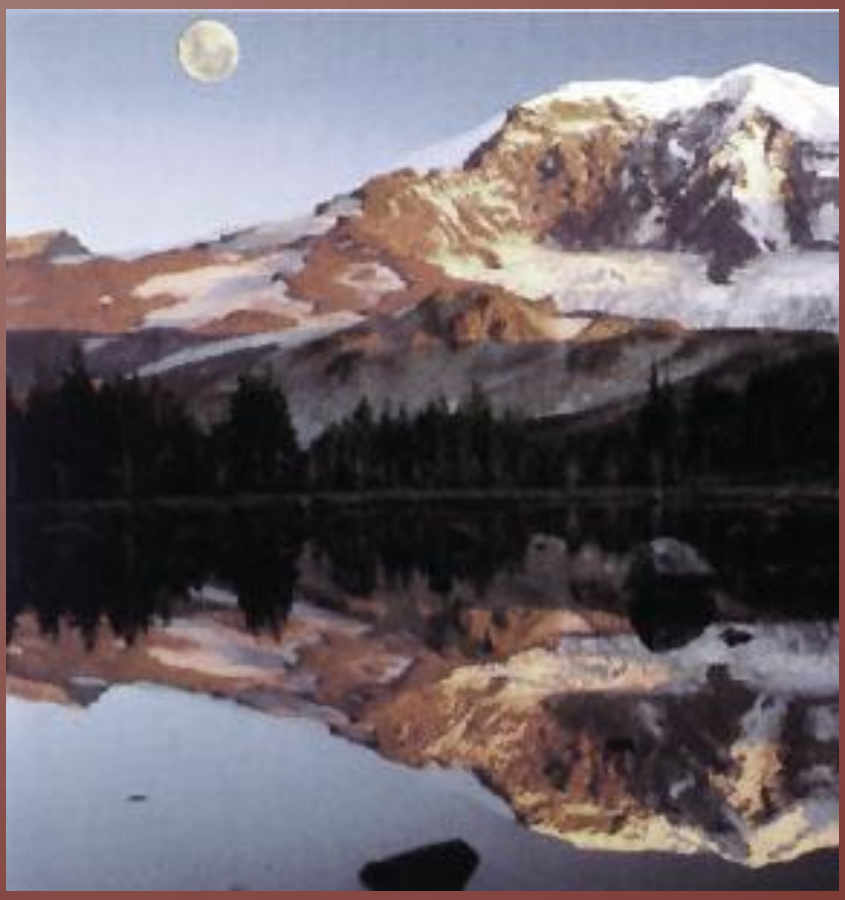

Washington State Mental Health Diversion Guidebook

A Guide for Juvenile Courts

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Introduction

The high rate of mental health need among youth involved in the justice system as compared to nondelinquent youth is well-established,[1][2] with estimated proportions of youth with diagnosable mental health disorders ranging from 55%-70%. Further, after excluding conduct and substance use disorders because of their direct relationship to offending behavior, nearly 40% of justice-involved youth will have also have anxiety (34%), or mood disorders (18%).[3] This poses a considerable challenge for an infrastructure ill-equipped to manage this volume of psychiatric need. While it is incumbent on the system to provide adequate care to youth in custody, it is not necessarily desirable that the justice system should act as a de facto mental health system.[4] Doing so would create an incentive for charging youth with crimes in order to access services and create a duplicate treatment infrastructure that would be unnecessarily costly. Instead, many courts are attempting to address this issue through diversion strategies designed to reduce contact with the system while connecting youth with services.

[1] Cocozza, J. J., Shufelt, J. L., & Phillippi, S. W. (2007). Louisiana Juvenile Justice System Service Provider Survey: A report of findings. Delmar, NY: National Center for Mental Health and Juvenile Justice.

[2] Teplin, L. A., Abram, K. M., McClelland, G. M., Dulcan, M. K., & Mericle, A. A. (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry*, 59(12), 1133-1143.

[3] Cocozza, J. J., Shufelt, J. L., & Phillippi, S. W. (2007). Louisiana Juvenile Justice System Service Provider Survey: A report of findings. Delmar, NY: National Center for Mental Health and Juvenile Justice.

[4] Grisso, T. (2004). Double jeopardy: Adolescent offenders with mental disorders. Chicago, IL: University of Chicago Press.

Benefits of Mental Health Diversion

Diversion is an attractive option for courts, because it avoids the potential cost and collateral consequences of court involvement. Increasing the effectiveness of the court in responding to special needs is the motivation behind an increasing array of specialty, problem-solving courts in the juvenile and adult systems.[5] The juvenile court was, itself, one of the first specialty courts when, during the Progressive era, reformers used the developmental differences between juveniles and adults as a justification for a unique approach that removed juveniles from adult courts and adult corrections.[6] Since then, the juvenile court still adheres to a basic ethic of juvenile rehabilitation but in many ways has grown to mimic the adult process in process and outcomes. The juvenile court operates within an adversarial process of prosecution and defense with judges making final dispositions. The requirements for due process and representation ensure that defendants' rights are respected but also narrows the focus on the limited charge and matter at hand, rather than the broader context of the youth's behavior and, often, the family's hopes for intensive intervention. Increasingly, diversion strategies have developed to allow the youth and family the option of potentially more intensive treatment needs and avoidance of typical court processing. The term diversion can also be used to describe a range of practices that mitigate juvenile justice involvement at multiple levels, from arrests through community-based alternatives to the avoidance of long-term incarceration.

[5] Madell, D., Thom, K., & McKenna, B. (2013). A systematic review of literature relating to problem-solving youth courts. *Psychiatry Psychology and Law*, 20(3), 412-422.

[6] Platt, A. M. (2009). The child savers: The invention of delinquency (40th anniversary ed.). New Brunswick, NJ: Rutgers University Press.

