nature and prevalence of youth with mental health issues

Additional guidance should be provided to clarify commonly used mental health terms, including "mental health issue," "mental health problem," "mental health disorder," "mental health condition," and "mental illness." This recommendation falls in line with the call for developing a common language and universal measurement system outlined in the *Report of the Surgeon General's Conference on Children's Mental Health* (2000).

[3] Possible venues for this discussion include the Judicial Council's Task Force for Criminal Justice Collaboration on Mental Health Issues, a renewed State Commission on Juvenile Justice, a subcommittee of the Mental Health Services Oversight and Accountability Commission, or a newly created gubernatorial advisory group.

When youth come into contact with the juvenile justice system, there are two stages of decision-making related to appropriate identification and referral to mental health treatment. The first stage involves determining, through screening and assessment instruments,[4] if the youth has mental health needs. The second stage, which is covered in Part 3 of this brief, entails appropriately matching services to meet those needs.

However, prior to the administration of screening or assessments, it is critical to determine whether the youth's behavior is delinquent and warrants the jurisdiction of the juvenile justice system, and whether the youth is competent to stand trial.[5] Efforts must be made to prevent the inappropriate criminalization of youth who would be better served by other school, community, or social services (Cohen and Pfeifer, 2008). As Grisso notes, the "juvenile justice system is not and should not become the nation's child mental health system; it has neither the financial nor the professional resources to assume that role" (Grisso, 2004).

Proper mental health screening and assessment at the earliest point of contact in the system is critical to improving the provision of mental health services. While there is a lack of consistency regarding precisely when the earliest point of contact takes place—as some youth come into the system immediately via detention, while others are referred out-of-custody—early mental health screening is vital to determining the need for additional assessments and appropriate referrals. To avoid misallocation of resources, it is equally important to identify youth who do not need serious treatment.

> "Families, schools, community centers, extended families, churches… these are the safety nets that society provides to save kids in trouble. The juvenile justice system is not a safety net. We are the cold, hard floor kids hit after every other safety net has failed."

—Kurt Kumli, California Superior Court Judge, Santa Clara County

BUILDING THE CASE

Lack of Validated Mental Health Screening and Assessment Tools

Much has been written about the paucity of validated screening and assessment instruments for mentally ill youth in the juvenile justice system (State Commission on Juvenile Justice, 2009; Cohen and Pfeifer, 2008; Skowyra and Cocozza, 2007; Burrell and Bussiere, 2005; United States House of Representatives Committee on Government Reform, 2005). Since the early 1990s, evaluation research has highlighted the lack of empirically validated assessment instruments, escalating the need for evidence-based assessment tools. Additionally, research suggests that youth of color and girls have been historically underserved populations, particularly with regard to the use of instruments that are culturally sensitive and gender responsive (Veysey, 2003).

[4] Mental health screening and assessment share the same purpose of evaluating youth, however they diverge in the way they are carried out. Mental health screens are relatively short and intended to identify youth who have mental health issues that require immediate attention or further evaluation. Assessment follows screening only if the screen reveals issues that warrant urgent attention, and involves a more time-consuming and comprehensive examination of psychosocial issues (Skowyra and Cocozza, 2007).

[5] Competency is an especially confounding issue, as the system is not equipped to handle youth who are not competent to have their case proceed through juvenile court. Though there are criminal justice statutes directing competency procedures for adult defendants, there are no clear statutory provisions for incompetent youth referred to the juvenile justice system, and case law has not made the process any clearer. Practitioners around the state raise competency proceedings as a major systemic problem that needs to be addressed through legislation. Youth whose competency is in question pose particular problems for detention facilities, and incarceration can be harmful for them. The issue of competency, while extremely important, falls outside the scope of this policy brief.

Limited and Inconsistent Use of Validated Mental Health Screening and Assessment Tools

Validated screening and assessment tools are vital to ensure that youth most in need of intervention and services are identified. Assessment results are necessary to inform future decisions about the most appropriate treatment and environment for youth (Skowyra and Cocozza, 2007). While much of the research and literature continues to recommend the use of evidence-based tools, this has generated what practitioners refer to as "assessment tool fatigue." In California, only a handful of counties utilize validated mental health assessment tools,[6] while other states have mandated their use at the early stages of a youth's involvement with the system (Skowyra and Cocozza, 2007).[7] In addition, many jurisdictions still do not use validated screening and assessment instruments consistently (Little Hoover Commission, 2008).

