

MENTALLY ILL JUVENILES IN LOCAL CUSTODY

ISSUES AND ANALYSIS

JUNE, 2011

A RESOURCE PAPER DEVELOPED BY
THE CALIFORNIA CORRECTIONS STANDARDS
AUTHORITY (CSA)

AT THE REQUEST OF
THE CALIFORNIA
DEPARTMENT OF CORRECTIONS AND REHABILITATION (CDCR)
COUNCIL ON MENTALLY ILL OFFENDERS (COMIO)

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EXECUTIVE SUMMARY

In 2009, CDCR's Council on Mentally Ill Offenders (COMIO) asked the Corrections Standards Authority (CSA) to produce a pair of 'white papers,' one discussing key issues and best practices related to the growing population of mentally ill people in jails and the other addressing similar topics related to mentally ill youth in local juvenile facilities. The first paper, "Jails and the Mentally Ill: Issues and Analysis," was released in September 2009. This second paper, "Mentally Ill Juveniles in Local Custody: Issues and Analysis," deals with the wide ranging and complex mental health considerations facing local juvenile halls, camps and ranches charged with the care of juvenile offenders.

To accomplish the second half of its charge from COMIO, and to continue its leadership in facilitating local corrections practice, CSA convened the Mentally Ill Juveniles in Local Custody Work Group. Comprised of local juvenile justice, judicial, health and mental health personnel and including representatives from the California Association of Probation Institution Administrators (CAPIA), the Chief Probation Officers of California (CPOC) and CDCR's Division of Juvenile Justice (DJJ), the Work Group endeavored to describe existing best practices and promising strategies in use in local juvenile corrections facilities as well as innovations being developed in these facilities for effectively dealing with offenders with mental health problems.

While the primary goal of this paper was to focus on custody-related issues, the Work Group felt it important to also address systemic and structural concerns as well as such non-custody matters as reentry, post-custody supervision, the need for more appropriate community and treatment placements, family involvement and continuity of care. Because local juvenile corrections is moving toward more comprehensive, collaborative, evidence based, client and family centered systems of care, the Work Group opted to address issues related to this emerging culture change, in addition to specific, facility related practices and considerations.

If one idea or theme were to be singled out as most vitally important to the delivery of appropriate mental health services for youth in the juvenile justice system that theme would be collaboration. It is clear that the responsibility for youth in custody who have mental health problems is shared among multiple agencies and individuals. Courts, custody, health and mental health staff, substance abuse, school and social services / child welfare personnel all have important roles to play, as do family members and community support providers. No one agency has all the answers or all the best approaches. Mentally ill youth in custody present complex, multi-layered problems which demand collaborative, multi-agency solutions.

One of the collaborative methods stressed throughout the paper is the use of multi-disciplinary teams. Such teams are recommended for assessment, service design and delivery, reentry planning and aftercare, among other functions. Information sharing among members of such teams is strongly recommended, as is information sharing between and among agencies, including the courts. The Work Group emphasizes that information sharing is essential to plan for and provide the most appropriate services to youth in custody, those transitioning out of custody and those in reentry / aftercare.

Also important is determining and documenting what programs and interventions are effective with specific populations of youth in custody. Gathering data about what works and what does not for various kinds of mental health and behavioral problems is vital to enable agencies to sustain effective programs and strategies, expand those that work and eliminate those that do not. Regular process evaluations and outcome studies position agencies to sustain system successes, as well as compete effectively for limited grant and other resources. Agencies are encouraged, not only to do good work, but also to document what is achieved with whom under what circumstances, so as to both sustain effective approaches and enable others to replicate their successes.

The paper's final recommendation speaks to budgetary and funding concerns and acknowledges the extreme difficulties correctional agencies experience as they are continually asked to do more with less. Juvenile halls, camps, ranches and probation departments in general have been remarkably adaptive in implementing evidence based practices and attempting to design cost effective strategies for serving the youth in their care. The Work Group urges probation agencies to continue trying to break down existing silos and encourage its partner agencies to blend money to accomplish the treatment and service goals which generate positive outcomes and thereby enhance public safety.

The paper discusses a number of approaches, interventions and programs in use in local juvenile corrections facilities and systems across California. Some of these are common practice; others may be more or less unique to specific jurisdictions. The paper's goal is to help facility personnel exchange information with and learn from one another and to widen the perspective that each practitioner brings to the difficult work of providing appropriate care to mentally ill juvenile offenders in custody. This paper is also intended to help juvenile correctional and mental health personnel share ideas, resources and strategies and to further dialogue among local juvenile justice systems' multiple key players. It is the Work Group's hope that the ideas presented here will foster continued efforts to seek innovative and collaborative ways to provide needed services to youth and families in the juvenile justice system.

I. INTRODUCTION

In 2009, CDCR's Council on Mentally Ill Offenders (COMIO) asked the Corrections Standards Authority (CSA) to produce a pair of 'white papers' – one discussing key issues and best practices related to the growing population of mentally ill people in jails and the other addressing similar topics related to mentally ill youth in local juvenile halls, camps and ranches. The first paper, "Jails and the Mentally Ill: Issues and Analysis," was released in September 2009. It is reportedly being used by COMIO, CSA, the California State Sheriffs Association (CSSA) and jail managers statewide as an information resource to further interagency communication and collaboration as well as programming for and management of jail inmates with mental illness. CSA has been advised additionally that CDCR is using the paper to inform its interactions with the Legislature regarding potential realignment.

In March 2011, to accomplish the second half of its charge from COMIO and continue its leadership in facilitating local corrections practice, CSA convened the Mentally Ill Juveniles in Local Custody Work Group. Comprised of local juvenile justice, judicial, health and mental health personnel the Work Group met in Sacramento for two days of discussion focused on gathering the field's best thinking about the increasingly complex issues surrounding mentally ill youth in local custody.

As with the Jails paper, this effort has multiple goals. It is intended to help juvenile corrections personnel share ideas, resources, successes and strategies. It seeks to further dialogue among key players – courts; probation departments, with particular emphasis on their juvenile facilities and/or custody divisions; medical and mental health agencies and service providers; children's services agencies; and CDCR's Division of Juvenile Justice (DJJ).

While juvenile halls, camps and ranches are the major focus of this paper and were the primary areas of the Work Group's discussion, it is clear and critical that transitions into and out of custody (i.e. intake, reentry, post custody supervision, etc.) are intrinsically

related to the delivery of mental health services to juveniles in local custody. Even though the goal was to focus on custody-related issues, the discussion, and this paper, found it necessary to also address such non-custody matters as the need for more appropriate community and treatment placements, family involvement, and continuity of care.

Prior to meeting, members of the Work Group were asked to identify what they considered the most important topics for the group to discuss in order to fully identify issues, share experiences, and recommend potential strategies for effectively managing mentally ill juveniles in local custody. Discussion of the resulting extensive list of agenda topics¹ yielded a wealth of information, which this paper seeks to summarize for the field.

Given the extraordinary fiscal limitations with which correctional, mental health and other human service agencies must contend, the Work Group focused on ways to maximize existing resources and employ cost effective, as well as programmatically effective, proven interventions. It looked at furthering development of cohesive and sustainable systems through collaboration, data collection and ongoing evaluation. It sought to identify best and evidence based practices, emerging interventions, programmatic or operational successes and promising innovations departments may have tested that they could share with other agencies.

This paper seeks to describe as many of these ways of ‘working smarter’ and as many of the key issues as possible. It seeks to share the wealth of information the Work Group provided so as to support local juvenile justice facilities and personnel facing the multiple, ongoing challenges inherent in managing mentally ill youth in local custody at this time of significant change.

¹ The Work Group’s agenda topics are attached as Appendix I.

II. WHAT HAS COME BEFORE

The current paper is nowhere near the first effort to address issues related to mentally ill youth in the juvenile justice system. A comprehensive bibliography of documents wrestling with these matters (which is way beyond the scope of this project) would be many pages long and would prove beyond a doubt that the issues are complex and long standing, that they have been addressed by a host of agencies from a variety of perspectives and with a range of orientations, and that they require ongoing attention, patience, perseverance, and collaboration to be dealt with effectively.

California has been working on these issues for a very long time. Note, for example, a 2001 report by the Little Hoover Commission entitled Young Hearts and Minds: Making a Commitment to Children's Mental Health. Among other key points, that document says:

A core group of children in California are burdened with the greatest troubles. ... These children – often in foster care or juvenile justice facilities – place an enormous demand on limited public resources. They are often a threat to themselves, their families or the public at large. And problems that are not resolved in their childhood influence their actions as adults. ... Estimates suggest nearly all children in juvenile detention programs have mental health needs ... [and] research suggests that 80 percent of adolescent substance abusers have multiple mental health needs, with some evidence that mental disorders predate and contribute to their initial drug use. The prevalence of mental illness in the general population is roughly 10 percent. For children in the juvenile justice system, that rate jumps to 50 to 90 per cent.

Inadequate mental health treatment has led to higher juvenile justice costs and more children failing in school. ... A legislatively mandated study calculated that providing mental health services to all children in juvenile justice and foster care programs would cost California an additional \$100 million to \$300 million. Unfortunately, the report does not estimate what it will cost communities, neighborhoods and the State if those services are not provided.²

² Little Hoover Commission, Young Hearts and Minds: Making a Commitment to Children's Mental Health, October 2001, pages 27, 30, and 33

In addition to the Little Hoover Commission, such agencies as the Cathie Wright Center for Technical Assistance to Children's Systems of Care (CWTAC), have studied and addressed key mental health problems facing youth in the justice system. A series of CWTAC guides and updates can be found at the California Institute for Mental Health web site, www.cimh.org.

Many of the CWTAC documents as well as Little Hoover Commission and other reports call for reforming services and creating a comprehensive and coordinated system of mental health care for children. Critical steps have been accomplished in this regard, often against formidable odds. It is essential to maintain those successes and build on them. At the same time, it is important to acknowledge that the complexity of the issues and the facts of economic downturns, shifting policy priorities and divided public attitudes make the development and maintenance of a comprehensive continuum of care for mentally ill juveniles in the justice system a long-term project requiring collaborative and multi-faceted strategies in every county and every facility in the state.

This point is addressed in a more recent study of interest, the Juvenile Delinquency Court Assessment, 2008, conducted by the Administrative Office of the Courts, Center for Families, Children and the Courts. This study was intended to "help improve both the administration of justice and the lives of youth, victims and other community members affected by the delinquency system by helping set an agenda for system improvements over the coming years."³ In its extensive review of issues facing delinquency courts, the document reports "especially high levels of dissatisfaction" among probation officers, prosecutors and defense counsel with the availability and quality of mental health services, saying that "the dearth of appropriate mental health services is one of the juvenile justice system's most significant problems."⁴

To correct these deficits, the report calls for "additional efforts to ensure that youth receive appropriate, individualized sanctions as well as the services, guidance and

³ Administrative Office of the Courts, Center for Families, Children & the Courts, Juvenile Delinquency Court Assessment 2008, Volume 1, April 2008, page 1

⁴ *Ibid.*, page 51

support that are in the youth's best interest while meeting the goals of public safety and victim restoration." Further, the report recommends that "the courts and probation comprehensively examine and address all aspects of the needs of youth with mental health issues who are involved in the delinquency system."⁵

The courts have continued to work on these challenges through the AOC's Task Force for Criminal Justice Collaboration on Mental Health Issues. That Task Force is seeking to improve "the response of the criminal justice system for mentally ill offenders by promoting inter-branch collaboration at the state level and interagency collaboration at the local level." It also seeks to improve "practices and procedures in cases involving mentally ill offenders, ensure the fair and expeditious administration of justice, and promote improved access to treatment for litigants in the criminal justice system."⁶ The Task Force expects to release its report in May 2011. Members of the Juveniles in Local Custody Work Group, who also participated on the AOC Task Force, advise that the AOC discussions were similar to – and the recommendations will be consistent with – what is covered in this paper.