Effectiveness of Mental Health Diversion

Diversion for any youth, regardless of mental health status, is an attractive option for low level offenses, because it reduces the risks of negative youth labeling which is of considerable concern during a time when youth are actively forming identities.[7] In addition, some diversion strategies can minimize court administration costs by redirecting youth to community services. In a review of 73 youth diversion programs, Wilson & Hoge (2013)[8] found that diversion programs were more effective (modestly) in reducing recidivism than traditional court processing. They used a broad definition of diversion that included diversions occurring before arrest, before formal court processing or before incarceration. Programs that included intervention components and those consisting of only a brief "caution and release" component (for pre-arrest) both outperformed regular processes. Providing a diversion prior to arrest was the most effective strategy for reduced re-offending as was diverting low-risk youth.

A separate meta-analysis restricted to studies using only experimental or quasi-experimental designs[9] found that only family-based programs were significantly related to a reduction in recidivism when diversion was used. This is somewhat consistent with other research on program-specific effects. In Lipsey et al.'s (2000)[10] meta-analysis of program effects on juvenile delinquency, mentoring, family-based and skills-based programming emerged as effective programs while punishment-oriented approaches had no effect or worsened recidivism. To the degree that diversion programs are also skill or treatment oriented, they are likely to have greater effects.

However, the literature on the effectiveness of mental health treatment on youth offending is mixed, particularly depending on how mental health treatment is defined. Studies using well-defined interventions that focus on behavioral aspects of mental health distress (e.g., aggression, conduct disorder behaviors) in addition to contextual supports (e.g., family, natural supports) perform well in reducing offending behavior for youth with and without and diagnosable mental health disorders. Multi Systemic Therapy, for example, is a flexible and intensive intervention that has demonstrated effects for reducing out of home placements for youth with critical psychiatric needs as well as substance abuse and offending.[11,12] However, when youth are referred to generic mental health counseling in which the substance of the treatment is not known or does not explicitly address behaviors that trigger justice involvement, the effects of treatment are not

[7] Cohen, G. L., & Prinstein, M. J. (2006). Peer contagion of aggression and health risk behavior among adolescent males: An experimental investigation of effects on public conduct and private attitudes. *Child Development*, 77(4), 967-983.

[8] Wilson, H. A., & Hoge, R. D. (2013). The effect of youth diversion programs on recidivism: A meta-analytic review. *Criminal Justice and Behavior*, 40(5), 497-518.

[9] Schwalbe, C. S., Gearing, R. E., MacKenzie, M. J., Brewer, K. B., & Ibrahim, R. (2012). A meta-analysis of experimental studies of diversion programs for juvenile offenders. *Clinical Psychology Review*, 32, 26-33.

[10] Lipsey, M. W., Wilson, D. B., & Cothern, L. (2000). Effective intervention of serious juvenile offenders. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

[11] Schoenwald, S. K., Chapman, J. E., Henry, D. B., & Sheidow, A. J. (2012). Taking effective treatments to scale: Organizational effects on outcomes of Multisystemic Therapy for youths with co-occurring substance use. *Journal of Child & Adolescent Substance Abuse*, 21(1), 1-31.

[12] Wells, C., Adhyaru, J., Cannon, J., Lamond, M., & Baruch, G. (2010). Multisystemic Therapy (MST) for youth offending, psychiatric disorder and substance abuse: Case examples from a UK MST Team. *Child and Adolescent Mental Health*, 15(3), 142-149.

substantial.[13] Research on the relationship between mental health and offending offer some clues for this lack of effect. Conduct disorder and substance use disorders are highly related to offending; however, a mental health diagnosis in isolation of these other behaviors does not robustly predict offending, violent or otherwise.[14,15] While youth with serious mental illness (SMI) are three times as likely as their counterparts to be involved in the justice system, youth with SMI are also much more likely to experience early trauma, social and financial disadvantage and disrupted home lives which have an independent association with offending.[16] These studies provide strong evidence that for mental health treatment to be effective in reducing recidivism*, the treatment should directly address the drivers of offending behavior, incorporate family and community support systems and address substance use as needed.*

Purpose of the Guidebook

This guidebook presents a number of policies and programs occurring within Washington State that are bridging services between the judicial system and the community to serve youth with mental health disorders and their families earlier and more effectively. This guide is intended to increase knowledge of practices being implemented in the state to foster communication and local innovation. The guide begins by describing the policy context for diversion and mental health needs in Washington State through HB1524, *Providing for Juvenile Mental Health and Diversion Strategies.* We summarize the bill and the implementation of the 3rd diversion component of the bill since its enactment. Next we describe local examples of practice at various levels of the justice continuum including law enforcement, school-based, court-based, probation-based and embedded court services. Each of these sections includes a brief introduction highlighting national programs in these areas and then includes in depth descriptions of Washington State-specific practices.

Lastly, we include a resource page with additional information on diversion resources and current efforts seen across the country.

[13] Stout, B. D., & Holleran, D. (2012). The impact of mental health services implementation on juvenile court placements: An examination of New Jersey's SOC initiative. *Criminal Justice Policy Review*, 23(4), 447-464.

[14] Schubert, C. A., Mulvey, E. P., & Glasheen, C. (2011). Influence of mental health and substance use problems and criminogenic risk on outcomes in serious juvenile offenders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 50(9), 925-937.

[15] McReynolds, L. S., Schwalbe, C. S., & Wasserman, G. A. (2010). The contribution of psychiatric disorder to juvenile recidivism. *Criminal Justice and Behavior*, 37(2), 204-216.

[16] Erickson, C. D. (2012). Using Systems of Care to reduce incarceration of youth with serious mental illness. *American Journal of Community Psychology*, 49(3-4), 404-416.