RECOMMENDATION

Probation must use validated screening and assessment instruments that are culturally appropriate and gender responsive at the earliest point of contact.

Probation departments should review their internal policies and practices regarding mental health screening and assessment instruments to ensure that the instruments are validated, gender responsive, and culturally appropriate for the population served. These instruments should be routinely administered early in the process by trained staff. Properly assessing the mental health needs of youth entering the system—and then using the most effective, least intrusive intervention possible while still protecting public safety—should be a high priority (Arredondo, 2006). To the extent possible, reallocation of existing dollars combined with investment in proven, community-based therapies will save resources over time.

EXAMPLES

Many validated screening and assessment instruments exist that can be used to identify mental health disorders (among other issues), including:

- Massachusetts Youth Screening Instrument, Second Version (MAYSI-2): A self-report inventory of 52 questions designed to assist juvenile justice facilities in identifying youth ages 12 to 17 that may have mental health needs.
- Voice Diagnostic Interview Schedule for Children-IV (Voice DISC-IV): A self-report, comprehensive diagnostic instrument that is administered on a computer, designed specifically for youth in juvenile justice settings. The DISC-IV generates provisional DSM-IV diagnoses on a variety of disorders, including anxiety, mood, disruptive, and substance use disorders.
- Problem-Oriented Screening Instrument for Teenagers (POSIT): A questionnaire designed to identify problems and potential treatment or service needs in 10 areas, including substance abuse, mental and physical health, and social relations.
- Global Appraisal of Individual Needs (GAIN): An assessment instrument used for diagnosis, placement, and treatment planning. It is used in a variety of settings, and is designed for youth 12 years of age and older.

Additional resources:

- *Screening and Assessing Mental and Substance Use Disorders Among Youth in the Juvenile Justice System,* National Center for Mental Health and Juvenile Justice, Research and Program Brief (Grisso and Underwood, 2003). www.ncmhjj.com/pdfs/publications/Screening_And_Assessing_MHSUD.pdf
- *Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System: A Resource Guide for Practitioners,* United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention (2004). www.ncjrs.gov/pdffiles1/ojjdp/204956.pdf
- *Mental Health Screening and Assessment for Juvenile Justice* (Grisso, Vincent, and Seagrave, The Guilford Press, 2005).

[6] Mental Health screening and assessment tools are one of several kinds of assessments—including risk and criminogenic needs assessments—that have a higher level of use. According to the State Commission on Juvenile Justice, 83 percent of counties have acquired (and many are using) validated instruments (2009).

[7] Citing Texas and Minnesota as two states with statutes requiring mental health screening with minimal exceptions for youth entering the juvenile justice system.

Fight Crime: Invest in Kids California estimates that proven intensive family therapies serve just four percent of the more than 20,000 eligible juvenile offenders in California (Lee and Wondra, 2007). Currently, there are few mental health treatment options available to youth either in the community or in custodial environments, and there is a general shortage of mental health professionals in California (Burrell and Bussiere, 2005; Cohen and Pfeifer, 2008; Moran, 2003). Existing programs are frequently inadequate, difficult to access, and may not incorporate successful outcomes-based elements (Hartney et al., 2003). The lack of adequate, accessible mental health services, coupled with the workforce shortage of mental health professionals, represents one of the largest gaps in service provision within the juvenile justice system (California Department of Corrections and Rehabilitation, 2005).

While scarce funding and resources contribute to the lack of mental health professionals and treatment programs, these factors also point to the need for investment in evidence-based programs that result in positive outcomes. In addition to funding limitations, a common obstacle to providing appropriate treatment is the lack of knowledge and understanding of empirically based programs within the juvenile justice system. Also, program implementation can be complex and difficult to achieve in every jurisdiction, largely due to differences in funding, resources, institutional structure, or populations served.