While probation agencies have made significant efforts to enhance services to mentally ill youth in the justice system, many critical concerns remain. A 2007-08 study by the Chief Probation Officers of California (CPOC), in conjunction with the California Mental Health Directors Association (CMHDA), highlights the assessment instruments and evidence based and promising programs that have been, and continue to be, introduced and evaluated in a number of county juvenile justice systems. It also describes a great deal of work still to be done.

That study's final report, Costs of Incarcerating Youth with Mental Illness,⁷ seeks to inform public policy development and to

⁵ Ibid., pages 54- 55

⁶ <http://www.courts.ca.gov/xbcr/cc/crimjust-mentalhealth-factsheet.pdf>

⁷ Edward Cohen and Jane Pfeifer, "Costs of Incarcerating Youth with Mental Illness Final Report" prepared for the Chief Probation Officers of California and the California Mental Health Directors Association, 2008, CPOC website, www.cpoc.org,

... advocate for better services in order to prevent the inappropriate criminalization of youth who would be better served in mental health treatment settings, to improve services to youth who must be separated from the community, and to ensure continuity of mental health care upon re-entry of such youth to their communities.⁸

The report also notes there continues to be a significant need for standardization, consistent policy development and comprehensive interagency communication. This paper seeks, among other things, to continue the discussion about those concerns.

One of the “*Costs*” study’s most significant – even if not surprising – findings is that youth with mental health problems stay in custody longer than other minors and severely strain facility resources and facility staff. The report says:

Youth with mental illness experience longer lengths of stay in detention facilities primarily due to placement delays and gaps in community services. The burden on facilities is high as these youth continue to require extraordinary resources to maintain them in an environment that was not originally intended to provide an appropriate treatment response. ... Facilities have made adaptations in order to respond to the increasing numbers of youth with suspected or diagnosed mental disorders. There is recognition that a majority of youth require some mental health-related intervention along a continuum of need, ranging from those youth who have serious and disabling symptoms to those who are experiencing temporary adjustment problems or a post-traumatic response as a result of life circumstances prior to confinement or as a result of the confinement experience itself. ... For most counties there are ... serious gaps in local, regional and statewide placement alternatives geared towards providing treatment for these youth. Those counties with improved local placement alternatives reported success in reducing admissions and lengths of stay in detention facilities. ... Funding fragmentation, philosophical differences, and resource limitations pose challenges to effective collaboration among probation, county mental health, and other local agencies. Youth are caught in the middle.⁹

The “*Costs*” report recommends a number of systemwide steps to improve service deliver, including:

⁸ CPOC Policy Brief # 2, “Policy Implications and Recommendations,” page 1, www.cpod.org

⁹ Ibid., pages 1 - 2

- Clarify criteria statewide for the use of mental health and substance abuse services so as to improve the quality of care and equity of the distribution of services among juvenile detainees.
- Develop and provide training to facility staff to improve conditions in facilities by increasing staff understanding of emotional disorders and reactions in youth, maximizing consistent communication among staff and providers, and maximizing the rehabilitative opportunities of these facilities to improve social functioning and prevent subsequent recidivism.
- Develop more transitional services (such as those being piloted by ...The California Endowment's *Healthy Returns Initiative*...) so that youth leaving detention facilities and their families are provided coordinated and integrated services by probation, formal agency services, and informal supports.
- Through state policy, encourage or require evidence of county agency coordination for these youth through regular forums such as interagency case review meetings and placement committees.
- Provide information and technical assistance to judges and court personnel to improve the coordination between the courts, agencies and facilities.
- Convene statewide and regional planning efforts to inventory gaps in residential and hospital alternatives, and develop recommendations for specific statewide, regional and local county alternatives.
- Make available more alternatives for [a full spectrum of] residential care alternatives covering the continuum of need.¹⁰

The Mentally Ill Juveniles in Local Custody Work Group corroborated the vital importance of these recommendations and supports their implementation.

The studies mentioned above are but a few of the indicators that, although progress is being made, many thorny and complicated problems still exist. Comprehensive solutions are not easy to come by, especially in the current financial climate. No one imagines that this paper presents final or definitive answers to all the questions nor that

¹⁰ Costs of Incarcerating Youth with Mental Illness, pages 2 - 4

it will solve the multiple problems facing local juvenile correctional facilities charged with holding and intervening appropriately with mentally ill youth. What it does seek to do is to keep the dialogue going, make some suggestions, and present some strategies that may assist facility administrators and policy makers in working with those juvenile offenders with mental health and developmental difficulties who are a growing percentage of the population of youth in local custody.

III. SYSTEM ISSUES

Kinds of Mental Health Problems of Youth in Custody: It is well documented that a majority of the youth entering juvenile halls have mental health problems and many have co-occurring mental health and substance abuse issues. In fact, facility personnel say it is uncommon to see mentally ill youth in local custody who are *not* also using some substance or substances. Trauma is also a big issue for probation youth, since most if not all have experienced critical incidents of one sort or another at some point in their lives.

The kinds of mental health problems juveniles bring with them into custody span a wide spectrum, including but surely not limited to: behavior disorders such as Attention Deficit Disorders (ADD) and Intermittent Explosive Disorder (IED); mood disorders such as Depression, Oppositional Defiant Disorder and Bipolar Disorder; anxiety and trauma related disorders such as Adjustment Disorders, Reactive Attachment Disorder and Post Traumatic Stress Disorder; psychotic disorders such as Schizophrenia; and developmental disabilities such as learning disabilities, mental retardation, organic brain disorder and autism. As noted above, many have co-occurring substance abuse issues as well. Their diagnoses often affect juveniles' ability to learn and consequently a youth may be in special education under various disability classifications such as: Specific Learning Disorder (SLD), Emotional Disturbance (ED), and Other Health Impairment (OHI). Managing these multiple mental health, substance abuse and learning issues while juveniles are in custody can be very challenging.

As was pointed out above, the prevalence of mental health disorders and cognitive disabilities is much greater for young people in the juvenile justice system than for those in the general population – 50 - 90% for youth in the justice system as compared to 10% for youth in the general population.¹¹ Moreover, there is

... a significantly higher prevalence of youth with cognitive disabilities in juvenile justice than in the general population. While the prevalence of mental retardation in the general school-age population is 1.61%, an analysis of research on juvenile offenders found that approximately 12.6% have mental retardation. ... Juvenile offenders also have a higher prevalence than the general school-age population of specific learning disabilities that may affect, among other things, cognitive tasks such as the “ability to listen, think speak, read, write, spell or do mathematical calculations.” Researchers have found that anywhere from seven percent to fifteen percent of students in the general population have specific learning disabilities, [while juvenile offenders have] a prevalence rate of 35.6%. Moreover, the percentage of young people in juvenile correctional facilities who were previously identified as having learning disabilities and served in special education programs before their incarceration is at least three to five times the percentage of the public school population identified as disabled.¹²

The breadth of mental health disorders confronting justice system youth demand that local custody facilities and their correctional, as well as mental health, personnel distinguish among conditions and apply specific approaches appropriate to each. Just as physical health isn't all one thing – we don't use the same medicine for a headache that we use for an upset stomach – mental health is similarly diverse and far reaching. There are a vast number of different mental health problems, and each requires a particular treatment or intervention.

In large part, the mental health interventions currently provided in local custody are geared toward, and get good outcomes with, behavioral problems, i.e., conduct disorder, oppositional defiant disorder and the like. However, correctional facilities

¹¹ Young Hearts and Minds: Making a Commitment to Children's Mental Health, page 27

¹² Sue Burrell, Corene Kendrick, Brian Blalock, “Incompetent Youth in California Juvenile Justice,” Stanford Law & Policy Review, Volume 19, Issue 2, 2008, pages 204- 206; available at www.CPOC.org Data / Info, Other Publications

should also seek to address youths' trauma-based or other emotional disorders. Sound practice suggests it is necessary to treat both a youth's behavioral problems and his/her emotional disorders in order to reduce recidivism.

Interventions like Aggression Replacement Training (ART), for example, have been proven effective in dealing with many kinds of behavioral problems; however, ART does not address symptoms related to trauma, depression, anxiety, early psychosis or other emotional disturbances. Some evaluations indicate that, if used inappropriately, ART can result in improvement in one area while worsening others. Even for youth for whom ART is useful, ART may be only one of the interventions required.

RECOMMENDATION 1: *Personnel in local juvenile correctional facilities should be aware that there are specific evidence based practices and interventions for specific mental health problems and specific mental illnesses. Facilities should seek to provide targeted services as necessary, especially since the goal of treatment is to help reduce future recidivism.*

Overview of Local Juvenile Correctional Facilities: According to the most recent information available from CSA, there are currently 57 juvenile halls and 59 camps and ranches operating in California. Forty-six counties have juvenile halls; one county -- Santa Barbara -- has both a juvenile hall and a special purpose juvenile hall; and two counties -- Mariposa and Mono -- have only a special purpose juvenile hall. Eight counties -- Alpine, Amador, Calaveras, Modoc, Plumas, Sierra, Sutter (although they partner with Yuba County), and Tuolumne -- do not have a juvenile hall, a special purpose juvenile hall, or a camp or ranch.

Camps and ranches still exist in 26 counties, although a shocking number have closed in recent months due to budget constrictions.

Data calculated monthly through September 2010, the last month for which CSA has complete data, indicates that, in 2010, California's 57 juvenile halls reported an average

daily population (ADP) of 5,807 while camps and ranches reported an ADP of 3,397. The combined 2010 total average daily population was 9,204 youth in local juvenile correctional facilities across California.

Juvenile Halls: Most of California's juvenile halls were built for short term detention of youth charged with offenses, going through the adjudication process and/or awaiting placement or transfer to appropriate commitment facilities at the local or state level. Juvenile halls were not intended to be long term housing or treatment facilities, although many have had to be – and continue to be – used for those purposes. While some larger juvenile halls have been able to devote one or more units to mental health management, smaller and mid-size facilities do not have that ability

To date there is only one local facility, the Northern California Regional Facility (NCRF) in Humboldt County, which was purposefully designed and constructed as a juvenile hall for mental health treatment in a county probation department-operated secure environment. Open to all counties, the NCRF, provides New Horizons, a four to six month correctional and mental health program for juvenile offenders, built on best practices and focused on successful reentry after custody.

When the enabling legislation that resulted in the NCRF was passed, the intention was for there to be three regional facilities – the one in Northern California, one in Southern California and another in the Central Valley; however, only the NCRF came to fruition.

Camps and Ranches: Local commitment facilities, called camps in some jurisdictions and ranches in others, were intended to provide longer term housing and rehabilitative programming for post adjudicated juvenile offenders. Initial intentions aside, camps and ranches are increasingly being used to house, and in some cases treat, juvenile offenders with mental health issues.

Why Mentally Ill Juveniles are in Justice System Facilities: The reasons local juvenile correctional facilities are so frequently used to house mentally ill juveniles are multiple and complex. For one thing, mental health and children's services agencies are

inundated by increasing numbers of young people with mental health, substance abuse and developmental problems. Some of these agencies – and some members of the public – see dealing with youth who are in the juvenile justice system as taking services away from those who have not broken the law. Referred to in some circles as ‘penal code patients,’ law breakers, either adult or juvenile, are shunned by non justice system service providers out of fear or in relief, knowing the justice system will provide what services it can, albeit with very limited resources.

Some providers – and some members of the public – take the fact that courts have seen fit to order offenders into custody as validation for the conclusion that the justice system can and should handle these minors. Knowing that treatment will occur in a secure environment makes detention of mentally ill minors in juvenile justice facilities attractive to decision makers and the public, who are counting on probation to provide public safety along with treatment.

At the same time that more youth are in need of mental health, developmental and dual diagnosis interventions, budget cuts have decimated state and community treatment resources. Prevention and early intervention programs have all but disappeared; school and other community based services are being cut. There have never been a large number, and now are only a precious few, treatment programs willing to accept mentally ill or developmentally disabled youth who need secure housing, and, of the residential placements that do accept these minors, not all provide the various and/or specific kinds of treatment(s) individual minors require.