Policy Context

With funding from the MacArthur Foundation and the Washington State Partnership Council for Juvenile Justice, in 2012 the University of Washington and Center for Children and Youth Justice convened a working and advisory committee to identify current gaps and opportunities for reform in Washington State policy with the goal of moving towards reduced use of formal court processes for youth with mental health challenges. The product of these efforts was the development and passage of House Bill 1524, "Providing for Juvenile Mental Health and Diversion Strategies." The bill passed in the 2013 Washington State legislature with strong bipartisan support in the House (75 yeas, 23 nays) and Senate (47 yeas, 1 nay). In addition, the bill had strong support from diverse juvenile justice stakeholder groups including prosecutors and defenders.

Description of HB1524

HB 1524 provided adjustments to the following elements of the existing state statute:

1. Expanded the existing adult statute for law enforcement diversion to juveniles.

- Juveniles who are determined to need mental health services and who have not committed a violent offense are eligible to be taken to a placement other than detention which may include an evaluation and treatment facility; a location already identified by law enforcement for mental health diversion; or another alternative location that has the capacity to evaluate the youth, develop a behavioral health plan and initiate treatment.

- The alternative placement allows for a hold up to 12 hours and the youth must be examined by a mental health professional within three hours of arrival.

2. Expanded discretionary diversion from two to three times for allowable offenses.

- Allowable offenses exclude Class A felonies, Class B felonies or Class C felonies if the crime is against person or harassment.

3. Expanded allowable hours of counseling that could be ordered under a diversion agreement to 30 and expanded the definition of "community agency."

- "Community agency" includes physician, counselor, school, treatment provider in addition to a community-nonprofit organization.

Use of 3rd Diversions around the State

Since the implementation of the bill in June 2013, there has been anecdotal evidence of counties across Washington State with resources to support non-detention alternatives making use of the new statute flexibility. However, it is unclear to what extent this is occurring in various counties across the state. To assess

the prevalence of third diversion utilization, the University of Washington requested county court data on all youth who received third diversions directly after the new statute was implemented. The time frame for the data extraction was June to December 2013. Within this six month window, 73 youth from 14 county juvenile courts opted into third diversion agreements.

As indicated in Table 1 (below), approximately 66% of third diversions were filed in two counties, Pierce and Snohomish. While some counties saw comparable rates to the overall diversion distributions from 2011, other courts had disproportionately higher rates of third diversions in 2013.

County Referral Court n = 14	County Census (2012)*	All Diversions (2011) n = 6,640	3rd Diversions (2013) n = 73	3rd Diversion Crime Types
Adams	18,769 (17.9%)	79 (1.2%)	3 (4.1%)	Driving without license Malicious mischief-3 Minor possession/consume liquor
Benton / Franklin	263,190 (14.3%)	694 (10.4%)	2 (2.7%)	Assault-4 Disorderly conduct Theft-3
Clark	434,392 (12%)	969 (14.6%)	2 (2.7%)	Assault-4 Malicious mischief-3
Grant	90,431 (18.8%)	202 (3%)	2 (2.7%)	Assault-4 Marijuana Possession =< 40 grams
Grays Harbor	68,812 (20.4%)	140 (2%)	5 (6.8%)	Assault-4 Malicious mischief-3 Minor possession/consume liquor Possess stolen property-3 Theft-3 Unlawful drug paraphernalia
Kitsap	245,559 (11.2%)	384 (5.8%)	1 (1.4%)	Marijuana possession =< 40 grams
Pacific / Wahkiakum	24,245 (16.9%)	41 (0.6%)	1 (1.4%)	Minor possession/consume liquor
Pierce	794,114 (12.8%)	1,028 (15.5%)	31 (42.5%)	Assault-2 Assault-4 Attempted robbery-2 Criminal trespass-1 Criminal trespass-2 False statement to public servant Malicious mischief-2 Malicious mischief-3 Marijuana possession =< 40 grams Minor intoxicated in public Minor possess/consume liquor Probation violation Resisting arrest Theft-3 Unlawful drug paraphernalia use misd. Vehicle prowling-2, gross misd.
Skagit	116,801 (14.6%)	307 (4.6%)	1 (1.4%)	Marijuana possession =< 40 grams
Snohomish	722,662 (10.3%)	1,039 (15.6%)	18 (24.7%)	Assault-4 Disorderly conduct Failure to comply-diversion agreement Malicious mischief-3 Marijuana possession =< 40 grams Minor possession/consume liquor Theft-3 Unlawful drug paraphernalia
Spokane	462,171 (16%)	615 (9.3%)	2 (2.7%)	Malicious mischief-3 Minor intoxicated in public Minor possession/consume liquor Theft-3
Walla Walla / Columbia	58,996 (18.4%)	211 (3.2%)	1 (1.4%)	Theft-3
Whatcom	199,577 (16.1%)	372 (5.6%)	3 (4.1%)	Assault-4 Criminal trespass-2 Dangerous weapons Minor possession/consume liquor Theft-3
Yakima	243,088 (22.8%)	559 (8.4%)	1 (1.4%)	Marijuana Possession =< 40 grams

The diverted crime type varied by county, with drug / alcohol (36%) and assaults (19%) comprising the majority of offenses that were diverted (see Figure 1).

