Breaking the School to Prison Pipeline--

The school-based diversion initiative for youth with mental disorders

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Background

In the 1990s, when public fear of youth violence was at its peak, schools across the U.S. began adopting zero tolerance policies that imposed strict punishment for breaking a rule, regardless of extenuating circumstances. While these policies were originally designed to handle the most serious offenses, they gradually broadened in scope to include disruptive behaviors, often minor in nature that would have, in years past, been handled by school staff. These policies frequently result in a call to police or the school resource officer, an arrest and involvement in the juvenile justice system, criminalizing much behavior that had formerly been addressed by school disciplinary processes. Thus, zero tolerance policies shifted the responsibility of school discipline from schools to the juvenile justice system, with schools soon becoming an ever increasing source of referrals to the juvenile justice system[1]. This practice became so widespread across the United States that it has come to be known as the ñschool-to-prison pipeline.ò

Unfortunately, justice system contact has been shown to be a significant predictor of future school-related problems, including negative academic and behavioral outcomes, leading to greater entrenchment of school difficulties for children who are labeled as delinquent[2].

In fact, unnecessary contact with the juvenile justice system contributes to many children getting worse, not better[3]. Zero tolerance policies also create a significant workload and financial strain for schools, law enforcement, and the juvenile justice system. In recognition of serious concerns being raised around the criminalization of misbehavior, efforts are currently underway to mitigate the flow of youth from schools to the juvenile justice system. One such effort is based on the work of Judge Steven Teske and colleagues[4], a collaborative approach that has led to a significant decrease in court referrals, improvements in police officer and student relations, and an increase in graduation rates in Clayton County, Georgia and has achieved similar success when replicated in other states[5]. Other efforts have focused on developing specialized programs to address issues of disproportionality among youth caught in the school-to-prison pipeline.

Established in 2001, the National Center for Mental Health and Juvenile Justice[6] (NCMHJJ) at Policy Research Associates, Inc. provides a national focal point aimed at improving policies and programs for youth with mental health disorders in contact with the juvenile justice system.

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1 American Psychological Association Zero Tolerance Task Force. (2008). Are zero tolerance policies effective in the schools?: An evidentiary review and recommendations. *American Psychologist*, 63(9), 852-862.

2 Fowler, T., Lifford, K., Shelton, K., Rice, F., Thapar, A., Neale, M.C., et al. (2007). Exploring the relationship between genetic and environmental influences on initiation and progression of substance use. *Addition,* 102, 413-422.

3 Dishion, T. J., McCord, J., & Poulin, F. (1999). When interventions harm: Peer groups and problem behavior. *American Psychologist*, 54, 755-764.

4 http://safequalityschools.org/pages/clayton-county-ga

5 Clayton County Public Schools. (2007). Blue Ribbon Commission on School Discipline: A Written Report Presented to the Superintendent and Board of Education. Available at http://www.clayton.k12.ga.us/departments/studentservices/handbooks/BlueRibbonExecutiveReport.pdf.

6 www.ncmhjj.com

Research has consistently demonstrated that the vast majority of youth in contact with the juvenile justice system not only have diagnosable mental or substance use disorders, but that many meet criteria for both as well as trauma-related disorders[7,8,9]. The NCMHJJ has focused on developing, evaluating, and disseminating models of best practice and policy aimed at diverting children with mental and substance use disorders from the juvenile justice system at the earliest points of contact.

Mental disorders can alter the way children learn, behave, and develop ï all of which will have a profound effect on their life chances[10]. An estimated 14 to 20 percent of children in the United States are experiencing a mental disorder with some level of functional impairment each year[11], and approximately 11 percent of these children have significantly impaired functioning[12]. Unfortunately, less than half of these children receive treatment or have access to appropriate mental health services[13,14,15]. Not surprisingly, the school-to-prison pipeline captures a large number of children with underlying ï often undiagnosed and untreated ï mental and substance use disorders.

Too often, when children display disruptive behaviors in schools, authority figures respond without fully addressing the underlying problem. Many schools marginalize children with behavioral challenges through policies that disrupt their education, such as suspensions, expulsions, and even arrests.