A striking example is provided in instances of juveniles found incompetent to stand trial due to a serious mental disorder and/or developmental disability.¹³ While the relevant WIC sections enable the court to order these minors to be evaluated and/or treated in secure settings, only two of the five facilities in the state operated by the Department of Developmental Services (DDS) accept juveniles and only one of those – the Porterville Developmental Center in Tulare County – has a locked or secure unit.

¹³ Per AB 2212, Chapter 671, Statutes of 2010, or WIC Section 709, or WIC Sections 6550-6552

In terms of post adjudicated placement, there is some good news. Thanks in large part to probation agencies' concerted efforts to reduce placement through viable alternatives, there has been a 50% decrease in youth in placement statewide. The flip side of that coin is that the 'low hanging fruit' has all been picked; what remains are the most difficult youth and/or youth with the most difficult problems.

Placement officers continue to look to treatment-focused group homes (most of which are not secure) and the very limited number of other facilities that provide residential treatment services for children; however, these options are not always a good fit for the individual youngster. Group homes have produced mixed results, especially problematic since multiple placement disruptions can exacerbate the condition the placement was supposed to treat. So, while probation departments continue to seek the right or best placement and treatment option for each mentally ill juvenile offender, the task is increasingly difficult. Noted by the "Costs" study and almost all others, appropriate options are way too few, particularly for the more serious offenders and/or for those who need extensive periods of treatment in a secure setting.

Probation, mental health and children's services agencies, courts, families, youth advocates and a host of others agree that, in the best of all worlds, mentally ill young people do not belong in juvenile halls. There is a large body of research verifying that it can be less expensive, and often produces better outcomes, to treat young people elsewhere than in juvenile justice facilities. While alternatives do exist – foster homes, community treatment facilities (CTFs), regional centers, in-patient hospitals, etc. – each of these has drawbacks and none, with the exception of Multidimensional Treatment Foster Care (MTFC) has been empirically shown to produce consistently good outcomes as an alternative to a residential treatment setting.

Enormous gaps remain in placement and treatment – especially secure residential treatment – for justice system youth outside of juvenile halls, camps and ranches. The paucity of viable, proven alternatives, the intense financial pressures on mental health

and other youth serving agencies, and the mandate that probation agencies must accept the minors sent to them result in justice system facilities becoming the default. Juvenile halls, camps and ranches end up with the responsibility for treating mentally ill youth because other places either will not or cannot safely house and care for them.

RECOMMENDATION 2: *While the Work Group agrees it is less than ideal for mentally ill young people to be placed in juvenile correctional facilities, the Group noted that enormous gaps in placement and treatment – especially secure residential treatment – for justice system youth outside of juvenile halls, camps and ranches, make justice system facilities the current default. Understanding the difficulty of the task, and the likelihood that it will be a very long-term effort, the Work Group nonetheless strongly recommends that probation departments continue to collaborate with other agencies, the courts and community partners to encourage the expansion and/or development of proven effective treatment options and facilities for mentally ill youth outside of juvenile halls, camps and ranches.*

Purpose and Role of Local Juvenile Correctional Facilities: Juvenile justice facilities – juvenile halls and the camps and ranches that are still operating – are intended to protect public safety by keeping juvenile offenders safe, providing consequences for bad decisions, addressing criminogenic needs, facilitating positive behavior change, helping to nurture youths’ strengths, fostering successful reentry and thereby reducing recidivism.

In 2007, the California Association of Probation Institution Administrators (CAPIA) set forth the following purpose statement, which remains appropriate in the current environment.

Among the primary principles of juvenile corrections is that corrections' job is to provide a safe environment for youth and staff, to create opportunities for positive outcomes, and to encourage youth to work toward rehabilitation and reintegration after custody. Standing in loco parentis, juvenile corrections personnel protect the community by operating out of concern for the well being of the youth in our care. We seek to reflect that care in the culture of our institutions and the hiring and training of our staff.

We believe it is important that policy, procedure and practice balance the safety and security of juvenile institutions and staff with the safety and dignity of youth in custody. We seek to create environments in which positive outcomes can be fostered and thereby to uphold the safety and well being of both youth in custody and the community at large.

Many of the youth in local detention and correctional facilities are mentally ill, educationally delayed, and challenged in a number of developmental and social aspects of their lives. They are complex youth with complex problems, the solutions to which must be comprehensive and collaborative, involving service providers and all other personnel who interact with the youth in the facility and after custody. The culture of the entire service delivery system must be consistent in its treatment of youth in custody.¹⁴

Role of Staff in Local Juvenile Correctional Facilities: Obviously the role of correctional staff is intrinsically tied to the purpose of the correctional operation and/or facility. No juvenile corrections facility can function without well trained and committed personnel. It is the staff who keep juvenile offenders safe, provide consequences for bad decisions, address criminogenic needs, facilitate positive behavior change, help nurture youth's strengths, foster successful reentry after incarceration, and thereby help to reduce recidivism. Staff are responsible for maintaining the crucial balance among treatment, safety and security while interacting with youth to consistently demonstrate positive behavior and serve as role models. Staff seek to maintain a safe and nurturing environment while also providing elements of confined youths' continuum of treatment. Custody staff are expected to be a combination of social workers, educators, counselors and public safety personnel all in one, and are expected to know which 'hat' is the right one for each situation.

Culture Change: For a number of reasons, probation departments and their juvenile justice facilities are adopting evidence based and promising practices and seeking to emerge as more comprehensive, collaborative systems of care. In so doing, they are also undertaking 'culture change,' which research around the use of evidence based

¹⁴ California Association of Probation Institution Administrators (CAPIA), Force Options in Probation Departments' Local Juvenile Facilities, April 2007 CPOC website,

practices in juvenile facilities suggests is beneficial in terms of “both positive reform outcomes for youths and staff safety.”¹⁵

As facilities adopt the culture surrounding evidence based practices, some aspects of staff’s roles will be redefined. Focus will shift from telling juveniles *what not to do* to helping them learn *what to do*. Custody staff may be faced with a slightly different orientation and broadened responsibilities in the ways they work with and supervise mentally ill juvenile offenders. In addition to, or in place of, duty belts, hand cuffs and pepper spray, custody staff may be expected to rely on Motivational Interviewing (MI) and other interpersonal competencies to manage difficult youth and volatile situations. Staff – and management as well – may need to prepare for the fact that, as they work exclusively with higher risk offenders, there may be fewer positive outcomes.

Intake guidelines and detention criteria may change to include medical and mental health concerns. In fact, the AOC’s Task Force for Criminal Justice Collaboration on Mental Health Issues is recommending that these considerations be included in intake guidelines.

Culture change is a slow and long-term process. As with any other journey, it begins with single steps, one of the first of which is for staff to be involved from the start and from the ground up. Staff need and deserve to be told why things are happening, as well as what is happening. It may be beneficial to ask them to help design the new strategies to the extent that is feasible.

Staff may need to prepare for the shift in some of their approaches as well as in their working relationships with youth and with each other. One Work Group member said, in his facility, custody staff tend to be less involved with mentally ill youth when mental health staff are available. The emerging culture seeks to move away from that kind of

¹⁵ Cheryln K. Townsend, “New Practices in Juvenile Justice,” *Corrections Today*, February/March 2011, pg. 13

division of responsibility and make the treatment of mentally ill youth in custody everyone's responsibility.

In facilities that have in-house mental health personnel, custody and mental health staff should be encouraged to talk to each other and interact formally, informally and on an ongoing basis. Both custody and mental health personnel might consider avoiding jargon or shorthand that people outside their profession might not understand. Wherever there are multidisciplinary teams (MDTs) that develop and implement individual treatment plans for minors with mental health issues, custody staff should be members of those teams. Custody and mental health personnel need to work together on case management; having regular meetings about individual youths' treatment progress will help that along. Several facilities, including the NCRF, conduct weekly case management meetings that mental health and custody staff attend together.

The psychologist at Riverside County's Southwest Juvenile Hall, Dr. Tasha Arneson, has developed a tool custody staff say helps them understand and work with juveniles with mental health, medical or learning disabilities. This is a booklet of simplified descriptions of symptoms and/or behaviors along with possible approaches or interventions for each that staff can readily put to use. This intervention book encourages staff to work proactively by seeking, upon intake, to understand how each individual youth works and then setting up the appropriate environment conducive to his/her success. The intervention book also provides specific corrective teaching to be implemented if problems occur. It has been reported, by the custody staff managing many of these challenging youth on a day to day basis, to be a great help.¹⁶ Ongoing interactions, discussion and information sharing will yield great gains in treatment, as well as in facility operation. When mental health staff and custody staff become comfortable partnering with one another they will improve facility functioning as well as strengthen the delivery of treatment to mentally ill juveniles in custody.

¹⁶ Those interested in the intervention book may contact Dr. Arneson at Southwest Juvenile Hall in Riverside.

RECOMMENDATION 3: *Custody staff that interact with youth on a daily basis should be included in formulating and helping carry out those minors' case plans. Custody staff must be real partners in regular multidisciplinary team meetings and case reviews and should be relied on to support the mental health and behavior modification goals of minors under their care.*

Leadership: Culture change demands reliable leadership from the top, thorough planning, the consistent application of standards, repeated modeling of new strategies and approaches, and training for staff at all levels. Administrators, managers and supervisors must all convey the same message and encourage staff to familiarize themselves with the emerging mission, directions, goals and strategies of each facility and each unit as new programs and practices are put in place. Supervisors play a major part in helping further facility-wide understanding and acceptance as they are the front line of overseeing and reinforcing the transitions taking place.

Culture change is always difficult. It surely won't happen without patience, ongoing training, and frequent demonstrations of the new ways of doing the facility's business, as well as reinforcement and measurement of the new approaches. Even then there may be resistance to what staff perceive as very big changes, though management thinks it has simply made minor modifications. Organizations are like large ships; although the captain needs to make only a small adjustment to the trim tab to turn a vessel in a new direction, staff in the engine room are going to have to work harder and a lot faster to get on and stay on the new course.

Training: Training is a key component of culture change since training is the conduit for moving from how things used to be done to how they will be done going forward. (Please see Section VII, Training later in this paper for more on this subject.) At a minimum, custody staff should receive on-going and continuous training in evidence based practices. Supervisors should both monitor staff to ensure they are using the practices they have been trained in and serve as coaches, continually redirecting and demonstrating correct practice. In-house organizational development and related

training are additional valuable tools for enhancing custody personnel's buy-in to how the proposed approaches will work, how they relate to offender behavior change and how that may result in greater safety for staff.

Care of Staff: Through it all, agencies are urged to pay attention to staff welfare and wellness issues. Working in a custody setting is demanding under the best of circumstances, as is working with mentally ill youth. Combining the two and throwing in transitioning from 'the way we've always done it' to something even slightly different could give rise to additional stress, uncertainty and difficulty for staff. Staff will need support and positive reinforcement. Staff wellness should always be on management's radar, with particular attention being paid during periods of change.

Collaboration: Defined as working jointly with others; sharing knowledge and building consensus; cooperating with an agency with which one is not immediately connected; and working together to achieve a goal,¹⁷ collaboration is central to juvenile justice facilities' ability to manage mentally ill youth in custody. There are lots of reasons for collaborating, not the least of which are that "teams that work collaboratively can obtain greater resources, recognition and reward when facing competition for finite resources," and "collaborative methods ...increase the success of teams as they engage in problem solving."¹⁸ Moreover, most new grant opportunities require interagency cooperation.