Figure 1. Third Diversion Crimes by Category, as Defined by the Washington State Legislature

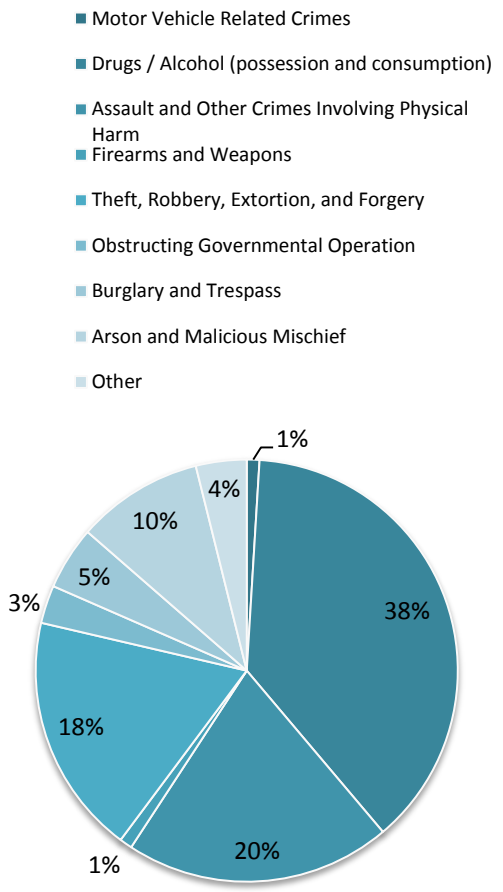


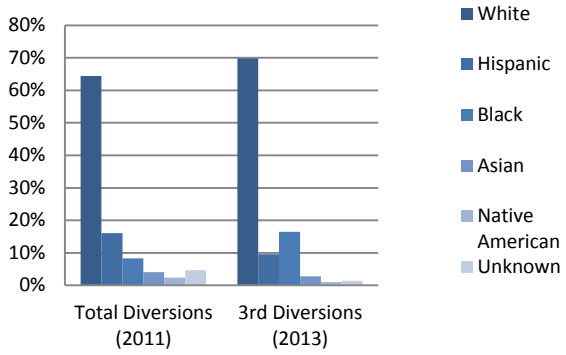
Table 2 and Figure 2 illustrate the demographic characteristics for all youth who received any diversion in 2011 as well as third diversions specifically in 2013.

Table 2. Demographic Characteristics of Youth who Received Third Diversions

Variable		n = 73
Race / Ethnicity	White	51 (69.9%)
	Black	12 (16.4%)
	Hispanic	7 (9.6%)
	Asian / Pacific Islander	2 (2.7%)
	Unknown	1 (1.4%)
	range	***m (sd)***
Age	9 – 17 years	15.48 (1.51)

Similar to overall diversion trends seen in 2011, the majority of youth who received third diversions in 2013 were white (approximately 70%), which is slightly higher than the representation of white youth for total diversion (including 1st and 2nd). The age range for youth who opted into third diversions was 9 to 17 years, with 15 being the average age for youth who received third diversions in 2013.

Figure 2. Race/Ethnicity Diversion Distributions



Summary

The use of the 3rd diversion is being assertively used in two of the largest courts in Washington State, with a number of other courts also taking advantage of the statute's new flexibility. The majority of diverted offenses are for drug and alcohol-related offenses and minor assaults. White youth appear to be benefitting from 3rd diversions at a slightly higher rate. Future efforts to expand the use of this diversionary discretion should focus on diverting more youth of color and supporting other courts to make more use of this option. Additional research on the outcomes of youth who received a third diversion and the kinds of programming provided to these youth would likely support expansion efforts.

Law Enforcement Diversion

Law enforcement diversion occurs at the time of arrest or in lieu of arrest. National examples include the Miami Dade County, FL civil citation program and the Jefferson County, CO Assessment Center. In the civil citation program, all youth who have committed a minor first-time misdemeanor are given the opportunity to be referred to the Juvenile Services Department rather than being issued an arrest. At the JSD, youth receive an assessment and application of targeted interventions and programs typically last 9-120 days. All data on civil citations are kept separately from criminal databases.[17] The Jefferson County Assessment Center in Colorado provides another example of diversion that occurs prior to arrest. Youth who are brought to the assessment center by law enforcement may or may not have new charges. Youth received an intake and motivational interview and are referred to services.[18] Having a location to take youth who may be experiencing family or mental health crises is a particularly useful option for law enforcement, who may feel pressured by family or community members to secure youth in some manner. The case study below of Yakima County's approach to managing mental health crises for youth with chargeable offenses that are diverted from court provides a local example of how this can work in Washington State. Another strategy for managing crises is provided by the Seattle Police Department's Crisis Response Team (CRT) which includes a mental health professional (MHP) embedded within the police department. As outlined below, the mental health professional works in both prevention and follow up to manage immediate crises and provide services to address ongoing needs.

[17] http://www.miamidade.gov/juvenileservices/civil-citation.asp
[18] https://www.jeffcojac.org/what-we-do/

Yakima County: Central Washington Comprehensive Mental Health Center

Background: The Central Washington Comprehensive Mental Health Center (CWCMHC) has developed and implemented an adolescent diversion program as an adaptation of their adult jail diversion program. The adult program operates as a pre-arrest behavioral health diversion agreement between law enforcement and CWCMHC. The CWCMHC juvenile diversion strategy relies heavily on Crisis Intervention (CIT) trained officers who are knowledgeable regarding the nature of behavioral disorders and resources available in the community.

Eligibility: As the first point of contact with youth, arresting officers are trained to notice indicators of mental health issues (via the CIT). These typically include disorientation/confusion, disorganized speech, depression, unusually anxious/scared/frightened, belligerent, hyperactive, and signs of possible developmental disability. If the arresting officer identifies that a mental health issue may be present and the youth has not committed a serious felony (excludable offenses also include DUI, domestic violence and sexual assaults), they will make a decision to divert the youth and immediately transport them to a CWCMH center location. While en route, the arresting officer will call staff to provide a basic understanding of the charge type and presenting issues. The majority of divertible crimes committed by youth are misdemeanor assaults, malicious mischief, or harassment charges.

