

National Health Policy Forum

Mental Health and Juvenile Justice: Moving Toward More Effective Systems of Care



A National View:

Youths with Mental Health Disorders in Contact with the Juvenile Justice System

Oct. 7, 2005



A National View:

Mental Health and Juvenile Justice

- **Ned Loughran, executive director, Council of Juvenile Correctional Administrators (CJCA)**
 - **National non-profit organization dedicated to the improvement of youth correctional services and practices so youths succeed when they return to the community**
 - **Unites nation's youth correctional CEOs to promote best practices, address common concerns and provide leadership for juvenile justice**
 - **Directs several grant projects: Performance-based Standards (PbS), New Directors Seminar; co-directs National Center for Mental Health and Juvenile Justice (NCMHJJ)**



Presentation Overview

- **History of Juvenile Justice and Mental Health**
- **Struggles and Problems**
- **Development of Research and Tools**
- **Approaches Around the Country**



History

- **Juvenile justice system established to protect public safety and rehabilitate youths**
- **1998: rash of school shootings began media focus on youths with mental health problems**
- **2000: Research and field experience start to show increasing numbers coming into juvenile justice**
- **2002: New Freedom Commission- President Bush asked the Commission to recommend improvements in the U.S. mental health service system for children with serious emotional disturbances.**



Juvenile Justice System Response

- **“We have to do something”**
 - **Address immediate issues of protecting youths from harming themselves, others**
- **“But what do we do?”**
 - **Lack of information, tools, resources, training**
 - **Increasing numbers of youths with increasing mental health problems and service needs**



Struggles

- **Juvenile justice system mandate: to protect the public and rehabilitate delinquents – not provide mental health treatment**
- **Juvenile justice cannot refuse a youth**
- **“Juvenile justice does not want more business.”**
- **Juvenile justice facilities are not designed, staffed or prepared to serve youths with mental health problems**



CRIPA Investigations

- **DOJ led based on variety of information**
- **Lengthy process**
- **Recently facilities cited for failure to provide adequate mental health services in: AZ, LA, MD, MI, MS, SD and Los Angeles County**



CRIPA Reports

Failure to provide adequate:

- **Suicide Prevention Measures**
- **Individual and Group Counseling/Therapy**
- **Training for Staff**
- **Communication between Mental Health clinicians, Caseworkers, Correctional officers, Unit Medical Staff, Probation**
- **Screening, Identification and Assessment**
- **Supervision**
- **Medication Management**



CRIPA Reports

Failure to provide adequate (cont)

- **Housing - many with safety hazards & blind spots**
- **Proper protocol when psychiatric hospitalization needed**
- **Psychiatric evaluations consistently and in a timely manner**
- **Treatment - many penalized for MH needs, placed in isolation for “safety”**
- **Treatment Plans - sometimes only “Crisis Response”**



Juvenile Suicide in Confinement: A National Perspective

(L. Hayes, 2004)

- **70% of victims were confined on non-violent offenses**
- **None of the victims were under the influence of alcohol and/or drugs at the time of the suicide.**
- **79% of victims had a history of prior offenses, most (76%) were of a non-violent nature**



Juvenile Suicide Research

- **88% of victims had a substance abuse history**
- **23% of victims had a history of medical problems**
- **58% of victims had emotional abuse history**
- **44% had physical abuse history**
- **39% had sexual abuse history**



Juvenile Suicide Research

- **74% of victims had a history of mental illness (and most thought to be suffering from depression at the time of death), with 54% of victims taking psychotropic medication**



Juvenile Suicide Research

- **71% of victims had a history of suicidal behavior, with suicide attempt(s) being the most frequent type of suicidal behavior (46%), followed by suicidal ideation and/or threat (31%), and suicidal gesture and/or self-mutilation (24%)**



Juvenile Suicide Research

- **70% of victims were assessed by a qualified mental health professional (QMHP) prior to their death (although only 35% of Detention Center victims received such assessments)**
- **Slightly less than half (44%) of all victims either had never seen a QMHP or had not seen a clinician within 30 days of their deaths**



Lack of Community Services and the Warehousing of Youths

**Report from the Committee on Government Reform:
*Incarceration of Youth who are Waiting for
Community Mental Health Services***

(Waxman and Collins, 2005)

- **“Thousands of children sit needlessly in the nation’s juvenile-detention facilities because they need mental health services, costing those facilities more than \$100 million a year.”**



Tools

- **Creation of scientifically-sound, standardized screening and assessment instruments for juvenile settings**
- **Documentation and implementation of evidence-based practices**
- **Development of promising practices and collaborative models**
- **Increasing awareness and leadership at the federal, state and local levels**



Collaboration Models

- **John D. and Catherine T. MacArthur Foundation Model Systems Project and CSCI**
- **Policy Academy**
- **OJJDP National Model**