Collaboration is in everyone's best interest. The multiple and complex problems presented by mentally ill youth in custody span a host of domains and require attention from a number of agencies and interests. Adjudication and placement decisions are made by the courts. Custody personnel must manage housing, programming, safety and security issues; in some facilities, they are responsible for screening new admissions and providing many of the treatment interventions as well. Assessments are performed and appropriate treatments are provided by, or under the guidance of, medical and mental health personnel. Educational services are necessary, as are

¹⁷ [Wikipedia.org/wiki/Collaboration](https://en.wikipedia.org/wiki/Collaboration)

¹⁸ Ibid.

reentry and family related efforts focused on reducing recidivism and subsequent returns to custody. Dealing with all the issues and services involved calls for the knowledge, skills and abilities of multiple individuals and agencies. No one entity can do it all. These are multi-agency problems requiring multi-agency solutions.

RECOMMENDATION 4: *It is essential that there be collaboration among all those who deal with mentally ill juveniles in custody. Judges, the defense bar, prosecutors; the education community; health and mental health departments and agencies; welfare and other child serving agencies; the faith community – all must be encouraged to partner with their local probation departments to most effectively work with mentally ill youth in local custody. How this is achieved may differ from jurisdiction to jurisdiction, but collaboration should be a primary focus for all juvenile correctional facilities and systems in every agency and every county in the state.*

Strategies for Collaboration: Probation agencies must help educate their partners. Among potential ways of doing this are formal and informal meetings and discussions to help judges and other partners understand the role and goals of detention and the problems facilities are facing. Juvenile Justice / Delinquency Prevention Commissions may help facilitate education and communication. Joint training sessions, joint conferences and regular interagency meetings are additional ways to foster understanding and strengthen collaboration.

Several counties have local interagency boards or committees that meet regularly to share information, resolve issues and work on collaborative strategies. Sacramento for example, has the Juvenile Institutions, Programs and Courts Committee (JIPCC), co-chaired by the Presiding Judge of the Juvenile Court and the Chief Probation Officer; the JIPCC seeks to resolve issues of mutual interest and concern. Humboldt has a Human Service Cabinet to drive program development, help reduce silos, and enhance the sharing of funds. San Luis Obispo has a Mental Health Criminal Justice Task Force which, among other notable accomplishments, implemented Crisis Intervention

Team Training (CIT) for jail and Juvenile Hall staff together with Mental Health and law enforcement.

Collaboration with the Courts: It is obviously crucial for local juvenile facilities to have good relationships and ongoing communication with the courts. One of the key issues the Work Group unearthed in this respect is that, while judges say they want to have whatever information is available about juvenile offenders' mental health as early in the judicial process as possible, many do not get information at the pretrial or detention hearing and some are still not fully informed by the time of disposition. Issues related to getting relevant mental health screening and assessment information to the court are discussed more thoroughly in the section on Screening and Assessment, later in this paper.

In San Bernardino County, key Probation Department and Juvenile Hall personnel meet regularly with juvenile bench officers – defense, prosecution and judges – in what they call Judges' Luncheons with Probation. These are reported to be educational and helpful for all involved

A different kind of collaboration with courts is demonstrated by the Juvenile Drug and / or Mental Health Courts in place in some California counties. Excellent examples of interagency collaboration, Juvenile Drug and / or Mental Health Courts, such as those operating in Los Angeles, Marin, San Bernardino, Santa Clara and Ventura Counties for example, provide a coordinated treatment approach, consistent oversight and wraparound services for mentally ill, substance abusing and/or dually diagnosed juvenile offenders. California's first Mental Health Court, the Court for the Individualized Treatment of Adolescents (CITA) in Santa Clara County, has been in operation since 2001 and continues to be a national model.

Collaboration with Health and Mental Health Agencies: Many counties' probation agencies rely on their local departments of health, mental health and/or behavioral health to provide mental health services in their local detention and correctional

facilities. CPOC's "Costs" study acknowledged a number of counties for doing a good job of that kind of collaboration, pointing to Alameda, Contra Costa, Los Angeles, Orange and Stanislaus Counties as exemplary "in the integration of county behavioral health staff into the [juvenile detention] facility milieu."¹⁹

Even counties that contract with outside providers like the California Forensic Medical Group (CFMG) or Catholic Healthcare West (CHW) for some or all of the mental health care of youth in local custody maintain strong collaborative relationships among local probation, health and behavioral health departments. Vital for a host of reasons, collaboration among human service agencies can support not only in-facility treatment but also prevention, family services, reentry and aftercare. Since, in many cases, these multiple county departments are all dealing with the same individuals and families, collaboration supports continuity of care while reducing duplication and redundancy.

Again San Bernardino is an instructive example. After being involved in a law suit, the Probation Department developed a host of effective interagency collaborations. Administrators of the Departments of Behavioral Health (DBH), County Schools (SBCSS) and Probation have committed to ongoing collaboration to provide the best possible services to mentally ill youth in local custody, because it is the right thing to do.

In 2005, as part of that collaboration, the County's Probation Department and DBH initiated a planning process for "structural and programmatic changes, to enhance services and improve youth, family and community outcomes."²⁰ A group of clinicians, supervisors and medical personnel from Probation and DBH, along with representatives of the County Administrative Office and County Counsel, and a consultant from the California Institute for Mental Health (CIMH), designed a comprehensive program which is still in place today. Policy and procedure statements, brochures and other literature describing San Bernardino's mental health programs for youth in custody carry a headline saying: "*All Juvenile Justice Programs are joint collaborations between DBH,*

¹⁹ "Costs of Incarcerating Youth with Mental Illness" Final Report, page 5

²⁰ San Bernardino County Mental Health Working Group, Final Report, November 15, 2005, page 1

Probation and, in some instances, the Courts.” In the County’s juvenile halls, the Health Services Manager / RN, and DBH’s Juvenile Justice Program Manager work hand in hand on a daily basis on such issues as the use and monitoring of psychotropic medications, developing procedures for youth who are mentally ill but not suicidal, facilitating multidisciplinary teams, and managing youths’ joint medical and mental health files.

Additionally, San Bernardino County has recently been awarded a grant to work with families who touch both the behavioral health and juvenile justice systems. This small grant, awarded by the American Academy of Child and Adolescent Psychiatrists, is for the purpose of convening family focus groups designed as open forums for families to express the specific frustrations and needs they experienced while trying to navigate in the two systems simultaneously.

Collaboration with Children’s Services or Child Welfare Departments: A notable example of interagency collaboration around mentally ill youth was Marin County’s Interagency Case Management Council (ICMC). The ICMC brought together Community Mental Health, Child and Family Services, Probation and other agencies in order to inform and collaborate with one another about youth being served in one or more of these major systems. The ICMC was dismantled recently, so the Probation Department has begun hosting multi-agency meetings to restore service collaboration for youth in this high risk / high needs category.

Another example is Solano County’s Interagency Case Management Committee known as ‘Interagency,’ in which the County Probation Department, County Health and Social Services - Child Welfare Services (CWS) and County Health and Social Services – Mental Health Division (MH) collaborate to evaluate and manage cases of Juvenile Court youth who have mental health issues. In cases in which a child who is referred to Interagency by the Juvenile Court may be at risk of mental health hospitalization under WIC Section 705, Interagency decision making is guided by a Memorandum of Understanding (MOU) which defines the roles and responsibilities of the individual

departments and determines which department shall provide treatment and case management services to each individual youth. Among other things, the MOU says, “Whenever the Juvenile Court has a question regarding the ability of a minor charged with an offense under WIC Section 602 to understand and/or participate in the proceedings against him/her, the Juvenile Court shall order that the case be referred to the Interagency for evaluation and determination of services appropriate to meet the child’s needs. The order to the Interagency shall include the release of mental health records, psychiatric, psychological and/or competency evaluations and criminal history information to the Department that will present the case at Interagency ... and to the Department that will manage the case.”²¹ The MOU also spells out the specific information to be considered in determining which agency will be the case management agency for each youth.

An additional important area for collaboration is presented by dual status youth, those minors described in WIC Section 241.1 who come within the description of both Section 300 and Sections 601 or 602 of the WIC, i.e., minors who are considered delinquent and dependent at the same time. Section 241.1 requires the probation department and child welfare services department in each county that has agreed to be a dual status county to jointly develop a written protocol “to ensure appropriate local coordination in the assessment of [such] a minor ... and the development of recommendations by these departments for consideration by the juvenile court.” While the two departments, in consultation with the presiding judge of the juvenile court, are authorized to create the joint recommendation that the minor be designated a dual status child, the law expressly prohibits “simultaneous or duplicative case management or services provided by both the county probation department and the child welfare services department.” It further says that “judges, in cases in which more than one judge is involved, shall not issue conflicting orders.” If this doesn’t demand collaboration, nothing does.

²¹ Memorandum of Understanding between Solano County Health and Social Services and Solano County Probation Department – Welfare and Institutions Code Section 705 Protocol, pg. 2; the MOU is available from the Solano County Probation Department.

Los Angeles County is piloting a Dual Status project known as the AB 129 Multi-Disciplinary Team (MDT) Pilot Program, which other counties might want to look at as an example. When a dependency court youth has committed a delinquent act, he or she may be referred to the program's MDT, which consists of representatives of the Department of Child and Family Services (DCFS), Probation, judicial officers and educational liaisons. The MDT will make a joint recommendation and submit it to the court for a disposition. For those cases assigned to camp via a camp community placement order, probation becomes the lead agency and is responsible for supervision and a case plan. The MDT's assessment and case / treatment plan is used by the camp to provide appropriate services during the camp stay and for aftercare planning. The MDT oversees the youth's progress while in camp and participates in a transitional MDT meeting to ensure the appropriate discharge plan; it also considers whether it is appropriate to offer services and assistance to the parent or caregiver in preparation for the minor's return to the community.

RECOMMENDATION 5: *In each county that has opted to participate in a Dual Status Youth process pursuant to WIC Section 241.1, it is strongly recommended that there be an interagency committee to ensure the appropriate management of these minors. To address the particular concerns of Dual Status Youth in custody who have mental health issues, custody and mental health staff should be members of this committee.*

Collaboration with Schools and the Education Community: Schools are another vital partner with whom collaboration is essential for youth in custody who have mental health issues. Because the federal Individuals with Disabilities Education Act (IDEA) ensures that children with disabilities are entitled to free, appropriate public education, as well as various types of mental health services, there is funding and support available for youth whose mental health needs interfere with their ability to access education and/or require them to have special education. These funds are available for youth in juvenile halls, camps and ranches and youth in group homes.

Services available from what are alternately known as AB 2726 or AB 3632 programs²² include assessment and case management, and such mental health treatment as individual, group and family therapies, day treatment and medication support. To be eligible for these mental health services, a juvenile must have a current individualized education program (IEP) on file and an assessment by mental health showing that the mental health issues are interfering with the youth's ability to learn. The services each youth receives must align with the needs identified in the IEP. Once these criteria are met, mental health, as well as special education, services are free to all eligible students regardless of family income or resources.

As intake, custody and court school staff know all too well, it is sometimes difficult to find out about and secure copies of a juvenile's IEP. Parents don't always know whether their children have IEPs or what those plans might say; youth won't always know or be willing to tell whether they have IEPs; the schools from which young offenders come into custody may not have or be readily able to find the information either. Nonetheless, given the funding available to support eligible youth's educational and mental health programming, and because doing so helps staff provide needed services, even though the process can be time consuming and frustrating, every effort should be made to find IEPs or bring special education personnel into the facility to help develop plans for appropriate youngsters.

Sustainability: Noting that it is easy to start things – new programs, new initiatives – but sometimes hard to keep them going, the Work Group encourages agencies to think about how to sustain viable programs when funding dries up or attention shifts elsewhere or the next new thing comes along. Sustaining such specialized entities as mental health systems of care in juvenile justice facilities requires considerable foresight and ongoing attention. At the very least, agencies need to ensure that they are continuing programs that work and eliminating those that don't. That can be pretty

²² These programs relate to Chapter 26.5 of the Government Code, "Interagency Responsibilities for Related Services" and are often referred to by the assembly bills that amended the initial statute: AB 3632, Chapter 1747, Statutes of 1984, and AB 2726, Chapter 654, Statutes of 1996. For more information, see the [California Department of Education](#) website on [Special Education](#) services.

tricky in general and particularly with grant funded programs because, all too often, when the money goes away, the programs do too.