Youth are assessed immediately upon arrival at the triage center. If the youth chooses to sign an agreement to participate, a treatment plan is developed. If they do not agree to participate, or if the intake assessment does not indicate the presence of a mental health issue, the youth is referred back to the arresting officer or prosecutor. If the youth signs an agreement and is unable to fulfill all the requirements of their agreement, they may be referred to the prosecutor's office in the arresting jurisdiction and charges are refiled. However, the probation department has a separate track for youth who are in the diversion program. If probation has a youth who is not complying with probation conditions, they can route them to diversion instead of imposing incarceration as a sanction.

Program Description: Ideally, staff are able to connect with the youth's parents who then come and get the youth after the treatment plan has been developed. If parents are unable to pick up the youth, staff will transport the youth home, or to the identified placement in the treatment plan (options often include placement in crisis or foster beds). If family conflict was a factor during the arrest, staff will work with the parents/caregivers to make sure the youth is returning to a stabilized, non-hostile home environment.

While the center has served a small number of youth to date (just under 50), the overall frequency of drop outs or refusals to participate has been low. The center provides approximately 12 different evidence-based treatment programs including Parent Child Interaction Therapy (PCIT), Triple P, Wraparound, Cognitive Behavioral Therapy (CBT), Multisystemic Therapy (MST), and Family Integrated Transitions (FIT). CWCMHC is unique in that 100% of youth who participate are referred to one (or more) of these programs.

Funding: Staff have found that most, if not all of the treatment programs youth receive as part of their plan are reimbursed through Medicaid, with the majority of youth being 100% Medicaid eligible. Each center location has computer portals for easy access to assessing Medicaid eligibility.

Evaluation: While evaluation efforts have yet to be incorporated into the juvenile adaptation of this diversion strategy, preliminary analyses of the adult program indicate a 4$ cost savings for every 1$ of mental health funds expended.

For more information, contact: Rick Weaver, Rweaver@cwcmh.org

King County: Seattle Police Department's Crisis Response Team (CRT)

Background: In 2010 the Seattle Police Department (SPD) launched a 24-month Crisis Intervention Team (CIT) and Mental Health Professional (MHP) pilot program with funding from a Federal Justice Assistance grant. The Crisis Intervention Team (CIT) is a collaborative effort between SPD and Seattle's Downtown Emergency Services Center (DESC), an emergency shelter for adults living with behavioral health disorders and chronic homelessness that provides an integrated array of clinical and supportive services. The goal of the CIT is to improve police response in situations involving mentally ill and chemically dependent individuals through a specialized mental health provider response in the field. Response includes assessment and referral of individuals to community based resources to meet their needs while avoiding the use of jail or hospital emergency rooms when applicable. In March of 2013, the CIT dedicated unit underwent a name change to Crisis Response Team (CRT) in an effort to differentiate CIT trained officers and the allocated CIT unit. The Department of Justice (DOJ) monitoring committee and the associated Crisis Intervention Committee (CIC) have designated the MHP position as the CRT MHP.

Eligibility: While it was originally intended as a true crisis intervention team, the community need has become so high that the CRT unit evolved into primarily a follow-up unit. The majority of cases assigned to, and managed by, the MHP come from repetitive 911 calls that are not emergency-oriented, unfounded complaints, calls regarding suicide ideation, warrant prevention efforts, behavioral issues that come from low coping in the community, case investigation, non-criminal follow-up, and addressing the needs of "frequent fliers" or individuals who are repeatedly involved in the system. Cases are typically flagged by the first responding officer and if deemed appropriate, sent to the MHP whose role is to work with community resource agencies to help the Subjects access or re-engage in services. In rare circumstances, the MHP serves as a direct responder. One common role for the MHP is to go on "knock and talks" in order to address housing disturbance complaints – in some cases, building managers will call the unit to come and talk with the Subject and develop plans to address the behavioral issue before an actual crime is committed. Additionally, these are also requested by community service agencies who provide services to individuals with mental health and chemical dependency issues.

Program Description: The CRT approach is unique in that a trained MHP works as part of a law enforcement team, taking direction from the sergeant and in collaboration with a sworn officer to exercise professional discretion in day-to-day contacts with individuals suffering from mental health and chemical dependency issues. CRT operates on the basis of two main goals: 1) connecting individuals in crisis with appropriate services that can help them achieve stability, including housing and social services for those who are homeless, and treatment for those suffering from mental illness and/or drug abuse; and 2) providing a linkage to crisis and commitment services for individuals who may require involuntary hospitalization and/or diversion from jail and costly hospital services and/or admissions. Ideally, the CRT unit is employed to address issues before criminal justice system involvement is needed; however, if charges are filed, the team will work closely with the Mental Health and Drug courts. When the nature of the case falls under this jurisdiction, the MHP serves as a liaison between court staff, social workers, and community service providers. In addition to the normal case practices and court collaborations, the CRT unit also provides trainings to community service agencies on awareness of the unit and the referral processes.

Funding: The CRT currently receives funding through the City of Seattle.

Evaluation: In 2012, post-pilot implementation, CRT was descriptively evaluated by researchers at Seattle University.[19] Results suggest that the CRT unit is relieving an otherwise substantial and unnecessary burden on law enforcement officers by triaging cases that are more appropriate for an MHP to address.

For more information, contact: Justin Dawson, Justin.Dawson@seattle.gov or jdawson@desc.org

[19] Helfgott, J. B., Hickman, M. J., & Labossiere, A. (2012). A descriptive evaluation of the Seattle Police Department's Crisis Intervention Team/Mental Health Partnership pilot project. Seattle, WA: Seattle University.

School-Based Diversion

School-based diversion involves strategies for identifying problematic behaviors that may lead to truancy, drop out or justice-involvement. Programs based in schools can be overseen by the schools, courts or other community systems.

In New Iberia, Louisiana, the Prosecutor's Early Intervention Program (PEIP) is operated out of the District Attorney's office Family Services Division[19]. Important elements of school-based diversion for youth with mental and behavioral issues include screening and referral systems for effective services. The Three Rivers School-Based Wraparound Initiative in Benton-Franklin counties provides an example of a local approach to early diversion with this population.