> "There need to be objective standards on identifying best practices, then institutionalizing and incentivizing those practices."
>
> *—Barrie Becker, California State Director, Fight Crime: Invest in Kids*

BUILDING THE CASE

Mental Health Service Provision is Inadequate and Hard to Access

Despite what is known in the research literature about effective mental health treatment, translating this knowledge into practice has not been easy for legislators and practitioners. According to a 2005 California Department of Corrections and Rehabilitation (CDCR) survey of county probation departments, mental health services are the "single most critical gap in juvenile justice services." The CDCR found that "the number of at-risk youth and youthful offenders with mental health problems continues to increase, as does the seriousness of their mental illnesses" (Cohen and Pfeifer, 2008). In a 2006 survey conducted by the Administrative Office of the Courts (AOC), delinquency court judicial officers identified youth with mental health issues as more difficult to match with appropriate supervision, treatment, or placement than any other category of youth (2008). The AOC study also found that 42 percent of prosecutors and 67 percent of defense attorneys were either dissatisfied or very dissatisfied with the effectiveness of available mental health programs and services, indicating that this issue is universally experienced.[8] Furthermore, it is estimated that California spends $10.8 million annually to house youth unnecessarily in the state's detention facilities—without any criminal charges in some cases—in part because needed mental health services are not available in the community (United States House of Representatives Committee on Government Reform, 2005).

The scarcity of mental health professionals is documented nationwide at near crisis levels, prompting a call for a federal investigation into the ramifications of access to quality care and treatment for those with serious mental

[8] Strikingly, only 18 percent of prosecutors and 10 percent of defense attorneys reported being satisfied or very satisfied with the effectiveness of available mental health services.

illness (National Alliance on Mental Illness, Policy Platform).[9] Latino and Spanish-speaking youth experience the shortage of mental health workers most acutely, as the demand is high and resources are grossly inadequate—especially for those relying on Medicaid (Moran, 2003). In addition, juveniles under court order to receive mental health treatment in the community struggle to gain access to treatment because of insufficient facilities and staffing.

The absence of quality mental health treatment both in custodial settings and in the community has a devastating effect on the youth who require these services. Existing treatment programs often are not based on program elements that have been shown to be effective, or have incorrectly implemented the elements of an evidence-based program, raising questions regarding program fidelity (Osher, 2005). The combination of ineffective programs and the well-documented shortage of mental health professionals creates a chasm in treatment options.

Mental Health Services are Expensive

The system must also grapple with the enormous financial burden of incarcerating mentally ill youth. A study conducted by the Chief Probation Officers of California estimated that incarcerating youth with mental illness can cost at least $18,800 more than other youth, taking into account average differences in length of stay (Cohen and Pfeifer, 2008). For youth who need treatment within the juvenile justice system, accessing services can be complicated by federal law which, in most circumstances, bars use of Medi-Cal for mental health services for juveniles in custody.[10] Mental health services can also be difficult to access due to lack of financial resources, lack of health insurance coverage, or lack of knowledge about the referral process in the community.

Impact of Legislative Policies

Senate Bill 81 (SB 81), which was signed into law in 2007, set limits on the circumstances under which youth can be committed to facilities administered by the California Department of Corrections and Rehabilitation, Division of Juvenile Justice (DJJ). For years, many juvenile probation departments sent their low-risk, high-need mentally ill offenders to DJJ (formerly the California Youth Authority) because their counties did not have the resources to house and provide care for the youth locally. With the passage of SB 81, those offenders can no longer be transferred to DJJ unless they have committed a sex offense or serious offenses such as murder, robbery, arson, or an assault likely to produce great injury.[11] The population of youth who have not committed serious offenses, but who have urgent mental health issues, will likely remain in local custody as commitment to DJJ is no longer an option, and access to bed space in secure psychiatric facilities continues to be limited (Burrell and Bussiere, 2005; Cohen and Pfeifer, 2008). While SB 81 provides counties with additional funding ($66 million in 2008-2009 and over $90 million in 2009-2010) through the Youthful Offender Block Grant (YOBG) to address this high-need population of juvenile offenders who now remain under local jurisdiction, it is anticipated that probation officials will have to find new ways to provide services and treatment locally for even more low-risk, high-need offenders. Recently introduced statutory amendments requiring a measure of accountability in the way the state spends these dollars will help determine whether YOBG funds are being used by the counties to improve mental health service and treatment capacity.[12]

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[9] Accessed Sept. 25, 2009, at http://www.nami.org/Template.cfm?Section=NAMI_Policy_Platform&Template=/ContentManagement/ContentDisplay.cfm&ContentID=45980

[10] With the passage of SB 1147 in 2007, juvenile offenders now have access to Medi-Cal benefits as they transition out of custody. By suspending rather than terminating coverage while youth are in custody, SB 1147 ensures that eligible juveniles will regain coverage immediately upon their return to the community, rather than face no coverage and less access to needed medication and therapy during the months-long application process.