These kinds of starts and stops and shifts are not only hard to manage, they also take a toll on staff. Staff are enthusiastic then disillusioned. The next time a new practice comes around, they are a little less eager to get on board, expecting once again to have their efforts count for very little over the long run. Managers need to be forthright with staff, to applaud their good work and try to explain the disappointments when they come in a way that conveys appreciation for staff's commitment to the mission and goals of the department, facility or unit.

Outcome Studies and Program Evaluation: One of the most effective ways to work toward sustainability is by performing regular, systematic outcome studies and program evaluations. Outcome studies and evaluations lead to consistency of operation and enable agencies to continue what works and stop doing what doesn't. Outcome studies show when the correct treatment is being applied to, and is effective with, the correct juvenile. Without such studies, jurisdictions can't really know how they're doing.

Additionally, evaluations and outcome studies make it possible to get funding. Every grant application requires a research basis and asks for reliable data. Every time the Legislature deliberates about whether or not to fund a program, it wants data to support the program's viability. Probation agencies are being considered for realignment funding today because they have outcome and evaluation data on their JJCPA and other programs, showing positive results, proving they work.

Clearly evaluation and outcome studies require data, and gathering and managing data can be daunting. But the effort can and does pay off. Data collection doesn't have to be cumbersome. It can be focused and incremental. Agencies don't have to try to do it all at once.

Look for example at the 20 counties working with CIMH on the California Gang Reduction, Intervention and Prevention (CalGRIP) Initiative. CalGRIP funds the implementation or expansion of anger management and youth violence prevention training programs for in-custody and community youth. All 20 grantees are keeping, recording and reporting data; they started slowly and are now all up to speed.

Consider too the mix of large, medium and small counties using the Positive Achievement Change Tool (PACT) for offender risk and needs assessment; these agencies are all gathering and pooling intake and outcome data and finding the resulting information enormously helpful in program design and program improvement. In April 2011, Assessments.Com (ADC) initiated an online User Forum by which agencies working with the PACT will be better able to pool information to help each other "...find solutions to the real world problems they confront as they go about the hard business of implementing Evidence-Based Practices (EBP) within their departments." ²³

A Champion: There is a lot to learn about sustainability, but one of the facts established by the National Implementation Research Network (NIRN) ²⁴ is that it often takes a champion, a leader (sometimes a cheerleader) to keep a program alive or to keep culture change moving forward. Sometimes the champion is a high level administrator; sometimes staff become the champions for what they are doing.

Unfortunately, in many agencies, staff don't get to see outcomes. They're not told or shown how well their efforts are paying off; they don't know how successful they've been in effecting offender behavior change. In other places, like Humboldt's NCRF for example, outcomes are shared with staff. It is noteworthy that some of the outcome data the NCRF collects comes from exit interviews the facility routinely conducts with detained youths' families. The facility gets a 'report card' from users and those closest

²³ Press release, April 14, 2011, available at www.assessments.com/content/press_releases

²⁴ The National Implementation Research Network can be accessed at www.fpg.unc.edu/~nirn

to them, and, by sharing that feedback with staff, creates an ongoing performance improvement loop.

Similarly, Marin County Probation's mental health Program of Responsive Treatment and Linkages (PORTAL) shares outcomes with department staff. Not only does PORTAL use the Youth Outcome Questionnaire (YOQ)²⁵ to measure conduct improvement in Functional Family Therapy (FFT) and ART programs, its clinicians also conduct one-year-post-treatment follow up for those youth and families that participated in and completed FFT. PORTAL's clinicians' questions focus on domains such as vocation, education, employment, family conflict and criminal recidivism. This process serves a dual function; it both tracks progress longitudinally and provides staff with the opportunity to hear how youth and families have been impacted by the treatment process.

When San Bernardino initiated ART programs in its juvenile facilities, the Department also began collecting program data and tracking outcomes, even though there was no requirement to do that at the time. Outcomes have been shared with staff ever since, and, as in Marin, staff – especially those involved in the ART program – are gratified by the results. The juvenile halls have a waiting list of staff wanting to become ART facilitators.

Training for Sustainability: Training and retraining are crucial to sustainability. Over time everything erodes, things begin to drift, skills fade. It is important to maintain the things one wants to keep in good order so people have their suits cleaned, their knives sharpened, their health checked. It is essential to do no less for correctional agencies, facilities and programs. Staff must be kept current about effective programs and emerging practices, about innovations being tested and those being considered. Personnel must be trained and retrained, not only to empower them to continually do

²⁵ Information about the YOQ can be found at: www.carepaths.com/assessment-center/youth-outcomes-questionnaire-yoq-2-0/

their jobs as well as possible, but also to help them prepare for potential turnover, reassignment and/or promotion.

Supervisors and Sustainability: As was said with regard to culture change, supervisors are also vitally important to sustainability. They provide the framework by which staff are encouraged to do things systematically, to abide by the principles and maintain fidelity to the program models they're working with. In that regard, supervisors are the drivers of program effectiveness. Unfortunately, supervisor positions are often cut when money is tight. Reducing the numbers of these key mid-managers means there are fewer people to support, review and reflect on program success, and that can lead to loss of effectiveness all the way around. Supervisors play key roles in supporting staff, ensuring standards and maintaining programs. They should be acknowledged for their important roles in helping to build and sustain agencies' mental health systems of care.

RECOMMENDATION 6: *Just as reentry planning should begin when an offender comes into custody, planning for sustainability should be part of the design, implementation and maintenance of each program and strategy local corrections agencies undertake. It is hard work to sustain gains; there are always new problems, but even now, when agencies are facing inordinate financial pressures and uncertainty about what the future will bring, it is exceedingly important to be proactive about sustainability. The Work Group strongly recommends that, local juvenile facilities make full use of data collection, outcome studies and program evaluations in order to know, and continue doing, what works. Eliminating what doesn't work, and being able to document what does is not only cost effective and good management, it is essential to, and the cornerstone of, sustainability.*

IV. BEST PRACTICES AND PROGRAMS

Screening and Assessment: A key principle of evidence based practices is that custody and programming decisions are all based on the risks and needs of individual

offenders. Screening and assessment are therefore central. Obviously it is essential for screening and assessment to happen early in a youth's time in custody so housing, programming and intervention decisions can be targeted appropriately. There are many levels and kinds of screening and assessment; they occur at various points in the justice process, and not all counties do them the same way.

Detention Risk Assessment: Many counties now employ an objective tool at booking to measure a youth's likelihood of reoffending pending court or failing to appear for court. Results of this screening determine whether the youth will be detained, straight released or released on a detention alternative. The booking assessment is different and distinct from the screenings and assessments performed once the detention decision has been made.

Intake Screening: Probation intake screening is a brief, broad view of many areas, looking for red flags that might be important to housing or programming decisions. Intake screening should include screening for trauma; however, at present, trauma screening is not being routinely done in all counties at intake.

Risk Needs Assessment: While intake screening may be focused on facility-related considerations, risk / needs assessments are more directed to benefitting the individual juvenile. Using such tools as the COMPAS, The Youth Level of Service / Case Management Inventory (YLS/CMI), the Los Angeles Risk and Resiliency Checkup (LARRC), the San Diego Risk and Resiliency Checkup (SDRRC), the Positive Achievement Change Tool (PACT), the Washington State tool or other validated instruments, risk / needs assessments seek to identify criminogenic areas and strengths important for case planning and linking each juvenile to the appropriate program or placement. These and similar tools are also used for re-assessment, important at such points as reentry planning.

Mental Health Screening and Assessment: Mental health screening and assessment are called for when intake screening, risk/needs assessment or behavior indicates a

juvenile may have mental health problems requiring attention. Many probation departments are now using the Massachusetts Youth Screening Instrument-2 (MAYSI-2) for mental health screening. A standardized, reliable, yes/no method, which includes a Traumatic Experiences domain, the MAYSI-2 provides information that alerts staff to the potential for such mental and behavioral problems as anger, depression and anxiety, suicide ideation, thought disturbances and traumatic experiences. Not a diagnostic instrument, the MAYSI-2 is intended as a “triage tool for decisions about the possible need for immediate intervention. ... It does not take the place of more comprehensive assessments that are needed for decisions about long-range placement or treatment planning.”²⁶

While the MAYSI is designed to be completed by youth and scored by intake or custody staff, in depth assessments can be conducted only by mental health personnel who are thoroughly trained in such assessments. One example of in depth assessment is provided by Marin County’s Juvenile Hall. In addition to the MAYSI, intake includes a clinical interview, sometimes supplemented by the use of the KID SCID (Structured Clinical Interview for DSM-IV Childhood Diagnoses). The purpose of the interview is to help staff understand each youth’s needs for mental health services and to make recommendations to the probation officer involved if there is a need for services upon exiting detention. This process is also used to facilitate services in Marin’s outpatient PORTAL program, with the goal being to ensure continuity of care in and after custody.

Psychological Evaluation: Further up the hierarchy of kinds of mental health assessments is the psychological evaluation. Psychological evaluation is defined as “an examination into a person's mental health by a mental health professional such as a psychologist. A psychological evaluation, usually consisting of the administration of a battery of psychological tests, an interview, and a behavioral observation, may result in a diagnosis of a mental illness.”²⁷ This process, which should also include a file review

²⁶ Assessments.com, MAYSI 2 , www.assessments.com/catalog/MAYSI_2.htm

²⁷ wikipedia.org/wiki/Psychological_evaluation

and obtaining the minors' medical and mental health history, is above and beyond what justice agencies do when they screen and initially assess juvenile offenders.

These distinctions are important in terms of addressing judges' concerns, mentioned in the "Collaboration with the Courts" section of this paper, that the court does not always get information about juvenile offenders' mental health issues early enough in the judicial process. Probation agencies and juvenile courts might consider exploring methods by which relevant mental health information from intake screening and the mental health assessments that are conducted when indicated by screening can be expeditiously conveyed to the bench.

The Work Group was told that some defense attorneys contend WIC Sections 711 and 712 limit the court's access to mental health assessments of pre-adjudicated juveniles. Others say those sections refer specifically to psychological evaluations and do not pertain to intake screening or assessments performed by juvenile hall or probation personnel. At least one probation department sends a psychologist to court to explain the difference between psychiatric and/or psychological evaluations and juvenile halls' assessments.

Judges may have to work out ways to convince defense counsel that the court's having access to the juvenile hall's mental health screening or assessment information is not an adversarial matter. In fact, having this information early in the judicial process is beneficial to the justice system as well as to the individual minor in so far as it facilitates mentally ill juveniles being properly treated in and by the justice system.

RECOMMENDATION 7: *In order for judges to learn about juvenile defendants' mental health problems as early in the adjudication process as possible, facilities might consider developing procedures by which to routinely convey screening and and/or mental health assessment information about in-custody youth to the court and counsel. Probation departments might also consider ways to expedite similar assessments for out-of-custody defendants, who constitute the majority of cases that come before the*

juvenile court. Intake officers and probation officers who write dispositional reports should be trained to understand mental health screening and assessment so their reports can accurately reflect the meaning and implications of assessment findings.

Out-of-Custody Screening and Assessment: Early screening and assessment are beneficial for case planning with out-of-custody youth as well as for youth in custody. In Riverside County, a Youth Accountability Team (YAT) screens and assesses out of custody juveniles very early on to determine service needs. San Bernardino, San Luis Obispo and Solano Counties have Community Service Teams (CST) which do intake screening and assessment and make decisions as to referral or diversion for out of custody juvenile offenders.

