National Center for
Mental Health and Juvenile Justice
NCMHJJ

June 2006

Research and Program Brief

Research and Program Briefs are periodic publications aimed at improving policy and practice for youth with mental health disorders in contact with the juvenile justice system. This publication is supported by a grant from the **John D. and Catherine T. MacArthur Foundation**.

Juvenile Diversion: Programs for Justice-Involved Youth with Mental Health Disorders

Kathleen Skowyra

Susan Davidson Powell, MA

Background

Over 2.3 million youth are arrested each year. Approximately 600,000 of these youth are processed through juvenile detention centers and more than 100,000 are placed in secure juvenile correctional facilities (Sickmund, 2004). Existing data suggest that 70 percent of these youth suffer from mental health disorders, with 25 percent experiencing disorders so severe that their ability to function is significantly impaired (Shufelt & Cocozza, 2006).

Many of these youth appear to be placed in the juvenile justice system as a means of accessing mental health services that are otherwise unavailable or inaccessible in the community. While this trend has been evident at the adult level for some time, it is now being observed at the juvenile level as well. For example:

- A 1999 survey by the National Alliance for the Mentally Ill (NAMI) found that 36 percent of respondents reported having to place their children in the juvenile justice system in order to access mental health services that were unavailable to them in the community (NAMI, 2001).
- A 2001 study conducted by the U.S. General Accounting Office (GAO) found that parents placed over 12,700 children in the child welfare or juvenile justice systems in order to access mental health services (GAO, 2003).
- A report issued by Congress in 2004 documenting the inappropriate use of detention for youth with mental health needs found that in 33 states, youth were reported being held in detention with no charges against them — there was simply no place else for them to go (US House of Representatives, 2004).

Further, recent investigations by the US Department of Justice of juvenile correctional and detention facilities have documented the failure of many facilities to respond to the mental health needs of youth placed in their care (US Department of Justice, 2005). Simply warehousing youth in juvenile justice facilities with no access to treatment exacerbates their conditions and creates a more dangerous situation for youth and the staff who are responsible for supervising them.

While it is recognized that some youth in the juvenile justice system have committed serious crimes and may not be appropriate for diversion to the community, many youth are in the system for relatively minor offenses with significant mental health issues, and end up in the juvenile justice system by default. Given the needs of these youth and the documented inadequacies of their care while in the system, there is a growing sentiment that whenever possible and matters of public safety allow, youth with serious mental health disorders should be diverted into effective community-based treatment.

The increasing recognition of the inappropriateness of relying on the justice system for mental health services has raised new questions about how best to identify and treat these disorders among youth, and how responsible systems can create more opportunities for youth to be safely and appropriately diverted into treatment. Mechanisms to divert youth such as juvenile mental health courts (Arredondo Kumli, Soto, Colin, Ornellas, Davilla, Edwards & Hyman, 2001), wraparound services (Bruns, Burchard & Yoe, 1995), and referral to community-based services are all gaining recognition as strategies for getting troubled youth into appropriate mental health services. Yet despite this interest, there has been no comprehensive examination of existing juvenile diversion programs in general, or of diversion programs that specifically target youth with mental health needs. Very little is known about what these programs look like, how they are funded, how they identify youth to participate, the kinds of services they provide, and their effectiveness in terms of their impact on psychiatric symptoms and juvenile recidivism. This absence of a national information source has limited the field's collective understanding about the most effective and promising models for diverting youth into community-based treatment settings.

A recent survey undertaken by the National Center for Mental Health and Juvenile Justice represents a first attempt to begin to identify the current state of juvenile diversion in this country. Conducted in 2003 with support from the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services and in partnership with the National Association of State Mental Health Program Directors and the Council of Juvenile Correctional Administrators, this survey serves as the most comprehensive attempt to date to identify and describe existing juvenile diversion programs particularly those that focus on youth with mental illness, and lays the groundwork for the further examination of key diversion models and approaches for youth.