[11] Section 707(b) of the Welfare and Institutions Code.

[12] On July 28, 2009, Sections 1955 and 1961 of the Welfare and Institutions Code were amended to incorporate language stipulating that each county receiving SB 81 funds must indicate in their Juvenile Justice Development Plan a description of "the program, placements, services, or strategies to be funded by the block grant allocation."

In addition, the Mental Health Services Act (MHSA)—which was enacted by statewide ballot initiative in 2004 as Proposition 63, and heralded as a rescue for the loss of funding in juvenile justice-mental health—has fallen short of expectations. The act promised to provide approximately $1 billion annually to counties for mental health services for adults and juveniles (Fight Crime: Invest in Kids, 2005). Fight Crime: Invest in Kids examined the county spending plans for Community Services and Supports (CSS), the largest componenet of MHSA funding. Their analysis found that while a majority of counties are using CSS funding to serve some juvenile offenders, only a small portion of overall CSS funding appears to reach juvenile offenders, and only a handful of counties are using CSS funding to support proven outcome-based programs (Fight Crime: Invest in Kids, 2005).[13]

Impact of Budget Cuts

Although the funding increases provided by SB 81 and MHSA are welcome, the benefit of these two measures has been counteracted by reductions in other funding streams available to probation departments—due in large part to the overall economic downturn and the resulting decline in state revenues. The 2008-2009 and 2009-2010 state budgets have been particularly devastating, significantly cutting Juvenile Justice and Crime Prevention Act (JJCPA) and Juvenile Probation and Camp (JPCF) funds, while putting additional strains on counties that may have more youth under their jurisdiction due to SB 81.

Most notably, in 2009, the State Legislature terminated its support for the Juvenile Mentally Ill Offender Crime Reduction (MIOCR) program. MIOCR provided $22 million to 20 counties for a variety of mental health interventions for juvenile offenders. More than half of the MIOCR-funded counties used these funds to provide proven intensive family therapies such as Functional Family Therapy and Multi-Systemic Therapy.

Placement Delays Increase Length of Stay

In recent years, the number of secure treatment facilities available to youth with severe mental disorders has become even more limited, often resulting in youth remaining in detention for long periods of time (Hennessy-Fiske, 2008; de Sà, 2009).[14] Because many jurisdictions have few or no facilities to handle youth with severe mental illness, this population is particularly difficult to place for treatment (Burrell and Bussiere, 2005). For example, Napa State Hospital in Northern California and Metropolitan State Hospital in Southern California no longer provide beds for juvenile offenders, unless referred by DJJ. In Los Angeles County, probation officials recently proposed building a 70-bed mental health facility next to one of the county's juvenile halls to house the most seriously mentally ill youth who must be held in custody due to the lack of a secure facility. Detaining mentally ill youth in juvenile halls is problematic for many reasons, including the stability and health of the minor, the safety of staff and other wards in the facility, the county's potential liability, and the cost of caring for these youth (Cohen and Pfeifer, 2008; Burrell and Bussiere, 2005; Skowyra and Cocozza, 2007).

RECOMMENDATION

Implement mental health programs that focus on outcomes-based criteria regardless of setting.

As suggested by the Little Hoover Commission and the State Commission on Juvenile Justice, juvenile court stakeholders should evaluate their existing treatment programs, and encourage the substitution or implementation of programs that contain key programmatic elements shown to produce desired outcomes or that are evidence-

[13] One of the legislative rationales for eliminating MIOCR was that counties could backfill with MHSA funds—but this does not appear to have happened. And while juvenile justice advocates worked hard to get the MHSA Oversight and Accountability Commission to adjust MHSA criteria to prioritize juvenile justice populations as eligible for Prevention and Early Intervention Proposition 63 funds, their efforts, though significant, have not solved the larger funding problem.