A report from the American Psychological Association (APA) in 2008[16] concluded that zero tolerance policies have failed to improve school safety or student behavior, and have resulted in a disproportionate number of children with mental disorders ending up in the juvenile justice system. Zero tolerance policies have contributed to the overrepresentation of minorities involved in the juvenile justice system, and are disproportionately applied to students with special educational needs[17]. A recent study found that nearly three-quarters of students who qualified for special education services were suspended or expelled[18] and students identified as having an emotional disturbance were especially likely to be suspended or expelled. This same study also found that children who are suspended or expelled are more likely to become involved in the juvenile justice system in the subsequent year.

Focus on Youth with Unmet Mental Health Treatment Needs

Reflective of emerging trends, the John D. and Catherine T. MacArthur Foundation (ñMacArthur Foundationò) established the Models for Change initiative[19]. The goal of this initiative is to accelerate the reform of juvenile justice systems across the country by using the experiences of a select number of states and communities to help create sustainable, effective, and research-based reform models. Four states were initially selected to participate in this effortð Pennsylvania, Illinois, Louisiana, and Washington. These states were strategically chosen, using criteria such as leadership, commitment to change, geography, and opportunities for reform. In their effort to bring about juvenile justice reform, consistent concerns were raised by these four states regarding the growing crisis surrounding the large numbers of youth with mental disorders in the juvenile justice system, and the lack of policies and practices for effectively identifying and treating these youth.

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

8 Teplin, L.A., Abram, K.M., Washburn, J.J., Welty, L.J., Hershfield, J.A., & Dulcan, M.K. (2013). *The Northwestern Juvenile Project: Overview*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

9 Wasserman, G.A., McReynolds, L.S., Schwalbe, C.S., Keating, J.M., & Jones, S.A. (2010). Psychiatric disorder, comorbidity, and suicidal behavior in juvenile justice youth. *Criminal Justice and Behavior, 37*(12), 1361-1376.

10 Breslau, J.; Lane, M.; Sampson, N.; Kessler, R. C. 2008. Mental Disorders and Subsequent Educational Attainment in a US National Sample. *Journal or Psychiatric Research,* 42, 708-716.

11 O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. National Academies Press.

12 Anglin, T. M. (2002). Mental health in schools. Handbook of School Mental Health: Advancing Practice and Research, *Issues in Clinical Child Psychology,* 89-106.

13 Green, J. G., McLaughlin, K. A., Alegría, M., Costello, E. J., Gruber, M. J., Hoagwood, K., & Kessler, R. C. (2013). School mental health resources and adolescent mental health service use. *Journal of the American Academy of Child & Adolescent Psychiatry*, 52(5), 501-510.

14 Greenberg, M., Weissberg, R., OÕBrien, M., Zins, J. E., Fredericks, L., Resnik, H., & Elias, M. J. (2003). Enhancing school-based prevention and youth development through coordinated social, emotional, and academic learning. *American Psychologist*, 58(6/7), 466-474.

15 Merikangas K. R., He J. P., Brody D., Fisher P. W., Bourdon K., & Koretz D. S. (2010) Prevalence and treatment of mental disorders among US children in the 2001ï 2004 NHANES. *Pediatrics*. 125(1), 75ï 81.

16 American Psychological Association Zero Tolerance Task Force. (2008). Are zero tolerance policies effective in the schools?: An evidentiary review and recommendations. *American Psychologist*, 63(9), 852-862.

17 Skiba, R. J., Michael, R. S., Nardo, A. C., & Peterson, R. (2002). The color of discipline: Sources of racial and gender disproportionality in school punishment. *Urban Review*, 34, 317ï 342.

18 Fabelo, T., Thompson, M.D., Plotkin, M., Carmichael, D., Marchbanks III, M.P., & Booth, E. A. (2011). *Breaking Schools' Rules: A Statewide Study of How School Discipline Relates to Students' Success and Juvenile Justice Involvement*. The Council of State Governments Justice Center: New York, NY.

19 www.modelsforchange.net

In response, the Mental Health/Juvenile Justice Action Network was created to develop, test, and disseminate best practices to address these concerns. Four additional statesð Colorado, Connecticut, Ohio, and Texasð were selected to join the effort. The goal of the Action Network was to work with the eight states to establish a leadership community of states at the forefront of mental health and juvenile justice reform that would collaboratively develop, implement, and evaluate new models and strategies for addressing common problems that could be sustained, expanded, and replicated in other jurisdictions. The NCMHJJ led and coordinated this Action Network.