Multidisciplinary Teams (MDTs): An important best practice, interagency collaborative multidisciplinary teams are a proven way to get things done. MDTs' multiple perspectives and varied areas of expertise are value-added ways to address the complex needs of justice system youth and their families. MDTs help ensure that youth receive the cross-agency and community services that can support their successful rehabilitation and return to the community. MDTs promote collaboration between agencies and enhance the professional skills and knowledge of individual team members by providing a forum for learning more about the strategies, resources, and approaches used by various disciplines.²⁸

In addition to being used for early screening and assessment of out of custody youth, MDTs are being used throughout probation agencies and their juvenile halls, camps and ranches for a variety of other functions as well. Humboldt County's New Horizons Program utilizes multidisciplinary Family Intervention Teams to coordinate aftercare services for youth transitioning out of the NCRF. Described at New Horizon's web site, the team is comprised of probation, mental health, office of education and health and human services personnel, and develops "individualized strength-based child and family

²⁸ [www.healthy returnsinitiative.org](http://www.healthyreturnsinitiative.org)

case plans using the Family Unity process, then incorporates wraparound services to support the minor and his/her family through community care programming.”²⁹

Los Angeles County’s 14 remaining camps have various kinds of multidisciplinary teams in place. In addition to the MDTs that oversee and work with Dual Status youth (described previously on pages 24-25), there are also “Initial” MDTs that do case plan development and monitoring, “Transitional” MDTs comprised of aftercare officers, health, mental health, and education personnel – and in some cases attorneys – that develop reentry plans and work to help families buy into and support their child’s reentry, and “As Needed” MDTs convened to develop solutions for behavioral problems that threaten a youth’s success in camp. There are also MDTs which work specifically with camp youth identified as high risk for recidivism or gang involvement pursuant to a demonstration project developed by the Countywide Gangs and Violence Reduction Strategy. These latter MDTs seek to coordinate service delivery for eligible youth and their families, identify and overcome barriers and emphasize opportunities to enhance reentry, reduce recidivism and improve outcomes for probationers and their families.

One of the most unique aspects of LA’s MDTs is the inclusion of parents or guardians in the meetings. When an MDT is held for a youth with an open mental health case, his or her family is eligible for transportation services provided by Behavioral Health. If unable to attend in person, the family is included via conference call or speaker phone whenever possible.

In San Bernardino County’s secure, 12-18 month Gateway Program for offenders with serious delinquent histories and mental health issues that can be effectively managed by medication, an MDT assesses and evaluates minors with special needs and develops treatment strategies to assist in their adjustment to the program. Made up of educational staff, special education staff, mental health staff, medical staff, dietary staff and probation staff, the MDT also evaluates and assesses minors who do not respond to established behavioral practices. Additionally, MDT meetings address case plans

²⁹ <http://co.humboldt.ca.us/probation>,

and transitional plans for aftercare services.³⁰ Weekly MDTs are also convened at both detention facilities in San Bernardino County.

Sacramento and many other counties use MDTs – in some places called interagency placement committees (IPC) – for placement screening, selection of appropriate placements and post-placement aftercare planning. In most cases, the IPC consists of representatives from the probation department, department of behavioral or mental health, health department, county schools, and department of children’s services.

Many of the treatment programs and interventions being used in juvenile facilities as well as in outside placements depend on MDTs for their service delivery. Regular team meetings are the vehicle for developing, implementing, monitoring and updating case plans and tracking youths’ progress with treatment. The value of frequent MDT meetings cannot be emphasized enough.

Note that, for MDTs to access essential and sometimes confidential information, court orders may be required. Known as TNG orders, per the case of T.N.G. v. Superior Court (4 Cal. 3rd 767), these orders allow pertinent probation and/or juvenile court records regarding minors to be released to “...agencies or individuals providing remedial or rehabilitative services for the minor so long as the information is limited to that which is reasonably necessary to assist an agency with case planning and service delivery...”³¹

RECOMMENDATION 8: *Every probation agency should seek to develop multi-disciplinary teams to do early screening and assessment so as to facilitate referral to diversion and/or to appropriate in and out of custody programming. MDTs are also strongly recommended for case planning and monitoring service delivery in and out of custody, and for transition, reentry and aftercare planning as well. The Work Group suggests that substance abuse services, education and children’s services / child*

³⁰ San Bernardino County Probation Department, Gateway Program Description, page 8

³¹ CA Rules of Court, Rule 5.552 and WIC section 827

welfare personnel be included on MDTs wherever possible and that MDTs have frequent and regular meetings to share information and monitor individuals' progress with their case plans. It also recommends that, where they are not already in place, facilities ask the court for standing TNG orders for information sharing.

Programs: Juvenile halls, camps and ranches are successfully using a number of evidence based programs in their dealings with mentally ill youth in custody. To review what is being done where and to help people looking for information about specific programs know whom to contact in other jurisdictions, descriptions of some of the more widely used, proven programs follow.

Readers should be aware that the National Institute of Corrections (NIC) has recently published a thorough review of many evidence based programs which includes detailed descriptions. This material is available at NIC's National Information Center web site www.nicic.org and at the Justice Research Center's web site www.thejrc.com under 'What Works Curriculum.'

Cognitive Behavioral Therapy: Because many proven programs are built on the cognitive behavioral model, it may be instructive to look to the research on cognitive behavioral therapy (CBT) to understand their conceptual bases. The CBT approach holds that most people can become aware of their own thoughts and behaviors and can change them for the better. Therefore,

... CBT focuses on patterns of thinking and the beliefs, attitudes and values that underlie thinking. It has been shown to be reliably effective with a wide variety of personal problems and behaviors, including those important to criminal justice such as aggression, substance abuse, being anti-social and persistent delinquent and criminal behavior. ...CBT places responsibility for thinking in the hands of the client and supplies him or her with the means of solving problems in everyday living, focusing on the present rather than the person's past. CBT has been shown to reduce recidivism ... even with high risk offenders. ... It also appears that CBT is more effective in reducing further criminal behavior when delivered with

other program items such as supervision, education and training and with other mental health counseling.³²

Among the “brand name” or prepackaged examples of CBT are Aggression Replacement Training (ART) and Thinking for a Change (T4C), both of which are integrated, cognitive behavior change programs for offenders that include cognitive restructuring, social skills development and development of problem solving skills. One or the other, and sometimes both, of these programs are among the most widely used in local juvenile justice facilities and agencies.

Also widely used is Motivational Interviewing (MI), a directive, engagement-oriented, client-centered helping style for eliciting behavior change. MI is a technique that helps youth to change themselves by increasing their desire to change. It helps them see the benefits of moving in a new direction by leading the youth through a comparison between his or her goals and his or her current behavior. Like TV’s Dr. Phil, MI asks “how’s that working for you?” with a focus on getting the person to rely on inner motivation rather than external control.

Family Based Interventions: Family involvement can be instrumental in supporting youths’ behavior change and recidivism reduction. Probation agencies are using a variety of proven, family-based interventions to work with juvenile offenders, including those who have serious mental health problems. Probation is seeing good results from many of the following programs.

- ✓ **Functional Family Therapy (FFT)** is a prevention and intervention program targeted to youth 11 to 18 and their families. It includes five phases: 1) Introduction, 2) Motivation and Engagement, 3) Assessment, 4) Behavior Change and 5) Generalization. FFT works on changing emotional and attributional, especially blaming, components of family interaction and provides specific behavior change techniques that are culturally appropriate, family

³² Patrick M. Clark, “Cognitive Behavioral Therapy: An Evidence-Based Intervention for Offenders,” *Corrections Today*, February/March 2011

appropriate and consistent with the capabilities of each family member. “When compared with standard juvenile probation services, residential treatment and alternative approaches, FFT is highly successful, reducing recidivism between 35 - 75% and also significantly reducing the potential for new offending by siblings of treated adolescents.”³³ Fresno, Humboldt, Los Angeles, Marin, Riverside, San Diego and San Bernardino are among the many counties using FFT. Yolo County introduces FFT and FFP (see below) to start building relationships with detained youths’ families prior to release.

- ✓ **Functional Family Probation (FFP)**, sometimes called Family Focused Probation, is emerging as another powerful family-based intervention. Developed by the founders of FFT, FFP is a case management model for working effectively with higher risk youth and families. It is family focused, strength based and risk and protective factor driven and emphasizes family engagement, motivation to change and building a balanced alliance between the case manager (probation officer) and each member of the youth’s family to reduce recidivism.³⁴ The probation officer maintains a relational focus, rather than dealing only with the individual youth, with the understanding that probation is temporary and it is the family / support system that must be relied on to encourage and sustain positive change. Los Angeles and Yolo Counties have implemented FFP for out of custody youth and Yolo County also uses it as part of release planning for youth in custody. Through a grant from The California Endowment, Sacramento County began using FFP at the end of 2010; in Sacramento, FFP officers received 16 hours of specialized training and continue to have weekly conference calls with FFP instructors to staff cases and do problem solving.

- ✓ **Multisystemic Therapy (MST)**, which its web site says targets youth involved in the juvenile justice system who exhibit violence, substance abuse or chronic

³³ www.fftinc.com

³⁴ www.fftinc.com/resources/FFPbrochure4.pdf

offending, is present-focused and seeks to identify and extinguish behaviors of concern to the community and family. Services include strategic family therapy, structural family therapy, behavioral parent training and cognitive behavioral therapy. MST has been demonstrated to reduce rates of criminal activity, institutionalization and drug abuse and is also successful at engaging and retaining families in treatment and encouraging completion of substance abuse programming.³⁵

- ✓ **Multidimensional Treatment Foster Care (MTFC)** “is a cost-effective alternative to regular foster care, group or residential treatment, and incarceration for youth who have problems with chronic disruptive behavior. The evidence of positive outcomes from this unique multi-modal treatment approach is compelling.”³⁶ MTFC treatment goals are accomplished by providing: close supervision, fair and consistent limits, predictable consequences for rule breaking, a supportive relationship with at least one mentoring adult and reduced exposure to peers with similar problems. MTFC targets teenagers who have shown chronic or severe criminal behavior. The program involves the recruitment, training and supervision of foster families who offer youth treatment and intensive supervision in home, school and community settings. Youth receive behavior management and skill-focused therapy; parent training and related services are offered to natural parents in preparation for the youth returning to their homes. San Diego County, among many others, uses MTFC.

- ✓ **Therapeutic Behavioral Services (TBS)** is designed to help children, youth, and parents manage challenging behaviors by utilizing short-term, one to one behavioral interventions to achieve measurable goals based on the needs of the child, youth and family. TBS is available to youth who have serious emotional challenges, are eligible for a full array of MediCal benefits without restrictions or limitations, i.e., full scope MediCal, and are at risk of placement in an RCL 12 or

³⁵ www.mstservices.com

³⁶ www.mtfc.com

higher group home. Intended to modify behaviors of concern and/or teach appropriate alternative behaviors, TBS is never a stand-alone therapeutic intervention but rather is used in conjunction with other mental health services.³⁷ TBS can be used for youth in juvenile halls awaiting placement. While being in custody can exacerbate mental health symptoms, TBS can help stabilize a mentally ill youth so he/she can get accepted into a placement and thereby transition successfully to a more therapeutic environment. The key requirement in juvenile hall is that the youth has a placement order so the service is billable. TBS is used by Los Angeles, Riverside, San Diego and San Luis Obispo Counties, among others. These jurisdictions suggest it is beneficial to educate the judiciary about the fact that TBS can be available under some circumstances for youth in juvenile hall with treatment paid for by MediCal.

- ✓ **Wraparound, aka Wrap** was established in 1997 by SB 163 (Chapter 795, Statutes of 1997) and has been extended and/or modified by subsequent legislation and by the Mental Health Services Act (MHSA) enacted by California voters as Proposition 63 in 2004. Wrap provides collaborative, intensive one-on-one counseling “to eliminate barriers to service delivery, strengthen and support families, and reduce the risk of out of home placement and recidivism by bringing individuals, agencies and the community together to meet the needs of the child and family.”³⁸ As described in WIC Section 18250 and the following sections, Wrap is intended to provide service alternatives to RCL 10 and above group homes through the development of expanded family-based services programs. Accordingly, any Wrap program meeting the requirements of the MHSA should have access to the State and county AFDC-FC share of the group home rate for each wraparound slot.