Understanding Diversion for Juvenile Offenders

Diversion can cover a wide range of interventions, all of which are alternatives to initial or continued formal processing in the juvenile justice system. Broadly, diversion is an attempt to channel out youthful offenders from the justice system (Bynum & Thompson, 1996) with a goal of offering youth an experience that is significantly different from that which would occur in the juvenile justice system (Osgood & Weichselbaum, 1984). Ideally, diversion should occur at the earliest stages of juvenile justice processing, to refer a youth to necessary services and prevent further involvement in the system. However, diversion mechanisms can be instituted at later stages of justice processing, to prevent further penetration into the system and costly out-of-home placements.

Diversion can cover a wide range of interventions, all of which are alternatives to initial or continued formal processing in the juvenile justice system.

Efforts to keep youth out of the juvenile justice system who otherwise would be processed by the courts have existed since the creation of juvenile courts in various states (Nejelski, 1976). During the 1960's, increasing levels of delinquency and crime, coupled with criticisms of the juvenile justice system, led to the development of alternatives for responding to youth outside of the traditional justice system. As such, the 1970's reflected considerable growth in diversion programs, bolstered by significant federal investments in these initiatives. Rising juvenile crime rates in the 1980's and early 1990's caused the political pendulum to swing in the opposite direction, giving birth to the term "superpredator", and fueling fears that the country was under assault by a generation of violent youth (Zavlek, 2005). In response, many educational and rehabilitative alternatives, including diversion programs, were abandoned in favor of strict zero-tolerance policies and increased law enforcement response to typical adolescent behavior (Browne, 2003).

In the last decade, interest in juvenile diversion programs and mechanisms has resurfaced, due, in part, to heightened awareness of the large numbers of youth with mental health disorders in the juvenile justice population. Earlier evaluations of diversion programs yielded mixed results, largely due to the diversity of the interventions and services provided by the programs as well as variations in evaluation design and duration. Despite this, the potential benefits of diversion for youth with mental health needs are compelling:

- Reducing recidivism
- Providing more effective and appropriate treatment
- Decreasing overcrowded detention facilities
- Facilitating the further development of community-based mental health services

- Increasing the safety of detained youth
- Improving working relationships of cross-systems groups
- Expediting court processing of youth into services; and
- Encouraging family participation in treatment (Arredondo et al., 2001; Cocozza & Skowyra, 2000).

Family and community-based treatment have been found to be the most effective form of intervention for successfully treating youth with mental health disorders and reducing recidivism. A 2000 review of the research of the characteristics of effective treatments for youth in the juvenile justice system found that community-based treatment and programs are generally more effective than incarceration or residential placement in reducing recidivism, even for serious and violent juvenile offenders (Lipsey, Chapman & Landenberger, 2001). Despite this knowledge, relatively little work has been done to date to examine strategies and programs that divert youth from the juvenile justice system into community-based services and settings, particularly youth with significant mental health needs.

A National Portrait

The lack of information and knowledge about existing juvenile diversion programs provided the impetus for the national survey conducted by the National Center for Mental Health and Juvenile Justice. The goal of this effort was to collect basic information about the state of juvenile diversion programs in this country and to identify those programs that target or prioritize youth with mental health needs.

The NCMHJJ collaborated with two national membership organizations to conduct the survey — the National Association of State Mental Health Program Directors (NASMHPD), which represents state mental health commissioners and directors and their agencies; and the Council of Juvenile Correctional Administrators (CJCA), which represents state juvenile correctional administrators. Working with these organizations, the NCMHJJ developed a brief survey and mailed this to all commissioners in the NASMHPD and CJCA membership. The survey asked respondents to identify and provide contact information for any juvenile diversion program of which they were aware. The criteria indicated that the programs had to:

- Serve juveniles
- Operate as a formal program
- Reduce justice involvement
- Maintain linkages to community-based resources and services

This brief survey led to the identification of 779 programs. A second, in-depth survey was mailed to these programs requesting more specific information about program eligibility, the point at which youth are diverted, how programs are organized and funded, and the kinds of services offered to youth. A total of 230 programs responded to the in-depth survey, yielding an overall response rate of 30 percent. In order to obtain some sense of whether the program targeted youth with mental health needs, programs were also asked to self-rate the program on the extent to which they serve youth with mental health disorders using a seven point scale (1= not at all to 7= extremely). The mean program rating was 4.18 and this scale allowed for the classification of the programs into one of two categories: general juvenile diversion programs (n= 111) or mental health focused programs (n= 105)[1].