Teams from each of the eight states participating in the Action Network identified diversionð specifically, the need to create more opportunities for youth with mental health needs to be appropriately diverted to community-based services and supports at the earliest points of contact with the juvenile justice system. Three key contact points were chosen ï schools, probation-intake and law enforcement. Working under the leadership of the NCMHJJ, two states ï Connecticut and Ohio ï focused specifically on stemming the flow of children with mental disorders from schools into the juvenile justice system. Based on existing knowledge and expertise, the approach developed was the School Responder Model (SRM)[20]. This program model is based on *WrapAround* Milwaukeeõs Mobile Urgent Treatment Team Model[21] (MUTT), which at its core, uses mental health clinicians/practitioners to respond to school-based incidents involving youth with a suspected mental disorder who are at risk of referral to juvenile court or to the police. The core components of the SRM are:

- Collaboration among schools, law enforcement, courts and behavioral health. Cross-systems coordination and collaboration, built around a common vision statement for reform efforts are critical to the overall success of the program.
- Cross-systems training. Training for all school staff on the signs and symptoms of mental, substance use, and trauma disorders is key, as is providing cross-systems training on the diversion model so that all collaborators ï schools, law enforcement, and behavioral health providers ï know each otherõs roles and responsibilities.
- Availability of a ñresponderò able to provide timely assistance. For diversion to work, school personnel must have access to an alternative to law enforcement that can provide a timely crisis or behavioral health response.
- Cooperative agreements with community-based behavioral health service providers. Beyond having a ñresponderò to address the immediate crisis, children and their families must have access to community services and supports. To facilitate referrals, schools and behavioral health services providers should enter into agreements that prescribe how referrals will be made and handled.
- Establishment of revised school protocols to replace zero tolerance policies. In order for school personnel to respond differently, policies and procedures must be revised to allow for a mental health response rather than a punitive response to children acting out in schools.

Implementing the School Responder Model

The SRM specifically target children who have come to the attention of school disciplinary staff, such as administrators and school resource officers. The problem might be one or more specific incidents involving disruptive or threatening behavior, such as bullying or fighting, or an ongoing problem like chronic tardiness or truancy. Instead of referring a youth to law enforcement officials, responders work with school personnel to help better identify mental health needs in students, and to link children and their families with treatment and case management services. Strong linkages between the schools and the mental health system, as well as training and support for school staff on how to recognize the signs and symptoms of mental illness among youth, create a new ñprocessò for responding to these youth. Both Connecticut and Ohio implemented school responder programs with this core structure, with only minor variations to allow for local circumstances and accommodations for structural differences.

Connecticut. Connecticut created their SRM, known as the School-Based Diversion Initiative (SBDI), to provide mental health crisis teams in schools. The goal of SBDI is to build capacity and skills among teachers and school staff to recognize and manage mental health crises in the schools instead of contacting the police. The local Emergency Mobile Psychiatric Services team (EMPS) serves as the ñresponderò to calls from the schools and provides in-school crisis stabilization, brief intervention, and referral and linkage to ongoing services and supports. SBDI offers school personnel a high level of training, both in adolescent mental health and behavior and in understanding and accessing local resources. The program also works with the schools to help them develop more effective disciplinary policies.

[20] Weiss, G. & Skowyra, K. (2013). *Schools turn to treatment, not punishment, for children with mental health needs*. Chicago, IL: John. D. and Catherine T. MacArthur Foundation, Models for Change.

[21] http://wraparoundmke.com/programs/mutt/

SBDI has been collecting data that allows them to assess changes in rates of arrest, suspension, expulsion, and referral to EMPS. Among the findings: EMPS use in SBDI sites increased by 64 percent in 2012-2013, a rate that is eight times higher than the statewide average; school-based court referrals are down 29 percent on average since program inception, with some schools demonstrating reductions as high as 92 percent from the year prior to implementation; and analyses indicate that over time, children initially served by EMPS are less likely to experience subsequent court referrals compared to students who initially experience a court referral[22]. These differences remain significant even when controlling for age, gender, race/ethnicity, and prior court referrals.

