Mental Health / Juvenile Justice

ActionNetwork

A Project of ModelsforChange

School-Based Diversion: Strategic Innovations from the Mental Health/Juvenile Justice Action Network

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Background

The majority of youth involved with the juvenile justice system have a diagnosable mental disorder. A recent study found that 70% of youth involved with the juvenile justice system met criteria for a mental disorder, over 50% met criteria for multiple disorders, and almost 30% are experiencing disorders so severe that their ability to function is highly impaired (Shufelt & Cocozza, 2006). Their illnesses include major depression, bipolar disorder, conduct disorder, attention deficit/hyperactivity disorder, anxiety disorder and other potentially debilitating conditions (Skowyra & Cocozza, 2006). Many of these youth also have education-related disabilities (Burrell & Warboys, 2000), are marginally literate or illiterate, and have frequently experienced school failure and grade retention (Center on Crime, Communities and Culture, 1997).

Schools are a primary source of referrals to the juvenile justice system, and frequently refer disruptive or unruly youth to the police or to juvenile court. It is recognized that a youth's acting out behavior is often the result or a symptom of a mental health need that has gone undiagnosed or untreated (Skowyra and Cocozza, 2006). Further, many of these referrals involve students with special education needs whose behavior is related to their disability (Lynagh & Mancuso, 2004). In recent years, the number of school to justice referrals has steadily increased due to schools referring students for the type of behaviors that in the past had been handled by school administrators (Rimer, 2004). Zero-tolerance policies, which were originally designed to target the most serious offenses, have been broadened in many communities to punish youth for even the most minor of offenses (National Council on Crime and Delinquency).

Schools, lacking the resources to appropriately respond to these youth and operating under the pressure of school safety policies, often find it easier to refer youth to juvenile court than to address the underlying reasons for the misbehavior. This confluence of trends has resulted in schools becoming much more restrictive and punitive, funneling greater numbers of youth with mental health and other disabilities into the juvenile justice system (Mears and Aron, 2003).
Mental health experts have long contended that it is preferable to treat children and youth with emotional problems in community settings, outside of the correctional system (Koppleman, 2005). Further, it is critical that these youth remain in school and continue their education, with additional academic supports provided as necessary to keep them engaged and on grade level.

Models for Change Mental Health/Juvenile Justice Action Network

Responding to this need, the Mental Health/Juvenile Justice Action Network, part of Models for Change and supported by the John D. and Catherine T. MacArthur Foundation, decided to take on the issue of mental health diversion. The Action Network is a partnership of eight states working together to improve services and policies for youth with mental health needs involved with the juvenile justice system. These states, which include Colorado, Connecticut, Illinois,

Louisiana, Ohio, Pennsylvania, Texas and Washington, focused their first year efforts on creating more opportunities for youth with mental health needs to be appropriately diverted to community-based treatment at their earliest points of contact with the juvenile justice system. Each state selected where they wanted to focus their mental health diversion efforts- Texas selected probation intake; Colorado, Louisiana and Pennsylvania selected law enforcement; and Connecticut, Illinois, Ohio, and Washington selected schools.

School-Based Responder Model

The four participating states (Connecticut, Illinois, Ohio and Washington) developed school-based diversion initiatives that target youth with mental health needs who are at risk of involvement with the juvenile justice system. Each state has developed a program model that is based on WrapAround Milwaukee's Mobile Urgent Treatment Team Model (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. These "responders" work with school personnel to help them better identify potential mental health issues in children in schools, as well as with referred youth and their families to link them with necessary 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 "process" for responding to these youth. Each of the states designed a school-based diversion model that shares this core structure, but with enough flexibility to ensure that local circumstances and structural differences can be taken into account. Below is a summary of each state's school diversion program.

Connecticut created their School-Based Diversion Initiative (SBDI) to provide mental health crisis teams in three middle schools within two school districts- Bridgeport and Southington. They recently expanded to serve two additional school districts- East Hartford and Meriden. The goal of SBDI is to build capacity and skills among teachers and school staff to recognize and manage behavioral health crises in the schools instead of contacting the police. In each site, the local Emergency Mobile Psychiatric Services Provider (EMPSP) serves as the responder to calls in the schools, and provides in-school crisis stabilization services and follow-up case management services. They developed a standardized training curriculum on the principles of WrapAround, crisis de-escalation and community referral sources, and delivered this training to school personnel starting in 2009. They also completed an SBDI manual to guide project replication and dissemination throughout the state. A recently completed evaluation, which assessed the impact of SBDI in the initial demonstration sites compared to two comparable non-SBDI sites found:

- A significantly greater percentage of youth referred from the SBDI schools met criteria for a Serious Emotional Disturbance (SED) than non-SBDI schools and ;
- The SBDI schools referred a greater proportion of youth with trauma histories than non-SBDI schools.