Follow-up telephone interviews were conducted with those programs that self-identified as having an above average focus on serving youth with mental health disorders to clarify or verify the survey information and obtain additional information about program structure, services, youth served, and perceived efficacy. Guided by the telephone interviews, a pool of promising program models were identified based on the following criteria:

- Their ability to identify mental health needs
- Their ability to provide services to youth with identified mental health needs
- The level of collaboration between systems
- The level of parental involvement; and
- The availability of evaluation data.

Key Survey Findings

The survey findings revealed important differences between the general diversion programs and those with a mental health focus. These findings are presented below.

Eligibility Criteria: The majority of programs in the survey reported limiting eligibility to youth within a certain age range, typically serving youth with an average age of 15. Involvement with the juvenile justice system, both in terms of the seriousness of the current offense and the number of prior arrests or convictions was an eligibility restriction for most programs. Mental health focused programs have less stringent restrictions than general diversion programs

[1] Fourteen programs did not rate mental health focus and were excluded from the follow-up telephone interviews and from the comparative analysis of the survey data.

and are more likely to admit youth with more serious charges and with a prior history of involvement with the justice system. Conversely, general diversion programs are more likely to serve nonviolent status offenders and those with no prior history with the justice system. Some of the general diversion programs exclude youth with a mental health disorder. While all of the mental health diversion programs accept these youth, some exclude youth with specific disorders (e.g. mental retardation or youth experiencing severe psychosis), while other mental health focused programs target specific disorders (e.g. mood or anxiety disorders).

Point of Diversion: The majority of the programs accept youth from multiple points of entry; however, the most common point of diversion is probation intake. Mental health focused programs are more likely to accept youth into their programs at the later stages of juvenile justice processing. This suggests that mental health needs are not routinely identified at a youth's earliest point of contact with the juvenile justice system and are more likely to be identified once a youth in placed in detention or seen by the court in an adjudicatory hearing.

Funding: Funds from state juvenile justice agencies are the most common source of support for all diversion programs, and are used to fund a greater proportion of general diversion programs. Not surprisingly, mental health focused programs are more likely to receive financial support from a range of interagency sources, including juvenile justice, mental health, and substance abuse agencies. Many of the mental health focused programs reported having undergone budget cuts or encountered changes in their funding status, despite increasing referrals.

Screening & Assessment: Just over half of all programs screen youth for mental health and substance use disorders, with mental health focused programs significantly more likely to screen for these disorders than general programs. Of those programs that conduct mental health screening, over half reported using a standardized instrument to collect this information, while the remaining programs rely on a set of questions developed by the program itself or ask questions based on what appear to be the presenting problems.

Services: The most common general services provided by all of the programs include educational classes focused on fire setting, substance use or shoplifting; job skills training; and victim awareness classes. In terms of mental health services, more than half of all programs indicate they provide some mental health or substance abuse services to youth, although the mental health focused programs provide significantly more services specific to mental health and substance use than do the general programs. Typically, mental health services include individual counseling, substance use counseling, crisis intervention, and medication management. The overwhelming majority of programs do not rely on evidence-based practices or refer to community providers who do.

Promising Program Models

Among the programs reviewed, the following four programs emerged as promising models for providing mental health and other services to youth at key points of juvenile justice system contact.

The Special Needs Diversionary Program, Harris County, Texas.

This is a jointly funded statewide initiative involving both the juvenile justice and mental health agencies. Co-located Probation/Licensed Practitioners of the Healing Arts (LPHA) teams work together to staff cases and are responsible for jointly securing, providing, or supervising the provision of services to youth on their caseload. These teams serve youth ages 10 to 18. There are multiple points of entry to a Probation/LPHA team, and referrals can be made from virtually all key juvenile justice processing points, from intake through post-adjudication. The state of Texas requires probation departments to use the MAYSI-2 to screen all youth at Probation Intake. The results of the screen are passed to the Probation/LPHA teams, where youth then undergo a clinical assessment and family interview to assess their appropriateness for the Special Needs Diversionary Program. If appropriate they are diverted for further processing and admitted to the program. Following these assessments, an individualized treatment plan is developed for the youth and family. All program services are based on a wraparound philosophy of team treatment planning and the teams strive to provide the majority of services in the home or school. Services includes benefit coordination, to assist with Medicaid or CHIP enrollment; psychiatric services, including medication management, group and individual counseling; health care; parent and child support group groups; and transition planning to prepare for discharge from the program.