Ohio. Ohio created their SRM, known as the Responder Program, to promote early intervention, improve school attendance and performance, and to divert children with mental disorders out of the juvenile justice system to appropriate, community-based mental health services. Responders, based out of the Juvenile Courtôs Family Resource Center in Summit County, answer calls from the schools concerning incidences involving students believed to have unmet mental health needs and whose behavior puts them at risk for referral to the juvenile justice system. A team approach that brings in relevant school staff and any providers already serving the child is used. Working with the team, the Responder provides in-school intervention services and case management. They conduct mental health screens, arrange for full assessments when needed, and work with families to develop a service plan and link them to community resources. The Responder Program also works with Mental Health America to provide parent peers who support and advocate for families referred to the program.

During the 2011-13, 124 youth were referred by the school to the program[23]. Results of the MAYSI-2[24], a research-based mental health screening tool, was used to screen the youth for mental disorders. Based on results from the diagnostic assessment, nearly 90 percent of the students were linked to local mental health providers. Nearly two-thirds of the participants had no involvement with the juvenile court in the year following their referral into the Responder Program.

To help ensure the success of the program, school personnel receive training in how the program works, the types of behaviors that might indicate mental disorders in children, and how to make referrals to the Responder Program. Feedback from schools, parents, and the juvenile court has been overwhelmingly positive, and the Responder Program has expanded steadily. The program now reaches 15 schools, including three elementary schools, nine middle schools, and three high schools in Summit County.

Sustainability and Diffusion of School-Based Diversion

The school-based diversion programs have proven to be very helpful and effective in both Connecticut and Ohio, across a variety of urban, suburban, and rural communities. These programs were begun with a relatively small amount of seed money, and over a short period of time ï about three years ï both states have shown they can sustain and grow their programs and find independent sources of funding.

Although research is continuing to assess how school-based diversion is changing the long-term outlook for children and families, some general statements about the value of the programs can be made. Both states have:

- Reduced school-based arrests and subsequent court referrals
- Increased mental health and related services for children and families.
- Established good working partnerships among schools, service providers, law enforcement, and the juvenile justice system.
- Demonstrated success in introducing school staff to the model and helping them to feel comfortable with it.
- Shown that professionals and the public see value in and are willing to support effective strategies that increase access to needed mental health services while also decreasing the unnecessary involvement of youth in the juvenile justice system.

These findings have led to the expansion of the SRM within both states. In Connecticut, a partnership among four state agencies ï the State Department of Education, the Department of Children and Families, the Court Support Services Division of the stateôs Judicial Branch, and the Department of Mental Health and Addiction Services ï has not only sustained this program in the original three schools but has supported the programôs expansion into 21 schools in 10 districts. In 2015, Connecticutôs Governor was successful in adding $1 million for each of the next 2 years in the stateôs budget to provide ongoing support for the School-Based Diversion Initiative. This funding will allow for expansion of the program- with the goal to reach an additional 40 to 50 schools over the next two years and support expanded evaluation activities.

[22] Bracey, J. & Vanderploeg, J. (2013). Annual Report 2012-13: Hartford Public Schools, Waterbury Public Schools, and New Britain High School. Child Health and Development Institute: Farmington CT.

[23] Kretschmar, J. (2014). Personal communication.

[24] See Prof K Schmeck, Chronicle July 2015 p35 Editor

The Child Health and Development Institute of Connecticut (CHDI), responsible for overseeing the program, has developed a comprehensive school training curriculum and an SBDI manual to guide project replication and dissemination throughout the state.

In Summit County, Ohio, following the initial grant, the program has been sustained by a combination of state and local funding. The Family Resource Center of the Juvenile Court has helped to support its continuation. To guide replication and dissemination, a School Responder program manual was developed and is widely available for download. Jackson County, Ohio successfully replicated the model, as Teen Talk, which provides responders for grades 6-12. Teen Talk now reaches all schools in the county. Its success led one of the few mental health providers in the county to expand its small satellite clinic into a full-scale behavioral health clinic. This clinic is now the official responder for Teen Talk and is committed to supporting and expanding the program.