[14] Citing the increased number of mentally ill youth in Los Angeles County juvenile halls and camps as a result of the elimination of long-term beds at Los Angeles Metropolitan Medical Center.

based. It is important to stress that there is no one-size-fits-all approach to service provision. Each county needs to identify outcomes specific to its jurisdiction, adapting core elements to match the county's particular cultural variance, and determine appropriate treatment design.

In addition, juvenile justice practitioners should use the most effective, least intrusive interventions possible while still protecting public safety (Arredondo, 2006; Koppelman, 2005). Research indicates that when public safety is not an issue, youth with mental health needs are better served through community-based treatment in a natural setting. Treatment is likely to be more effective if behavioral issues are addressed when and where they occur (Melton and Paglicocca, 1992). For some youth, referral to community counseling services or family-centered services provided in the home—or using family insurance to receive therapeutic services from a private therapist—would be a sufficient and effective rehabilitative tool. Unwarranted or excessive therapeutic intervention and mental health services that are necessary but poorly delivered can have equally damaging effects (Latessa, 2004; Lowenkamp et al., 2005). Finally, youth who do not need serious treatment should be identified so that limited resources are not spent where they are not needed, and less intensive treatment can be provided as appropriate.

A continuum of services should be provided with a range of proven treatment options, including early intervention and community-based services, more intensive supervised treatment programs, mental health services in residential placements, and secure mental health facilities. Services should be available from the front end to the back end of the system as a diversionary option before a youth is referred to court, before the youth is adjudicated, while he or she is in custody or in an out-of-home placement, upon re-entry after leaving custody, and as part of a dispositional treatment plan.

Funding of Mental Health Treatment

Investment should be directed toward innovative programs that are able to clearly articulate and achieve outcome measures and demonstrate success. Legislators could tie funding to the achievement of those county-defined outcomes, thereby effectively eliminating treatment programs that are unable to do so. The use of a qualified, independent evaluator is also recommended to determine which programs offer good returns on investment, as well as to provide outcome-oriented research.

Accountability of Mental Health Treatment

Additional concerns regarding the accountability of programs both in the community and the custodial environment pertain to whether court-ordered treatment is carried out, as well as issues surrounding a general lack of enforcement and advocacy across all stakeholders. At issue is the combination of inadequate and largely unavailable treatment programs together with the mental health workforce shortage, which leaves an unknown number of youth unable to access needed services and comply with conditions of probation. One way to address this concern is through legislation that would mandate accountability through court reviews by adding mental health treatment compliance to the court review process for youth in placement or during other annual reviews mandated by law.[15]

EXAMPLES

The State Commission on Juvenile Justice lists five nationally recognized organizations that offer information on model mental health programs with demonstrated, repeated success after rigorous evaluation. These five organizations are listed below:

Blueprints for Violence Prevention, a Project of the Center for the Study and Prevention of Violence, University of Colorado at Boulder – To date, Blueprints has identified 11 model programs and 18 promising programs based on evaluation of over 600 programs. See http://www.colorado.edu/cspv/blueprints.

[15] Mental health treatment compliance may be assessed during the Annual Restitution and Public Service Work, pursuant to Section 730.8 of the Welfare and Institutions Code, or during Out-of-Home Placement reviews, pursuant to Section 727.2 of the Welfare and Institutions Code.

Washington State Institute for Public Policy (WSIPP) – WSIPP offers numerous publications, including meta-analysis and cost models for evidence-based adult and juvenile justice programs and practices, based on review of thousands of research studies. All publications are available on the WSIPP website at http://www.wsipp.wa.gov.

Model Programs Guide, Office of Juvenile Justice and Delinquency Prevention (OJJDP), United States Department of Justice – The OJJDP Model Programs Guide has identified eight programs as exemplary, 28 as effective, and 20 as promising for adolescents ages 12 to 18. These include both prevention and intervention programs, not all of which are applicable to juvenile offenders. See http://www2.dsgonline.com/mpg.