The Integrated Co-Occurring Treatment (ICT) Model, Akron, Ohio

The ICT program is an intervention specifically designed to serve justice-involved youth with co-occurring mental health and substance use disorders. The model is an integrated treatment approach that uses an intensive home-based model of service. The ICT program is both a diversion program for youth referred from the court as a

condition of probation, as well as a reintegration program (for youth returning home from placement) and serves youth ages 13 to 18. Youth who are referred to the program undergo comprehensive screening and assessment, using standardized instruments, to determine mental health and substance abuse status and needs. Program clinicians are available to youth (and their families) 24 hours a day, 7 days a week, and use a treatment stage approach, geared toward meeting the youth and family's primary presenting needs prior to proceeding to more complex needs. Assessment and intervention services are delivered in the home, school, and community. Program clinicians use individual and family therapy interventions, and individual treatment focuses on skill and asset building, while simultaneously focusing on risk reduction. Family interventions include building parenting skills and rebuilding family relationships.

Mental Health Diagnostic and Evaluation Units, Jefferson County, Alabama

The Diagnostic and Evaluation (D&E) Unit is a county program exclusively targeting youth with mental health disorders. There are four D&E units in Jefferson county — two units in schools, one in the child welfare agency, and one in the Family Court. These units are managed by the Jefferson County Community Partnership (JCCP), and serve youth ages 5 to 21. The goal of the court unit is to complete a timely assessment of the youth and family and develop an individualized service plan. Referrals to the court unit come from Probation intake or from the family court judge. A master's level professional, known as a D&E specialist, performs an initial mental health and substance abuse screen and determines which youth need to be referred for further evaluation. A family advocate is often present for the initial screen. Evaluations are provided by either the D&E specialist or a licensed psychologist under contract to the unit. For those youth diverted to the program a range of mental health services are provided by the court unit, including medication monitoring, crisis intervention, and coordinated case management services. Out-patient therapy is provided on-site by a full-time therapist who receives referrals from the D&E specialist. Court unit staff also includes a part-time psychiatrist, two full-time case managers, and a family advocate. In addition to these on-site staff, the JCCP contracts with 17 additional providers to whom youth can be referred.

Indiana Family Project, Monroe County, Indiana

The Indiana Family Project serves youth under the age of 18 in Monroe County involved with the juvenile justice system. Eligible youth are diverted into the program from all points of the juvenile justice system, from initial contact with law enforcement to adjudication. Pre-adjudication referrals come from Probation and post-adjudication referrals come from the Family Court judge. To assess mental health needs, parents and youth complete a questionnaire similar to the Child Behavioral Checklist, which includes mental health and substance abuse subscales. Functional Family Therapy (FFT), an evidence-based intervention, is provided to all youth in the program. A family preservation team is assigned to work with the family as they progress through the three standardized phases: Phase 1 is the engagement and motivation phase, Phase 2 focuses on behavior changes, and Phase 3 emphasizes the generalization of skills learned in therapy. Transition planning begins with the start of treatment so a plan is in place upon a youth's discharge from the program.

Summary

There is growing pressure on the juvenile justice system to more appropriately respond to the mental health needs of youth. For many of these youth, diversion to community-based services is a much preferred strategy that results in better outcomes for the youth without sacrificing public safety. Yet, up until now, there has been virtually no information in the research or knowledge bases about effective juvenile diversion programs and strategies for youth in general, and even less information about diversion programs specifically designed for youth with mental health needs. This survey represents a first attempt to identify existing diversion models, and lays the groundwork for the further study of key strategies, approaches, and models for effectively diverting youth with mental health needs into community-based treatment. ■

About the authors...