[20] http://16thjdc-g.com/index.html

Benton & Franklin Counties: Three Rivers School-Based Wraparound Program

Background: The School-Based Wraparound program was designed to provide a community-based intervention for middle-school youth who have frequent unexcused absences, and for whom attempts by the school to engage the youth and family have been ineffective. These youth are at significant risk of referral to juvenile court for truancy, and experience an increased risk for involvement in delinquent behavior.

Eligibility: The program is designed for youth who have frequent, unexcused absences from school that put them at-risk of having a truancy petition filed by juvenile court. Program referrals are made by School Counselors, Vice Principals, and Attendance Clerks when the school's efforts to engage the youth and family have not been effective in reducing out-of-school behavior or behaviors that are subject to school discipline that may result in suspensions or expulsions. In particular, the program targets youth and their families for whom individualized support is needed to address behaviors that interfere with the youth's success in school and for which other school–based interventions have not been successful. Common behaviors targeted by this intervention include social withdrawal, isolation, drug/alcohol use, and frequent physical altercations.

Program Description: Referrals are sent to the program's Care Coordinator, who facilitates the Wraparound process. Upon receiving the referral, the Care Coordinator accompanies a school staff person to a meeting with the family at a time and place identified by the family, such as the family's home, church or school with the primary responsibility of developing a partnership between the youth, his/her family and the team. While engagement is the initial step of the Wraparound process, it continues through the duration of the intervention. Initial visits with a youth, family and Care Coordinator are focused on building rapport and completing the intake paperwork. The next step of the Child and Family Team is to develop and implement a Plan of Care (PoC) – a comprehensive, individualized plan which identifies the family's strengths and needs, as well as services to address those needs. This process helps the Care Coordinator learn about the strengths, resources and history of solution-finding that the family already has in place.

After initial meetings, families are offered one of three interventions based on identified needs and willingness to engage: 1) **Universal intervention**: Informs and connects families with available community resources; 2) **Targeted intervention:** School-Based Wraparound intervention; or 3) **Intensive intervention:** A referral will be made to the Three Rivers Wraparound Program if a youth is determined to be involved in multiple systems and requires long-term support from a Wraparound team. Three to five Child and Family Team meetings occur per client, which take approximately three months to complete. The intervention ends when the team feels the right set of interventions have been successfully delivered to produce the desired outcome.

Funding: Funding for the pilot project (2009-2010 academic year) was provided by the MacArthur Foundation, Models for Change Initiative. Unfortunately, at this time the program is no longer in operation because of loss of funding.

Evaluation: During the 2009-2010 pilot, preliminary program evaluation efforts found that participating youth and their families (n = 21) accessed a variety of services including counseling, medical services, credit retrieval, tutoring, mentoring, and assistance with clothing, food, utilities and rent. Data demonstrated improved attendance and academic success among participating youth both during the program and three months after the program. Truancy petitions were not filed on participating youth with the exception of one student whose truant behavior was resolved without the formal juvenile court process.

For more information, contact: Sharon Gentry, sgentry@lcsnw.org

Court-Based Diversion

Court-based diversion refers to strategies to connect youth to treatment options after the case is filed on and before the youth is adjudicated. This can involve diversion programming that is monitored by the court before review from a judge or the judge can be involved through therapeutic courts. The purpose of these approaches is to minimize the recording of adjudications in official court files and, in the case of diversions that do not involve a judge, reducing court processing expenses for low risk youth. A national review of juvenile mental health courts conducted by Policy Research Associates[20] presents seven common characteristics of juvenile mental health courts: 1) Regularly scheduled dockets; 2) Less formal style of interaction among court staff; 3) Team management of treatment; 4) System-wide accountability; 5) Use of graduated incentives; 6) Defined criteria for program success; 7) Use of screening and assessment. Research on mental health courts, in general, is mixed but courts appear to be most effective when evidence-based programs are an element of service[21]. The Kitsap Individualized Treatment Court (ITC) provides an example of a juvenile mental health currently running in Washington State.

[21] http://gainscenter.samhsa.gov/cms-assets/documents/122718-887312.common-characteristics-jmhcs.pdf

[22] Callahan, LA, Cocozza, JJ, Steadman, HJ, & Tillman, S. (2012). A national survey of juvenile mental health courts. *Psychiatric Services, 63,* 130-137.

Kitsap County: Individualized Treatment Court (ITC)

Background: In 2006, a Kitsap County judge launched a mental health court for youth. The court was modeled after a court in Santa Clara, California which requires that the youth have a dual-diagnosis, whereas the Kitsap County Individualized Treatment Court (ITC) only requires a youth has a mental health diagnosis.

Eligibility: Youth are typically brought to the attention of ITC in one of three ways: 1) a prosecutor may flag a youth when reading a police report; 2) a defense attorney may flag a youth after a client meeting; or 3) a probation officer may flag a youth on supervision who commits a new offense.

Excluded charges include firearms, sex offenses or serious violent crimes. If a youth is recommended for ITC the traditional court process pauses. The ITC team is charged with gathering information on the youth, including pending charges. The next hearing is set after arraignment and the youth is ordered to observe two weeks of ITC.

Youth must be at least 13 years old and have a mental health diagnosis. Eligible diagnoses include: anxiety disorder, bipolar disorder, depressive disorder, generalized anxiety, major depression, mood disorder, obsessive compulsive disorder and/or post-traumatic stress disorder. Youth are selected based on whether they are amenable to treatment. Participating youth almost always already have a mental health diagnosis, but a youth can be diagnosed if needed.

If the ITC team deems the youth eligible and the youth chooses to participate after observing court, the youth signs an ITC contract.