Center for Evidence-Based Corrections, University of California, Irvine – The Center for Evidence-Based Corrections identifies evidence-based and promising programs, conducts research on justice policy issues relevant to California, and assists the CDCR in implementing and evaluating these practices. Adult offenders are the primary focus of the Center for Evidence-Based Corrections. See http://ucicorrections.seweb.uci.edu.

Association for the Advancement of Evidence-Based Practices – This group publishes a quarterly newsletter, identifies various resources for evidence-based programs and practices, and is developing web-based tools for program assessment and quality assurance. See http://www.aaebp.org/index.htm.

In addition, Fight Crime: Invest in Kids endorses the following therapies that have been used successfully with youth suffering from mental health issues:

Proven Community-based Intensive Family Therapies

Functional Family Therapy (FFT) is for moderate- to high-risk teens with delinquency, aggression and/or substance abuse problems. The therapy is delivered over a period of eight to 30 hours by trained providers, who range in background from paraprofessionals to mental health professionals (Alexander et al., 1998).[16] In one randomized study, FFT cut re-arrests by participants in half, compared to a control group.[17] FFT can save as much as $14 for every $1 invested, and over $31,000 for every juvenile offender served (Aos et al., 2006). At present, 14 California counties offer FFT for juvenile offenders.[18]

Multi-Systemic Therapy (MST) serves moderate- to high-risk teens, and typically involves 60 hours of professional interventions over four months. The staff members are on call around the clock. One MST study followed juvenile offenders and a randomized control group until they were 29 years old. Individuals who had not received MST were 62 percent more likely to have been arrested for any offense, and more than twice as likely to have been arrested for a violent offense (Schaeffer and Borduin, 2005). MST can save over $5 for every $1 invested and over $18,000 for every juvenile offender served (Aos et al., 2006). As of 2007, seven counties in California offered MST for juvenile offenders.[19]

Multidimensional Treatment Foster Care (MTFC) may be appropriate when home placement is not a viable option. Youth are placed with specially trained foster families that usually only work with one child at a time. Foster parents strictly monitor the youth's whereabouts, while professionals train teens in the social skills needed to avoid fights or situations that can lead to further crime. Randomized control group research shows the MTFC approach successfully cuts the average number of arrests for seriously delinquent juveniles in half compared to group home placement,

[16] See Functional Family Therapy Online at http://www.fftinc.com.

[17] Id.

[18] Personal communication with Todd Sosna, Senior Associate at the California Institute for Mental Health (Feb. 18, 2009).

[19] Personal communication with Keller Strother, President of MST Services (Feb. 27, 2007).

and boys placed in MTFC homes were six times more likely to have no new arrests than boys placed in group homes (Chamberlain and Mihalic, 1998). MTFC can save over $12 for every $1 invested, and over $77,000 for every juvenile offender served (Aos et al., 2006). At present, four counties in California offer MTFC to juvenile offenders.[20]

Proven Cognitive Behavioral Therapy

Aggression Replacement Training (ART), also known as Teaching Pro-Social Skills (TPS), is aimed at reducing aggressive behavior among children and youth on probation, in custody, or returning to their communities following custody. At under $1,000 per young offender, this is a relatively low-cost 10-week cognitive behavioral therapy intervention that can be used fairly widely with many juveniles who have serious problems with aggression. One study of ART with juvenile delinquents returning to their communities found that within six months after release, juveniles not receiving ART were almost three times more likely to be re-arrested for a crime. Young people in Brooklyn gangs not receiving ART services had four times the number of arrests of similar young gang members receiving ART. Tests of ART for delinquents in custody were also positive (Goldstein et al., 1989). ART saves over $17 for every $1 invested and saves over $14,000 per participant (Aos et al., 2006). As of 2007, 28 California counties were implementing ART for juvenile offenders, primarily to serve youth in custody.[21]

Cognitive Behavioral Therapy (CBT) is a 12-week treatment program that focuses on changing an individual's thoughts in order to change his or her behavior and emotional state. With costs typically ranging from $800 and $1,200 per participant, the program is a low-cost treatment option for a range of mental disorders, including affective (mood) disorders; personality disorders, such as conduct disorders; substance abuse disorders; and post-traumatic stress disorder (PTSD). Evaluations of CBT suggest that it is effective in addressing an array of disorders for youth living in rural and urban areas from all socioeconomic backgrounds, and is culturally appropriate for use with African-American, Hispanic/Latino, and white populations.