Wraparound can be a cost effective way to collaborate and share funding across systems. Wraparound done well is less expensive than either juvenile halls or

³⁷ www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/docs/TBS

³⁸ www.dss.cahwnet.gov/cfsweb/PG1320.htm

group homes. Like TBS, Wrap requires that the youth be in or at risk of a high RCL placement; however, youth living at home who are placed in a Wraparound slot may, under some circumstances, be eligible for MediCal reimbursement. In Riverside County, the juvenile court judge must order screening for Wrap; in Marin, eligibility is determined by case review; in many other jurisdictions, MDTs decide which minors are referred to Wrap.

County Specific Programs: There are countless innovative and creative efforts underway in probation agencies and facilities across California for mentally ill youth in custody. A few examples include the following:

- ✓ **Forensic Adolescent Services Team (FAST)** serves minors detained in either of the San Bernardino County Probation Department's two Juvenile Detention and Assessment Centers (JDACs) and its Gateway Treatment Facility who need services for mental health issues. FAST targets youth in custody who have emotional distress and anxiety about being arrested and detained, have transitional mental and emotional issues and/or have severe mental illness. Treatment services include mental health assessments, medication support, crisis intervention and alcohol and drug programs providing substance abuse education services. FAST also assists in the training of Probation's custody and supervisory staff to ensure effective interventions with minors.

- ✓ **Stabilization Treatment and Transition (STAT) Teams**, funded through MHSA / Prop. 63 funds and staffed by County Mental Health personnel, provide crisis intervention, counseling, medical evaluations and brief assessment services as well as what they call reentry preparation, i.e., transitional mental health services and community stabilization in Fresno and San Diego Counties' juvenile halls and San Diego's camps. In these efforts, Mental Health starts a case plan while the minor is still in custody, and the plan provides the basis for continued treatment after release. Unfortunately, the cuts being made to mental health budgets are resulting in fewer minors being able to be followed in the community.

- ✓ Sacramento County Probation has recently started the **Skills Training and Enrichment Program (STEP)** in its Youth Detention Facility for minors with lower level mental health issues. STEP takes minors out of their normal housing units to a vacant unit where targeted training curricula are presented jointly by County Office of Education, Mental Health and Probation staff. Since STEP started in October 2010, facility personnel report a decrease in incident reports for participating youth.

- ✓ Sacramento County also continues to operate its very successful **Integrated Model for Placement, Assessment, Case Management, and Treatment (IMPACT) Program**. IMPACT serves minors court-ordered into placement for the first time at a 20 bed, non-secure, co-educational, pre-placement group home located in what was formerly a probation camp. IMPACT provides multi-dimensional assessments designed to determine functionality levels in ten areas: criminality, education, psychology, medical, social attachment, vocational skills, substance abuse, psychiatry, recreation and family dynamics. A comprehensive case plan is then developed with the goal of situating the minor in the most appropriate available placement by identifying the types of treatment and/or services that best address his/her assessed needs.

V. FACILITY RELATED TREATMENT AND SERVICE ISSUES

Limitations Facing Small Counties: Representing the perspective of California's very small counties, Glenn County reports being able to provide only a few mental health services for minors housed in its 22 bed Juvenile Hall. Through the combined efforts of custody staff and CFMG, with whom the County contracts for crisis care, the Juvenile Hall seeks to maintain the stability of youth with mental health problems. CFMG tries to ensure that medication and related care are continued for youth who come into the Hall with medications, unless circumstances (such as the minor's being under the influence

of methamphetamines, etc.) preclude their doing so. The County Mental Health Department, which provides services to probation youth in the community, does not come into the Juvenile Hall, thus counseling a youth may be getting in the community stops while that youngster is detained in the Hall. Glenn County's Deputy Chief Probation Officer points out that youth are often willing to listen to advice, attend counseling, make plans for the future and make connections with the community while they are in custody, so he considers it "a shame that we cannot start the process from within the Juvenile Hall. Juvenile Hall staff do their best in that capacity, but it would be nice to have counseling resources come into the hall" as well, he said. Title I funding from the schools pays for a therapist to come into the facility, but that therapist is available only to minors who have IEPs. Glenn County exemplifies the experience of the small, rural jurisdictions which must make do with severely limited public and/or private mental health resources.

Specialized Mental Health Units in Juvenile Halls, Camps and Ranches: While small and some medium size juvenile facilities do not have the capacity to devote an entire unit to detainees with acute mental health needs, many of the larger juvenile halls, camps and ranches have established specialized mental health – sometimes called behavioral control – units. Alameda, Contra Costa, Los Angeles, Orange, Riverside, San Diego, Sonoma and Stanislaus Counties, among others, have mental health units in their juvenile facilities and, of course, Humboldt County's NCRF is a specialized, totally mental health juvenile hall.

Los Angeles County has an Enhanced Supervision Unit (ESU) at its Central Juvenile Hall, where mentally ill youth are housed. The presence of this Unit is said to have made the Probation Department's Individual Behavior Management Program (IBMP) significantly better. The ESU is credited with helping to reduce assaults and self-injurious, violent behaviors even among minors charged with serious offenses. (See the following section on Violent and Disruptive Youth for more about LA's ESU and ESU Team.)

Los Angeles also has camps specifically for mental health services, some of which have been designated as placements. As part of Department of Justice Memorandum of Agreement with LA Probation facilities, mental health treatment services were significantly increased at all camps. A total of 88 mental health positions, consisting of clinical, supervisory and support staff, have recently been filled. The additional mental health personnel are enabling the camps to have extended mental health coverage daily, seven days a week.

RECOMMENDATION 9: *In systems or facilities where they are possible, specialized mental health units are valuable for managing, treating and supervising seriously mentally ill offenders. Where such units exist, it is important that staff be carefully selected and trained to prepare them for the demands of the unique settings to which they will be assigned. Staff should be trained in recognizing and responding appropriately to the characteristics of various kinds of mental illness and helped to understand that some of the behaviors youth exhibit are the result of their illnesses, not of malicious intent. Staff should seek to get beyond what one administrator called “the sanction mindset” if they are to be effective working in specialized mental health units or any other treatment oriented correctional environment.*

Psychotropic Medications: Section 1439 of the Title 15 Minimum Standards for Juvenile Facilities describes the policies and procedures necessary for the use of psychotropic medications. Subsection (a) (4) says each facility has to have procedures in place to determine whether to continue psychotropic medications prescribed in the community, and Subsection (a) (5) calls for determining the necessity of continuing a youth on psychotropic drugs in pre-release planning and prior to transfer to another facility or program. So psychotropic medications cause potential burdens on facilities for youth coming and going.

Facilities also have to deal with the sometimes difficult issues surrounding emergency administration, involuntary administration and parental consent for these medications. It is essential that all facility personnel, including custody staff, be trained about the use of

psychotropic medications, their effects and side effects, the relationships between these medications and physical health issues and the legal issues surrounding their use in custody.

Although the majority of youth entering juvenile halls are not on prescribed psychotropic medications, those who come into custody with a prescription are to be seen and evaluated for continuation of those medications by medical staff as soon as possible. In the Santa Cruz County Juvenile Hall, for example, a Mental Health Client Specialist sees the minor within 24 hours of admission and the County's child psychiatrist conveys a verbal order to continue outpatient medications until the juvenile is seen by the facility child psychiatrist. The youth's visit with the psychiatrist happens within one week of admission. In the Marin County Juvenile Hall, youth are evaluated for continuation of their meds on Monday and Friday when the psychiatrist from Community Mental Health (CMH) is on site at the Juvenile Hall. If a youth comes into the Hall on a weekend or when the CMH psychiatrist is on vacation, Psychiatric Emergency Services can authorize nurses to administer medications.

Again using Santa Cruz as the example, the process for youth who come into custody with dual mental health and substance abuse diagnoses is generally the same, unless the minor is acutely intoxicated. With dually diagnosed minors who are acutely intoxicated, Santa Cruz withholds medication until the child can be evaluated by the psychiatrist. In Santa Cruz, dual diagnosis patients are not treated differently from non-substance abusing mentally ill patients.

When an in-custody evaluation by a psychiatrist determines that a minor needs a psychotropic medication, the facility must get either parental consent or a court order before going forward with the medication.³⁹ In the Marin County Juvenile Hall, every youth on psychotropic medications must have a consent signed by a parent or guardian

³⁹ At the time this paper was being written SB 913 by Senator Pavley was moving through the legislative process. SB 913 allows a probation officer to authorize "medical, surgical, dental, or other remedial care" upon the recommendation of a physician if the P.O. has made a 'reasonable but unsuccessful effort' to notify the parent or guardian.

in order for medications to be administered. The CMH psychiatrist contacts the family, discusses the issues and will not prescribe over parents' objections.

Because family involvement and a balanced alliance with families are important to the success of custody and reentry programming, facilities are encouraged to consider seeking consent as a way to engage the parents or guardians. Trying to get parents involved in the medication decision is advisable before seeking a court order per the JV 220a process.⁴⁰ Some counties do not differentiate between Dependency and Delinquency Court and thus seek JV 220's on all youth ordered placed; this can hold up placement for three to four weeks unnecessarily awaiting approval from the court when a parental consent is already on file. If a child is a ward of the court pursuant to WIC Section 602, the parent or legal guardian retains the right to authorize the prescription and administration of psychotropic medication unless the Juvenile Court has restricted such right.

In those relatively rare instances in which a family's religious beliefs do not permit the use of medical treatment and/or medication, it may be advisable to ask the court to intervene so as not to create a greater breach between probation and the family. If a youth is in crisis and is a ward of court, the court can give permission to medicate and that order would serve as the signed consent. A court order imposing medication in the best interest of the child, counter to the family's wishes, may lead to the involvement of Child Protective Services (CPS) if there is a belief that the parents are neglecting the child. Facilities may want to check with County Counsel in such instances.

Of course, facilities make every effort to encourage voluntary medication. In some jurisdictions, the alternative is to send the individual to a hospital for stabilization. In other places, on the rare occasions when medications must be administered involuntarily, the facility asks the court for an order to do so specifically for that juvenile; however, not all courts are willing to issue such orders.

⁴⁰ Per WIC Section 369.5

While some facilities do not accept youth on psychotropic medications, e.g., stimulants for example, minors on psychotropic medications are generally not excluded from eligibility for camp or other programs if their behavior is properly controlled by the medications. Los Angeles, for example, currently has juveniles on psychotropic medications in seven camps including the Dorothy Kirby Center. (On May 27, 2011, three camps within the Challenger Memorial Youth Center were closed, reducing from 10 to 7 the number of camps in which juveniles prescribed psychotropic medications could be placed.) Camps are able to house juveniles who have been prescribed psychotropic medication based on the number of hours of medical coverage each has; The remaining three camps at Challenger Memorial Youth Center have 24 hour medical coverage; four other camps (two for males and two for females) have extended medical coverage. The psychotropic medication is delivered to the camps to ensure it is available for the juveniles for whom it has been prescribed.

RECOMMENDATION 10: *In order to effectively manage mentally ill youth in custody, it is essential to handle psychotropic medications in keeping with laws, regulations and best medical practices. All custody, medical and mental health personnel should be trained in how and why the medications are used, what their effects may be on offenders' behavior, the relationships between psychotropic medications and physical health and the legal requirements surrounding the use of these medications in the custody setting. Because it may be beneficial for juvenile halls to involve the parents of detained youth in their child's in-custody programming, it is also strongly recommended that parental consent to administer psychotropic medications be sought before a facility invokes the JV 220 process to ask for a court order even when placement has been ordered.*

Youth with Dual Mental Health and Substance Abuse Diagnoses: Every juvenile in local custody has individual needs and characteristics. Mentally ill juveniles additionally have conditions and issues for which particular interventions are necessary. Juveniles with co-occurring mental health and substance abuse disorders – who, according to many studies and corrections staffs' experience, comprise a majority of mentally ill

youth in custody – have needs in two distinct domains and thus require even more, and more specialized, attention. Because these youth are such a large part of the correctional population, intake staff might well be advised to be on the lookout for mental health and substance abuse problems occurring jointly. For youth who appear to be impaired, it may be better to ask “When did you start?” instead of “Do you use?”