Program Description: The treatment court team includes a probation officer, prosecutor, dedicated defense attorney and a full time mental health provider from Kitsap Mental Health Services. The team conducts weekly staff meetings before ITC to discuss each case and provide consultation. Youth participate in individual mental health counseling. While youth are not required to use Kitsap Mental Health Services, the majority of those accessing Medicaid do so.

The duration of youth's participation depends in part on their charge. For a misdemeanor, youth participate for a minimum of 9 months. For a felony, youth participate for a minimum of 12 months. A youth cannot participate for more than 24 months. Approximately 6 youth, but no more than 10, participate in ITC per year.

Funding: ITC is funded within existing court resources with the exception of the mental health therapist. Grant funding provides support for a full time dedicated therapist to ITC.

Evaluation: While there has been no formal evaluation, ITC tracks various data points. From inception through 2013, 46 youth had been served or were currently enrolled in ITC and 21 had graduated. Of the 46 served, there were 19 females and 26 males with an average age of 15. Four youth opted out of the program and were referred back to court. Twelve were terminated because of non-compliance, which often results from incurring new offenses.

For more information, contact: Patty Bronson, pattybronson@co.kitsap.wa.us

Probation-Based Diversion and Case Management

Probation-based diversion is similar to court-based diversion but involves specialized probation officers, or treatment teams, that work with youth and families. Programs are considered diversions if youth are pre-adjudicatory. In other cases, youth may already have adjudications on file but can received deferred dispositions or have records expunged if services are completed. The Front End Diversion Initiative (FEDI) developed out of Texas is designated as Promising Practice by CrimeSolutions.org.[22] In this program, specialized probation officers receive extensive training on adolescent mental health, crisis intervention, family engagement motivational interviewing. The probation officers provide case management and link families to community-based services. The Connections program in Clark County, WA provides similar services through team-based, wraparound, approach for youth with serious mental health needs.

[23] http://cfc.ncmhjj.com/the-texas-front-end-diversion-initiative

Clark County: Connections Program

Background: The Clark County Connections program was launched in 2001 when data indicated that youth who were high users of juvenile detention also experienced behavioral health, substance abuse or co-occurring issues. Connections targets juvenile offenders with behavioral health issues. The program delivers family-centered, strength-based wrap-around services to program youth and their families.

Eligibility: Eligible youth reside in Clark County and are on community supervision. Additionally, youth must: 1) exhibit symptoms of a behavioral health disorder; 2) score "moderate" or "high" on the Washington State Juvenile Court Risk Assessment which identifies risk and protective factors across ten life domains: Criminal History, School, Use of Free Time, Employment, Relationships, Environment in Which the Youth was Primarily Raised and Current Living Arrangements, Alcohol and Drugs, Mental Health, Attitudes and Behaviors, and Skills; and 3) score 1 or higher on the Mental Health section of the Washington State Juvenile Court Risk Assessment.

Program Description: The Clark County Juvenile Court shares a roster of youth in juvenile detention with Southwest Washington Behavioral Health to identify justice-involved youth who are eligible for services. A representative meets with youth who are determined to be eligible to receive services. In January 2014, Connections staff began working with the WISe model (Wraparound with Intensive Services).

All Connections staff are formally trained in wraparound, and incorporate wraparound values in work practices. Staff work in teams of four which include a Probation Counselor, a Care Coordinator/Therapist, a Juvenile Services Associate and a Family Assistance Specialist. The Probation Counselor is responsible for providing probation services that promote community safety, provide services to victims, increase youth competencies and provide offender accountability. The Care Coordinator/Mental Health Therapist completes mental health assessments for youth enrolled in the program to ensure youth meet program criteria, while also assisting the youth and family in identifying both formal and informal supports. The Juvenile Services Associate assists youth in setting goals and developing individual action plans to meet Court and service plan requirements. A Family Assistance Specialist empowers families by providing strengths assessment, support, mentoring, skills training, and system navigation to the adults in the family (generally the parent/guardian). Additionally, a clinical psychologist and doctoral interns are available for consultation and to complete psychological evaluations when needed. Connections can serve up to 100 youth at a time.

Funding: Initial funding for Connections was provided through a re-allocation of funding from a Special Intervention Program, which prioritized mental health dollars from both the RSN and Children Administration's federal Systems of Care grant. Funding is now maintained through general Juvenile Court revenue.

Evaluation: The program is designed to address several youth and family outcomes, including: 1) reducing recidivism, decreasing probation violations and decreasing detention stays; 2) reducing the episodes and length of time in out-of-home care; 3) increasing protective factors in the area of increased positive relationships; and 4) increasing family stability and capacity to provide adequate supervision and support for youth[1].

Evaluation efforts have found that similarly-situated youth who did not participate in Connections were 18% more likely to re-offend (Pullmann et al., 2006). Eighty-four percent of the comparison group reoffended while only 54% of youth who participated reoffended. Of those who did re-offend, youth in the Connections program had 2.8 re-offenses whereas the comparison group had an average of 5 re-offenses. Youth in Connections are: 1) less likely to reoffend; 2) take longer to reoffend; 3) re-offend less often; and 4) commit less serious crimes when reoffending.

For more information, contact: Dawn Young, Dawn.Young@clark.wa.gov

[24] Pullmann, M. D., Kerbs, J., Koroloff, N., Veach-White, E., Gaylor, R., Sieler, D. (2006). Juvenile offenders with mental health needs: Reducing recidivism using Wraparound. *Crime & Delinquency,* 52(3), 375-397.