Findings from Juvenile Corrections: A National Perspective 2004

- **Screening** - 67% responding states listed the MAYSI-2 as the instrument used for mental health screening
- **Screening vs. Assessment** – There is confusion in the field about the difference between screening and assessment; more education is needed
- **Treatment Services** – 26 states reported creating and/or operating specialized mental health treatment units; however there is no uniform definition of such a unit (ie staffing, selection of youths)
- **Reintegration** – 39 states coordinate community mental health services for youths scheduled to be released (doctor visits, mental health referrals, community mental health centers, & in-home services)

Different approaches used around the country:



- **Juvenile justice going it alone**
 - **New Jersey, Washington, Georgia, Ohio**
- **Mental health providing services**
 - **Maine, South Dakota – MOAs, MOUs for mental health departments to fund services to juvenile justice**
- **Blended funding**
 - **North Dakota, Wrap Around Milwaukee - Pool money from many departments and systems**



New Jersey & Washington

- **New Jersey**

- **The juvenile justice system pays for and provides mental health treatment for juveniles.**
- **State funds are utilized for services when a child has no eligibility for public insurance.**

- **Washington**

- **The Juvenile Rehabilitation Administration (JRA) is the sole source of funding for juveniles to receive mental health treatment.**



New Jersey Juvenile Justice Commission's Housing Unit for Youths with Mental Health Needs

- **Higher staff-to-resident ratio, with a greatly increased level of staff to resident interaction and supervision;**
- **Multi-disciplinary team approach, including a blending of contracted and state positions;**
- **Individual treatment plans driven by a mental health assessment of each resident's strengths and needs;**
- **On-site education for those who are unable to integrate into the Wilson School at the NJTS;**
- **Individual and group therapy, to include cognitive-behavioral interventions in areas including anger management, problem solving, social skills and substance abuse;**
- **Psychiatric prescribing and monitoring of medication as needed;**
- **Aftercare plan development to meet the specialized needs for community and family reintegration and alternative placement.**



Washington State Juvenile Rehabilitation Administration's (JRA) Integrated Treatment Model

- **Used in JRA's residential programs**
- **Framework for treatment planning across continuum of care**
- **Cognitive-behavioral basis**
- **Family-focused**
- **Evidenced-based approaches implemented**
- **Emphasis on skill acquisition and generalization**



Goals of Integrated Treatment Model

- **Motivation and engagement of youths and families**
- **Enhance skills**
- **Promote generalization of skills to community**
- **Structure environment to promote change**
- **Create a common treatment language for JRA**



Integrated Treatment Model: Methods of Change

- **Behavior Modification: Reinforcement, punishment, shaping, extinction, contingency management, cue removal and exposure**
- **Coaching and role playing**
- **Motivation enhancement**
- **Validation**
- **Cognitive restructuring**
- **Skills training (Dialectical Behavior Therapy)**



Components of Integrated Treatment Model

- **Dialectical Behavior Therapy**
- **Substance abuse treatment**
- **Relapse prevention**
- **Sex-offender treatment**
- **Aggression-replacement therapy**
- **Functional family therapy**
- **Family Integrated Treatment**



Maine & South Dakota

- **Memoranda of Agreement (MOA) and Understanding (MOU) to provide mental health services to juveniles in correctional facilities**

Maine's

Memorandum of Agreement

- **The Department of Mental Health, Mental Retardations and Substance Abuse Services (DMHMRSAS) is the lead executive agency responsible for the development and implementation of a system of care for children, adolescents, and their families.**
- **The Department of Corrections (DOC) is responsible for diverting juveniles referred by law enforcement officers from the correctional system, supervising youths on probation, providing care and supervision to youths detained or committed in Maine's juvenile correctional facilities and supervising youths on aftercare from those facilities.**

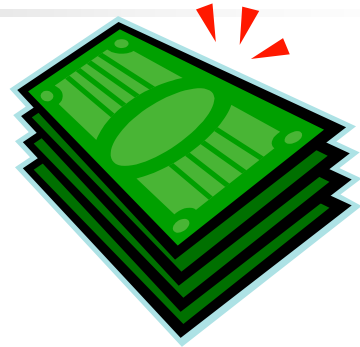


Services provided by mental health to DJS:

- **Mental health coordinators are provided to each of the regional DJS offices and to each of the juvenile correctional facilities;**
- **The behavioral health program in both facilities and is co-located and integrated with existing programs, education and individualized treatment;**
- **Assessment and crises intervention services for detained youths to include a minimum of a suicide screening; and**
- **Specialized services for girls.**

North Dakota & Wrap Around

- **Pooled Funding Methods**
 - **Case Rates**
 - **Capitation**
 - **Fixed Funding**
 - **Fee-for-Service**
- **Single Entry takes Responsibility to Manage Monies – Care Management Organization**
- **Shifting Funds from Institutional to Community-Based Care**