The following innovative outcomes-based efforts have helped connect youth with mental health needs to evidenced-based practices:

Healthy Returns Initiative (HRI) – HRI was developed and funded by The California Endowment to promote juvenile justice reform and systems change by strengthening the capacity of county juvenile justice systems to improve mental health and health services for adolescents in detention facilities, and to ensure continuity of care as youth transition back to the community. Launched in 2005, the project provided four-year planning and implementation grants to probation departments in Humboldt, Los Angeles, Santa Clara, Santa Cruz, and Ventura counties. Evaluations of HRI found that the implemented strategies improved probation officer recognition of mental disorders, facilitated better cross-agency collaboration, increased connection between youth and services, and improved relationships with families and community.

Juvenile Mental Health Court – California has seen an increasing number of juvenile mental health courts created in the hope of better addressing the needs of youth with mental health problems. While the number of courts is always changing due to cuts in funding sources and changes in county culture, at last count there were six counties operating juvenile mental health courts, including Los Angeles, San Bernardino, San Diego, San Joaquin, Santa Clara, and Ventura counties. An evaluation of the Court for the Individualized Treatment of Adolescents (CITA) in Santa Clara County indicates that violent, aggressive, and property crimes occurred in statistically lower numbers in the two years following the participants' involvement with CITA than in the preceding 18-month period (Behnken et al., 2009).

[20] Personal communication with Lynne Marsenich, Senior Associate with the California Institute for Mental Health (Feb. 24, 2009).

[21] Personal communication with Todd Sosna, Senior Associate at the California Institute for Mental Health (Feb. 18, 2009).

Many youth entering the juvenile justice system struggle with multiple issues, including learning disabilities, truancy, substance or alcohol abuse, mental health and behavioral disorders, and physical ailments. The rising number of youth identified with co-occurring disorders and multiple, complex needs who access services from many agencies and community-based organizations has generated the recognition that communication across agencies and providers not only improves service delivery, but also yields better outcomes and decision-making. Meeting the various needs of these youth and their families effectively and efficiently requires agencies and community-based organizations to work together.

> "We need to start from a principle of collaboration; it's about re-allocating existing money and resources."
>
> *—Gwen Foster, Director, CalSWEC, UC Berkeley School of Social Welfare*

BUILDING THE CASE

Working in Silos

There are two aspects of mental health service provision that would benefit from collaborative efforts. The first involves situations where many agencies and community-based providers may be involved in addressing multiple needs of a troubled youth and his or her family. Because agencies and community-based organizations rarely establish effective communication protocols, they often work in virtual silos, duplicating efforts, unaware of each other's endeavors. When collaboration has been attempted, conflict can arise related to financial responsibility, boundaries, and differences in personalities and cultures (Hartney et al., 2003). Despite these challenges, collaboration and communication across agencies and providers can enable efforts among agencies to be coordinated and more efficient, ultimately improving service provision.

Small Populations

A second issue, more prone to arise in smaller counties, pertains to circumstances where needed services for small populations of youth are unavailable. For example, a county may have a relatively small number of females or only a few youth who require intense treatment in a secure facility. It is difficult for the county to justify the expense of a facility that serves only a small number of youth.

RECOMMENDATIONS

Establish collaborations across agencies and providers

The availability of mental health services can be improved through enhanced collaboration between stakeholders—both among agencies and community-based organizations—creating a wider network of resources and services. Probation and juvenile court stakeholders should work with county mental health and child welfare agencies, local school districts, and community-based organizations to communicate about those youth and their families who interact with multiple systems. One way agencies can share information is through Memorandums of Understanding (MOUs). Also, statutes have been revised that allow for more flexible use of otherwise confidential information in order to provide multidisciplinary case services for crossover youth. An additional way to collaborate, which also addresses the shortage of service providers, is to partner with local universities or colleges; students who are looking to acquire training hours can be recruited to provide mental health services.