Since 2011, with joint funding from the MacArthur Foundation and the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the NCMHJJ has coordinated an effort to further disseminate diversion policies and programs for youth in contact with the juvenile justice system with behavioral health disorders. Sixteen states have been competitively selected to participate in this initiative. Six of these states have focused on expanding school-based diversion opportunities ï Minnesota, Nevada, New York, South Carolina, West Virginia, and Wisconsin. Given the process by which the SRM was developed ï multiple states working together to identify core components of an effective school-based strategy, while allowing flexibility to account for local and regional differences ï initial replication efforts look to be successful. In fiscal year 2016-17, the Minnesota Governorôs budget included funding to support both implementation and evaluation of the model throughout the state. The roll-out of this model represents a unique collaboration between Minnesotaôs Department of Human Services Childrenôs Mental Health division, the Minnesota Chiefs of Police Association, and select schools, local law enforcement, and the county attorneyôs office. This new approach is ñdesigned to assist schools and their partners to become more selective about making referrals to the juvenile justice system and develop school-and community-based alternatives for addressing student behavioral incidentsò (budget doc March 2015).

This drive to reduce the flow of youth through the school to prison pipeline is also being addressed at the national level. Three federal agencies, the federal Office of Juvenile Justice and Delinquency Prevention (OJJDP), Department of Education, and SAMHSA entered into a partnership to ñenhance collaboration and coordination among schools, mental and behavioral health specialists, law enforcement and juvenile justice officials at the local level to ensure adults have the support, training, and a shared framework to help students succeed in school and prevent negative outcomes for youth and communitiesò[25]. Their joint efforts culminated with the funding of a project entitled ñSchool Justice Partnership Project: Keeping Kids in School and Out of Court.ò This project is being coordinated by the National Council of Juvenile and Family Court Judges (NCJFCJ)[26]. The NCMHJJ is one of the key partners in this initiative. Through this project, jurisdictions around the country will have the opportunity to replicate models with demonstrated evidence for better responding to children with unmet mental health needs, including the SRM.

Lessons Learned

There are a number of critical lessons from these school-based diversion efforts that can be capitalized on by other jurisdictions seeking to implement reforms to stem the flow of children with behavioral problems from schools to the juvenile justice system.

1) Collaboration is a critical component to any effort aimed at addressing the school-to-prison pipeline. Not only must there be meaningful involvement of education, behavioral health providers, law enforcement and the juvenile justice system but all must share a common vision and understanding of the work.

2) Cross-systems training on the need for an alternative response as well as on adolescent development, mental and substance use disorders, trauma, and crisis response techniques must be provided. It is just as critical that all school personnel receive additional training on how to recognize mental health needs among children, how to respond appropriately to a child in crisis, and who to call for additional support.

3) Diversion policies and protocols should be put in a manual to guide the response in a uniform manner when a child is identified as in need, to increase the likelihood for sustainability within a community when staff turnover occurs, and to support replication in other jurisdictions seeking to address the same issue. Additionally, stakeholders should enter into formal agreements that specify who is eligible for diversion and how the process will work.

[25] https://schooljusticepartnership.org/about-the-project

[26] Judge David Stucki, past president of NCJFCJ is a Council member of IAYFJM Editor

4) For any alternative response to be used by school personnel, a ñresponderò must be able to provide timely assistance. School personnel recognize that law enforcement will always respond and, depending on the severity of the situation, will respond quickly when called. A mental health response must be just as reliable and should aim to provide support to school staff within a reasonable and agreed upon period of time.

5) Data must be collected and analyzed on a routine basis to evaluate the program effectiveness at achieving the stated goals. This will not only allow for ongoing adjustments to the model in order to increase overall effectiveness, but will provide the necessary support to advocate for ongoing resources to maintain and replicate school-based diversion efforts.

The efforts in Connecticut and Ohio, as well as in new states, demonstrate that a mental health response to disruptive behaviors in schools by children can disrupt the school-to-prison pipeline. By diverting these children from the juvenile justice system to community-based services and supports, these communities are improving the lives of children with mental and substance use disorders by providing a link and access to necessary treatment while maintaining continuity of educational services that are ultimately necessary for them to live healthy and productive lives

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