The CT Judicial Branch Court Support Services Division (CSSD) has agreed to continue funding the SBDI project through June 30, 2011. The Connecticut Center for Effective Practice (CCEP), which was hired by the CSSD to coordinate this project, has been funded to continue to publish and disseminate the program materials to school districts across the state, as well as continue to provide training to interested school districts. In addition, a collaborative relationship between the state departments of Education, Children and Families, the courts, CCEP and the Connecticut Juvenile Justice Alliance has been established to develop a funding plan for the expansion of SBDI into additional school districts and to submit a proposal to key state legislators interested in supporting school-based court diversion initiatives.

Ohio implemented their program in two counties. Summit County began their program in January 2009 in two middle schools in Akron, using a Responder based out of the Family Resource Center to respond to calls from the two middle schools concerning incidences involving students who are believed to have mental health needs and whose behavior puts them at risk for referral to the juvenile justice system. The family is contacted, an assessment performed and if mental health treatment is needed, an intervention plan is developed. The Responder continues to follow the youth and family for the remainder of the school year. If the event that brought the child to the attention of the Responder was one where charges could have immediately been filed by the school, compliance with the treatment and intervention plan will prevent the filing of the charge. Parent peers from Ohio Mental Health America work with families referred to the program.

Recently, Summit County expanded their responder program from three middle schools with a single responder to a total of 12 schools with four responders. They have developed a program manual and training materials to promote the replication of the model in other school districts in the state. The Summit County Juvenile Court has committed to sustaining the program and has secured funding (a combination of TANF and general funds) to continue operation in all of the current schools.

Jackson County, Ohio piloted their program in a middle and high school in the Jackson school district. Since then, they have expanded the program to serve the remaining two school districts in the county and are now operating the program- Teen Talk- in eleven school buildings in the county. The responders, working directly out of the school, coordinate the program and accept referrals. The biggest accomplishment in this small, rural community was using the success of the initial pilot to convince the operator of one of the few behavioral health care providers in the county to expand its satellite clinic to a full scale behavioral health clinic, which they did in October 2009. Tri-County Mental Health and Counseling Services, Inc. now serves as the responder to all participating schools in the county and has committed to continuing to support and expand the responder program going forward.

Illinois consulted with representatives from the other participating states on the design of their demonstration project before selecting Morton High school in the Cicero neighborhood of Chicago. They formed a school-based diversion committee that included school representatives, service providers, the police, and Action Network representatives, selected

their responder agency, and hired a Family and Community Liaison to serve as the responder. Referrals to the program began in January 2010.

After a successful effort to plan and create the program in a high school, the program was discontinued after nine months of implementation. There were multiple reasons cited for this decision:

- While school officials were supportive of the pilot in the planning phase, once the pilot began the principal became less engaged and appointed a teacher with little knowledge about adolescent mental health to oversee the project.
- The principal's lack of support and involvement with the program appeared to undermine the credibility of the program. It is speculated that the principal's diminishing interest in the pilot resulted from the school's extreme budget crisis which arose immediately after the pilot began.
- The responder spent the majority of time trying to respond to individual youth situations and was unable to complete tasks associated with staff training, relationship development and program planning.

Washington identified three middle schools within the Pasco School district to implement this initiative as a way to reduce school referrals to juvenile court. They contracted with 3 Rivers Wraparound, a community mental health services provider that provides traditional wraparound care to youth and families in the community, to serve as the point of contact and intervention for referrals from the school. A bilingual Care Coordinator from 3 Rivers works with the referred youth and family to reengage the student in school and access needed services in the community. 3 Rivers provided training to school staff on the project as well as specialized training on engaging families and youth with mental health needs. The program was fully implemented in the 2009-2010 school year and served 21 youth and families. A proposal for continued program support was submitted by 3 Rivers WrapAround to the United Way Foundation in 2010 but was not funded. However, the model developed from this SIG project is being shared with other communities in Washington interested in developing early intervention truancy programs as well as juvenile justice diversion programs for youth with mental health needs.

Summary

The MH/JJ Action Network focused its initial efforts on the development of front-end diversion strategies for youth with mental health needs. Connecticut, Ohio, Illinois and Washington, recognizing the large number of youth with mental health and other needs being referred to the juvenile justice system directly from the schools, worked to create school-based diversion programs, based on the successful Wraparound Milwaukee MUTT program. These programs use mental health responders to target youth with a suspected mental health need who are at risk of referral to the police or to juvenile court, and link that youth (and their family) with needed service to allow the youth to stay in school and out of trouble. Program manuals, to guide replication of the model, have been developed in CT and OH.

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