Below are some key elements set forth by the Office of Juvenile Justice and Delinquency Prevention's *Blueprint for Change*[22] for starting collaborative, multi-agency partnerships:

- Create an inter-agency task force or commission that includes representatives from involved systems as well as consumers, family members, and advocates.
- Designate a strong leader with good communication skills who understands the systems and related informal networks.
- Decide on common goals and develop clear objectives and strategies for meeting the identified goals.
- Emphasize strategic planning that is aimed at producing immediate but sustainable results.
- Recruit political support from community leaders such as judges or legislators.
- Develop a financing plan to support the group's proposed objectives and strategies, and explore multiple funding opportunities at the local, state, and federal levels.

Establish cross-county partnerships

Building secure mental health facilities (or creating new mental health programs in existing facilities) and accessing mental health assessment tools are costly endeavors, and such options may be more accessible if local jurisdictions partner with neighboring counties to pool resources. Inter-county collaboration—whereby counties with few high-risk, high-need youth contract with neighboring counties for bed space at their facilities, or a cluster of counties pools resources to build a shared facility—is an important strategy for serving this population. Leveraging resources can increase the number of available services through building or renovating facilities that can be shared, or by making space available on a contract basis.

EXAMPLES

Inter-Agency Collaboration: Placer County's "System of Care"

Placer County's Children's System of Care (CSOC) is unique in California. Under the direction of the Placer County Health and Human Services Department, CSOC delivers a fully integrated continuum of child social services to Placer County families. Placer County's integrated CSOC for public sector children and families was developed out of 17 years of inter-agency collaboration. The County's "no wrong door" approach targets children, adults, and families experiencing complex and often inter-related needs that require services spanning multiple disciplines and agencies.[23]

Inter-County Collaboration: Five-County Collaborative Effort

In 2009, Tuolumne County received a $16 million facilities construction grant to build a new 30-bed regional juvenile hall facility to house youth from Tuolumne County and the neighboring counties of Calaveras, Amador, Mariposa, and Mono.[24] This type of collaborative approach is necessary when each county alone does not have enough youth to justify the expense of a new facility.

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[22] For further reading on collaboration, see Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System, Kathleen Skowyra and Joseph Cocozza, National Center for Mental Health and Juvenile Justice (2007). http://www.ncmhjj.com/Blueprint/default.shtml

[23] For further information on the goals and vision of Placer County's Children's System of Care, go to http://www.placer.ca.gov/Departments/hhs/children/Vision - Mission Statement.aspx.

[24] Corrections Standards Authority May 21, 2009, Board Meeting notes, SB 81 Local Youthful Offender Rehabilitative Facilities Construction Financing Program, retrieved July 7, 2009, from http://www.cdcr.ca.gov/Divisions_Boards/CSA/CFC/Docs/5_09_Awarded_Projects.pdf.

CONCLUSION

The juvenile justice system was not designed to be a mental health treatment provider. It exists to protect public safety, hold youthful offenders accountable, and provide rehabilitative services. Unfortunately, when other social safety nets fail, the juvenile justice system is increasingly where youth with mental illness end up. Youth who find themselves in the justice system should receive proper evaluation and the treatment and resources necessary to meet their needs.

Given the trend of steadily increasing numbers of youth entering the system with mental health, substance abuse, and co-occurring disorders, this is a critical time for California to make positive changes in the way it delivers mental health services in the juvenile justice system. Other states and several jurisdictions in California have created momentum behind evidence-based practices and rehabilitative models, leading the way for statewide reform. Despite funding shortfalls, California has a real opportunity to dramatically improve the lives of this vulnerable population.

During times of uncertain funding and limited resources, it is more critical than ever to target juvenile justice funds to clearly delineated populations for evidence-based treatment. The following practical strategies explored in this policy brief provide solutions to help California's juvenile justice system more effectively address youth with mental health needs:

- Create universal, functional definitions of mental health linking DSM-IV diagnoses with treatment options across all systems serving youth.
- Implement validated, culturally competent, and gender-responsive mental health screening and assessment instruments.
- Administer treatment programs that are outcome-based and incorporate successful core elements.
- Utilize inter-agency, inter-county, and public/private collaboration to improve delivery of mental health services.

Successful implementation of these strategies requires cooperation and collaboration among all juvenile justice stakeholders, including policymakers, law enforcement, probation, mental health agencies, school officials, attorneys, and judges. The time is now for stakeholders to come together and take bold steps toward a system that meets the needs of its youth.

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