Kathleen Skowyra is a Senior Consultant to, and previous Associate Director of, the National Center for Mental Health and Juvenile Justice at Policy Research Associates. In this capacity, Ms. Skowyra has directed a national mental health and juvenile justice initiative to develop a Comprehensive Model for providing mental health services to youth at key stages of juvenile justice processing. Susie Davidson Powell, founder of LimeyPress Communications, is a consultant and freelance writer, and the former Associate Director of The SAMHSA National GAINS Center for Systemic Change at Policy Research Associates.

References

Arredondo, D., Kumli, K., Soto, L., Colin, E., Ornellas, J., Davilla, R., et al. (2001). Juvenile mental health court: Rationale and protocols. *Juvenile and Family Court Journal, 52*(4).

Browne, J. (2003). *Derailed: The Schoolhouse To Jailhouse Track*. Washington, DC: Advancement Project.

Bruns, E., Burchard, J., & Yoe, J. (1995). Evaluating the Vermont system of care: Outcomes associated with community-based wraparound services. *Journal of Child and Family Studies, 4*(3), 321-339.

Bynum, J., & Thompson, W. (1996). *Juvenile Delinquency: A Sociological Approach* (3rd ed.). Needham Heights, MA: Allyn and Bacon.

Cocozza, J., & Skowyra, K. (2000). Youth with mental health disorders: Issues and emerging responses. *Office of Juvenile Justice and Delinquency Prevention Journal, 7*(1).

Lipsey, M., Chapman, G., & Landenberger, N. (2001). Cognitive-behavioral programs for offenders. *The Annals of the American Academy of Political and Social Science* 578: 144-157.

National Alliance for the Mentally Ill. (2001). *Families on the Brink: The Impact of Ignoring Children with Serious Mental Illness*. Arlington, VA: National Alliance for the Mentally Ill.

Nejelski, P. (1976). Diversion: The promise and the danger. *Journal of Research in Crime and Delinquency, 22*.

Osgood, D. W., & Weichselbaum, H. (1984). Juvenile diversion: When practice matches theory. *Journal of Research in Crime and Delinquency, 21*(1).

Shufelt, J.S. & Cocozza, J.C. (2006). *Youth with mental health disorders in the juvenile justice system: Results from a multi-state, multi-system prevalence study.* Delmar, NY: National Center for Mental Health and Juvenile Justice.

Sickmund, M. (June 2004). *Juvenile in Corrections*. Washington DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

United States Department of Justice. (2005). *Department of Justice Activities Under The Civil Rights of Institutionalized Persons Act: Fiscal Year 2004*. Washington, DC: United States Department of Justice. Retrieved July 15, 2005 from http://www.usdoj.gov/crt/split/document/split_cripa04pdf.

United States General Accounting Office. (2003). *Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services* (No. GAO-03-397). Washington DC: United States General Accounting Office.

United States House of Representatives. (2004). *Incarceration Of Youth Who Are Waiting for Community Mental Health Services in the United States*. Washington, DC: Committee on Government Reform.

Zavlek, S. (August 2005). Planning Community-Based Facilities for Violent Juvenile Offenders as Part of a System of Graduated Sanctions. Washington, DC. US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

About the National Center for Mental Health and Juvenile Justice

Recent findings show that large numbers of youth in the juvenile justice system have serious mental health disorders, with many also having a co-occurring substance use disorder. For many of these youth, effective treatment and diversion programs would result in better outcomes for the youth and their families and less recidivism back into the juvenile and criminal justice systems. Policy Research Associates has established the National Center for Mental Health and Juvenile Justice to highlight these issues. The Center has four key objectives:

- Create a national focus on youth with mental health disorders in contact with the juvenile justice system
- Serve as a national resource for the collection and dissemination of evidence-based and best practice information to improve services for these youth
- Conduct new research and evaluation to fill gaps in the existing knowledge base
- Foster systems and policy changes at the national, state and local levels to improve services for these youth

For more information about the Center visit our website at www.ncmhjj.com.

Joseph J. Cocozza, PhD
Director