North Dakota

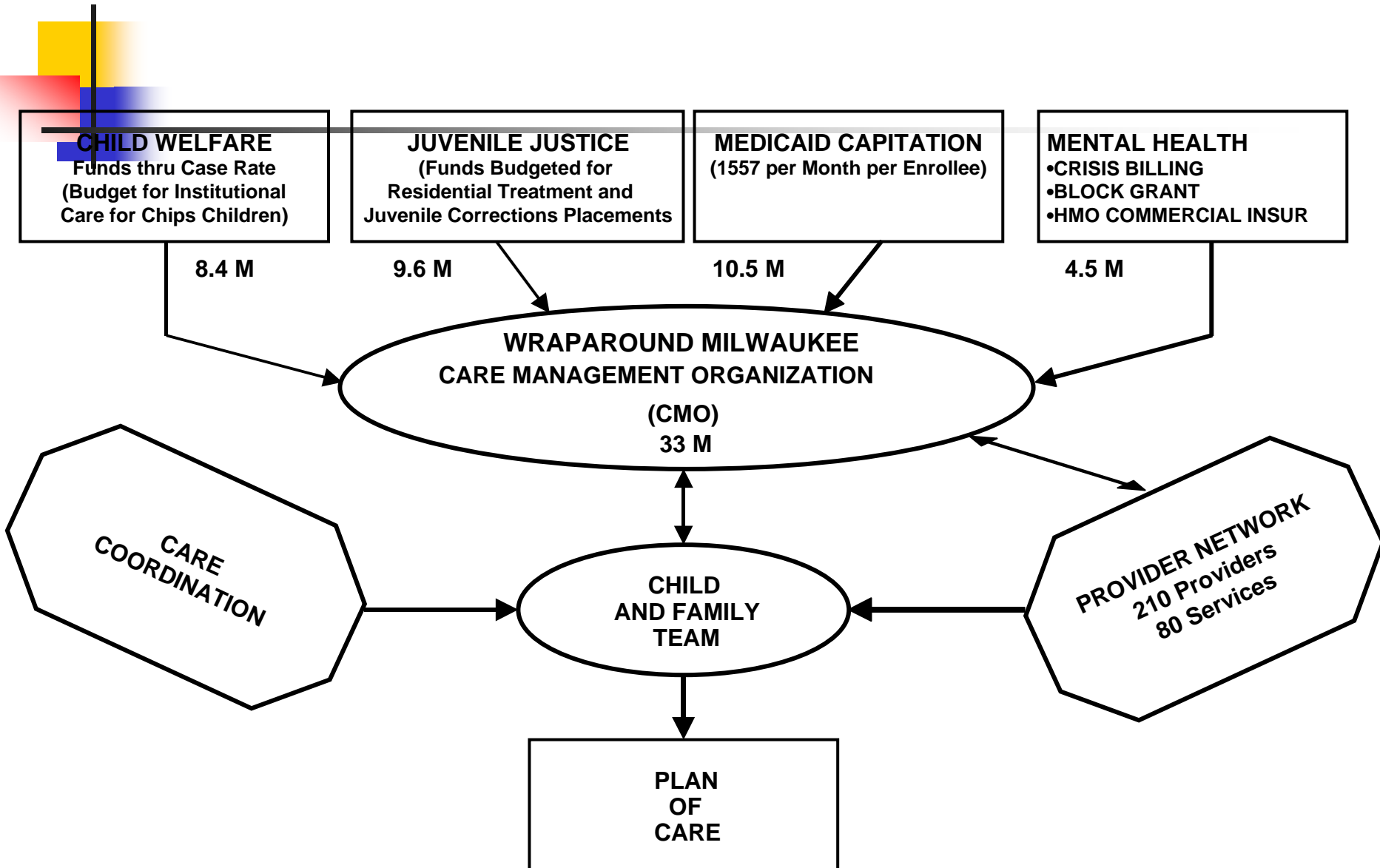
- **Mental Health (MH), Child Welfare (CW) and the Division of Juvenile Services (DJS) collaborate to provide services.**
 - **Room and board - Title IVE pays.**
 - **Treatment services - If youth eligible, Medicaid pays; if not Medicaid eligible, money is provided through state foster care funds.**
 - **Aftercare - Some go into DJS therapeutic foster care, others go home.**
 - **Only 3% of the youths with MH problems recidivate in the first year post discharge.**
 - **Case manager (1: 18/21 youths) is assigned immediately following placement with DJS.**



Wrap Around Milwaukee

- **Wrap Around Milwaukee pools \$32 million in Child Welfare, Juvenile Justice, Mental Health and Medicaid Funds**
- **Single record – access allowed only as appropriate**

What are Pooled Funds?





Recommendations for the future

- **Continue to disseminate the latest information regarding evidenced-based practices, tools and resources to help this population;**
- **Continue to foster better collaboration between mental health and juvenile justice at state and local levels;**
- **Encourage adoption of Wrap Around Milwaukee-type pooled funding;**
- **Advocate for changes to the Medicaid reimbursement rules to allow continued eligibility while a youth is confined.**