Embedded Services

Many of the programs and strategies outlined above involve case management and linking youth to community programs for mental and behavioral health services. Connecting to youth to community programs is cost-effective and reduces the duplication of services as well as minimizes the risk that families will attempt to access the court primarily for support with behavioral health issues. At the same time, courts cannot always be sure that the services being accessed by youth and families are effective or even correctly tailored to the presenting program. Waitlists and access to care for community treatment can also be barriers to receiving care. To address this, some courts have developed services in house to speed up the time to treatment, increase communication between court and treatment providers and oversee treatment quality. Not unlike programming provided through ART and FFT, in the embedded service model, courts are able to more directly manage the quality of intervention. Two examples of models for in house treatment are provided below. In Clallam County, the court is a chemical-dependency licensed site (True Star Behavioral Health) and can bill for services directly. In Thurston County, a mental health counselor (funded through the mental health system) is assigned to youth referred from multiple sources in the justice continuum and can provide continuity of services while youth are in detention or on probation.

Clallam County: True Star Behavioral Health

Background: The Clallam County behavioral health treatment program, True Star Behavioral Health, began in 1997 when the court administrator, Pete Peterson, started a licensed chemical dependency agency within the juvenile court.

Eligibility: Referrals to the chemical dependency or mental health programs come from a variety of sources including probation and truancy counselors, community accountability boards and judges. The referrals are made based on the assessment of treatment need from the person making the referral. Youth referred to the chemical dependency and mental health program receive the GAIN (Global Assessment Individual Needs); youth being referred for mental health receive the GAIN and the Millon Adolescent Clinical Inventory (MACI) for treatment planning.

Program Description: The chemical dependency agency largely serves youth referred from the court, but is also accessible to clients from the surrounding community. The chemical dependency staff see clients in the same building where juvenile court hearings are held in addition to maintaining the juvenile detention facility. The advantage of onsite chemical dependency counselors include familiarity between court and treatment staff, high numbers of referral to treatment, awareness of court process among treatment staff and availability of services to youth. The contract for services is managed by the Regional Support Network and the RSN decides which counselors will see youth referred from the court. The tax ensures that court-referred youth are seen more quickly than they would have otherwise through the provision of dedicated staff time for this population. The Behavioral Health Manager oversees the chemical dependency treatment program, manages referrals to contracted mental health providers and also directly provides mental health services to families and youth on an outpatient basis.

Funding: Services are covered by state funding and medical coupons – the agency is unique in that it is self-sustaining within the auspices of the court. In 2010, additional mental health services were added to the service array available through the court with the passage of the "Hargrove tax." This tax, also known as the 1/10th of 1% tax, is a tax city councils can pass to specifically fund mental health services and, when passed, is often used to increase the availability of services to adults and youth involved in the justice system. In Clallam County, funds from this tax have supported part of the salary of the Behavioral Health manager at the court in addition to services contracted through mental health counselors in the community.

Evaluation: True Star efforts have yet to be evaluated, but they have identified goals associated with reducing the wave of addiction and mental health concerns that are currently affecting youth within Clallam County communities.

For more information, contact: Patricia Bell, PBell@co.clallam.wa.us

Thurston & Mason Counties: Mentally Ill Juvenile Offender Program (MIJOP)

Background: The Mentally Ill Juvenile Offender Program (MIJOP) provides case management and mental health services for juvenile justice involved youth.

Eligibility: Youth can be referred to MIJOP from any number of sources such as detention staff, probation staff, parents, or school staff. Referral criteria are loose, and there are no identified charge types that might exclude a youth from participation. MIJOP accepts youth for a wide range of behavioral health related issues from a youth expressing concerning behaviors in response to being detained, to youth with serious mental health issues including depression, suicidal behaviors, self-harm, and other diagnosed or yet to be diagnosed mental health issues.

Program Description: MIJOP is led by a transition therapist who is employed by Community Youth Services (CYS), but based in juvenile court. CYS is a large local organization that provides a variety of services including mental health counseling, GED prep, shelter for homeless youth, and programming for LGBTQ youth. The MIJOP transition therapist has a Master's degree and has experience working in both the school and mental health systems. The current MIJOP transition therapist is also a certified chemical dependency counselor.

After the referral is received, the transition therapist meets with the youth. The youth will complete a CYS assessment which helps identify the youth's needs. The transition therapist and the youth will develop a plan and communicate next steps to probation. The transition therapist will continue to meet with the youth regularly while the youth is in detention. If the youth experiences problems in detention, the transition therapist will attend juvenile court team meetings to help develop a treatment plan. When the youth exits detention, the transition therapist will help coordinate with family members, the probation officer, resources and other service agencies that might be involved with the youth.

Funding: MIJOP is fully funded through the Regional Support Network (RSN).

Evaluation: While there have been no formal evaluations, MIJOP has discussed the development and implementation of plans to start tracking data.

For more information, contact: Mike Fenton, fentonm@co.thurston.wa.us

Resources

The discussion and examples provided in this guide are intended to promote the cross-fertilization of ideas for juvenile mental health treatment and diversion in Washington State. As a relatively new area of study and focus, the field of mental health diversion is in an innovation stage where the most effective strategies are likely to emerge from trial and error in the field around the best times and methods for diversion. Existing studies provide some early clues around the benefits of early, pre-arrest diversion and family-based treatment, but more information about the mechanisms for achieving these connections and funding services is needed. We encourage other jurisdictions to experiment with the services and resources available to them and we hope the examples provided here spur discussion and creativity.

Additional resources for diversion and mental health in the juvenile justice system are provided below.

Mental Health and Juvenile Justice Collaborative for Change Juvenile Diversion Guidebook
http://cfc.ncmhjj.com/resources/diversion-strategies/

Substance Abuse and Mental Health Service Administration Juvenile Mental Health Treatment Courts Database
http://gainscenter.samhsa.gov/grant_programs/juvenilemhc.asp

National Center for Mental Health and Juvenile Justice
http://www.ncmhjj.com/

University of Washington Evidence-Based Practice Institute
www.uwhelpingfamilies.org