Medical and mental health practitioners used to believe that, if they treated the underlying problem, the self-medicating would take care of itself. They don’t think so any more. The general consensus now is that it is necessary to treat both the mental illness and the substance abuse.

Some custody facilities take youth who are methamphetamine users off all medications when they come into custody. In other facilities efforts are made to withdraw youth from whatever medications they are on when medically necessary to observe the minor’s behavior and/or to see if treatment medications might be inconsistent with one another. Of course, those decisions are made and overseen by medical and/or mental health personnel.

While treatment is the responsibility of medical and mental health practitioners, it is nonetheless very important that custody staff be fully trained about co-occurring disorders. Appropriate, in-depth training will facilitate custody staffs’ interacting effectively with the dually diagnosed young offenders who make up such a large percentage of the population they supervise on a daily basis.

One of the more difficult aspects of working with dually diagnosed juveniles is managing all the issues surrounding their release from custody. There are not a lot of placements that will take youth with dual diagnoses. More than a few seriously mentally ill youth who are also substance abusers have been refused admission to substance abuse treatment facilities because of their mental disorder and/or refused treatment for their mental illness because of their substance abuse. During pre-placement planning, it is important to collaborate with a psychiatrist so as to avoid prescribing a medication that

will keep a youth from being able to go to placement. Some placements will not take youth on certain medications; others refuse youth on any medications at all.

RECOMMENDATION 11: *Particular attention should be paid to the co-occurring disorders juvenile offenders bring with them into custody. To accomplish that, custody staff should be fully trained about dual diagnoses and how best to interact with dually diagnosed youth. Where multidisciplinary teams (MDTs) are used for screening, programming and/or reentry planning, facilities should seek to include substance abuse counselors on those teams.*

Violent and Disruptive Youth: Everyone who works in a custody facility knows that just one obstreperous minor can completely disrupt the atmosphere and programming of a living unit or an entire facility. Dealing with serious acting out behavior, whether it results from mental illness or not, is critical for the safety of the minor involved, as well as for the safety and security of staff and the other youth in the unit or facility. Aggression Replacement Training (ART) is used in many facilities to work with these as well as other, less aggressive minors. Some experienced juvenile facility staff say it does not work to treat violent mentally ill juveniles on a regular mental health unit; others suggest that being on a regular unit can help normalize the person's behavior.

The most consistently voiced suggestion was for facilities to develop specialized supervision plans and, wherever possible, multi-faceted MDTs to address disruptive and/or violent behavior. Behavioral plans need to be simple to understand. They should target only the problem behaviors, set positive incentives for the minor to improve and be available to all staff working with the minor so they can be consistently applied and reinforced. Such plans should focus on keeping the disruptive minor in programming whenever possible, rather than isolating or segregating him or her

In Los Angeles County's Enhanced Supervision Unit (ESU) at Central Juvenile Hall, discussed above, a collaborative ESU Team helps develop and implement extensive treatment as well as behavior plans to ensure that minors receive necessary services

and interventions. Through interagency case planning meetings and discussion of individual youths' needs, the Team provides probation staff with pertinent information and effective tools to better interact with each of the high risk / high need minors housed in the unit. LA's camps use a similar MDT case planning strategy.

Solano County's Youth Detention Facility places acting out minors in a 15 bed special unit equipped with cameras. Such placement must be okayed by both mental health staff and a supervisor and employs the use of a corrective action plan for managing each youth's dangerous, disruptive behavior.

RECOMMENDATION 12: *Specialized supervision plans developed and implemented by multidisciplinary teams should be considered a first option for managing violent, disruptive youth in custody. Such plans should be simple to understand, targeted to problem behaviors, and available to all staff working with the minor to enable consistent application and reinforcement. Plans should seek to maintain the acting out minor in regular programming and treatment to the extent the safety of the minor, staff and other youth allow.*

Suicide Prevention: Many jurisdictions have developed or updated their suicide prevention protocols based on training by Lindsay Hayes, Program Director of the National Center on Institutions and Alternatives (NCIA) Jail Suicide Prevention and Liability Reduction program. NCIA's training focuses on:

... all aspects of suicide prevention in correctional facilities including, but not limited to, negative attitudes and obstacles to prevention, research, why correctional environments are conducive to suicidal behavior, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identifying suicidal inmates despite the denial of risk, guiding principles to suicide prevention, components of an effective suicide prevention policy, critical incident staff debriefing, and liability issues. [It calls on facilities to] implement a sound suicide prevention policy, including the critical component of staff training. ... All staff who come into contact with inmates, including correctional, medical, and

mental health personnel, should receive basic and recurring suicide prevention training.⁴¹

Noting that it is often “the silent inmate who is despondent,” Hayes urges facilities to find creative ways to identify at-risk juveniles, keep them safe and give them the care they need. His approach requires ‘constant watch,’ one-on-one supervision.

Facilities in many jurisdictions, including Los Angeles, Orange, San Bernardino and San Diego Counties, rely on one-on-ones for dealing with suicidal youth. LA camps particularly like one-on-ones because they are less expensive than sending two staff with a minor to a hospital. CDCR’s Division of Juvenile Justice (DJJ) has changed its suicide watch protocol from placing youth in a locked room with a camera to now providing one-on-one supervision in a general setting.

However, many agencies, particularly the very small ones, find it extremely difficult to free up staff for one-on-ones. There are also those who contend one-on-ones send the wrong message by giving youth a lot of attention and encouraging copycats.

In Riverside County’s Southwest Juvenile Hall, a unique and cost effective approach is proving very successful. Peer mentors are being used to assist with suicide prevention by interacting with youth who are acting out or on suicide watch. Born of the necessity to be creative when resources are limited and the firm conviction that suicidal youth should be kept in general population, the Peer Mentoring Program recruits and trains interested in-custody youth to help interact with those who are acting out and/or suicidal. The facility’s psychologist has developed applications, a training manual and procedures for the peer mentors. She trains the young mentors and trains staff to supervise and support them. While this kind of effort may not work in other facilities, Southwest reports that suicidal minors get personal attention from trained peers with whom they may be able to relate as equals, and the peer mentor gets to do – and be acknowledged for doing – something good for someone else.

⁴¹ National Center on Institutions and Alternatives Jail Suicide Prevention, www.ncianet.org

RECOMMENDATION 13: *High risk youth and youth at risk of suicide should be maintained in group settings rather than isolation to the extent consistent with safety considerations. All staff who come in contact with minors, including intake, custody, medical, mental health and education personnel, should receive basic and recurring suicide prevention training.*

Reentry: Since the goal of local custody is to facilitate positive behavior change that helps foster successful reentry and thereby reduces recidivism, planning for reentry is – and must continue to be – a vital component of everything that happens in custody. Screening, assessment and in-custody programming are all focused on enabling positive reentry; ‘transition’ or ‘reentry’ or ‘aftercare’ planning all have the same goal. Increasingly, as discussed previously, juvenile halls, camps and ranches have collaborative reentry planning teams and processes in place to address the critical transition points leading from custody to a return to the community. A pilot program in two LA County camps, for example, utilizes an MDT driven process that begins 90 days prior to a youth’s scheduled release from camp and continues to provide transition services for 6 months after release.⁴²

For youth with mental illness, reentry planning should also attempt to provide continuity of mental health care, transitioning treatment begun in custody to treatment in the community. An illustrative model is a family engagement approach being used in the Marin County Probation Department to improve outcomes and reduce recidivism and returns to custody for mentally ill youth in placement. Services include parent support groups facilitated by two mental health clinicians and the placement officers responsible for those youth in out of home placements. These groups, conducted in both Spanish and English, provide an opportunity for families to discuss the progress of their youth in placement, talk about issues of concern and receive psycho-education related to multiple mental health issues. Parents are also helped to prepare for their child’s transition back to their custody and care. In addition, a specific reentry meeting occurs

⁴² For more information about the transition program at LA’s Camps, contact Probation Director Alberto Ramirez.

2-3 months prior to the minor's return from placement. The goal of the reentry meeting is to assess the needs of the child and family and construct a plan that addresses continued mental health problems, family dynamics, vocation, education and other environmental considerations with appropriate interventions.

A particular concern in the transition from detention to supervision of mentally ill youth is the management of their psychotropic medications. San Diego County, for example, provides a 30-day supply of necessary medications at release; however, quite often the parents do not pick up the 30-day supply or fail to follow up after the 30-day supply is used. San Diego has dispatched county mental health Stabilization, Treatment and Transition (STAT) Teams to follow up with minors and families in the community and try to coordinate medication issues; however, the extremely limited funding available to county mental health agencies these days means there are fewer STAT Teams available and the teams that do exist are able to follow up on fewer cases.

Transitioning mentally ill youth to community schools after a stay in juvenile hall is another reentry-related problem. This is especially difficult for youth with IEPs or ILPs, who often spend additional time in custody waiting for a placement that can accommodate an IEP or a special education program. To mitigate these delays, several counties, including Los Angeles, San Bernardino and Solano, run their own IEP processes. To help mitigate education related delays, the Work Group suggests including a school transition counselor or school advocate, as well as an aftercare officer, on reentry planning teams to help facilitate transitions.

For youth who are aging out of the juvenile system – those for whom jurisdiction ends because they are turning 18 – housing, employment and immigration issues may compound mental health problems and complicate the reentry process. Probation facilities should look to Transitional Age Youth (TAY) programs if they exist in their jurisdictions as potential resources for aging out minors. It might also be useful to know that the Mental Health Association in California (MHAC) has created a project called

The Transition Age Youth Empowerment Project, specifically focused on transitional age youth with mental health needs.⁴³

RECOMMENDATION 14: *Continuity of care is among the primary goals of reentry planning for youth with mental health problems. Where they are available and able, families should be involved to the extent possible. Once again agencies are encouraged to use MDTs for reentry planning and to include on those teams mental health and education personnel as well as an aftercare officer to help facilitate transitions to mental health and education and/or special education services in the community. Youth aging out of the juvenile system should be encouraged to contact the county's TAY program for potential assistance with reentry.*

VI. ADDITIONAL TREATMENT AND SERVICES ISSUES

Medical Records: The prevailing notion used to be that mental health and other medical information regarding youth in custody was confidential and could not be shared with custody personnel. That is no longer necessarily the case. The Health Insurance Portability and Accountability Act (HIPAA) does not apply in juvenile facilities, and, as was mentioned in the discussion of MDTs above, WIC Section 827 allows access to essential information to “agencies or individuals providing remedial or rehabilitative services for the minor so long as the information is limited to that which is reasonably necessary to assist an agency with case planning and service delivery.”⁴⁴ Courts in many jurisdictions have issued these TNG orders,⁴⁵ as standing orders for information sharing in their county’s juvenile halls, camps and ranches. Other counties get releases for information as soon as a youth with mental health issues comes into custody.

⁴³ Mental Health Association in California(MHAC), California Youth Empowerment Network, www.mhac.org

⁴⁴ Rules of court and WIC section 827

⁴⁵ Per the case of T.N.G. v. Superior Court, 4 Cal. 3rd 767

The WIC, at Section 16010, calls for what are known as Health and Education Passports for youth going into placement. Health and Education Passports are to include, but are not limited to:

... the names and addresses of the child's health, dental, and education providers, the child's grade level performance, the child's school record,... a record of the child's immunizations and allergies, the child's known medical problems, the child's current medications, past health problems and hospitalizations, a record of the child's relevant mental health history, the child's known mental health condition and medications, and any other relevant mental health, dental, health, and education information concerning the child determined to be appropriate by the Director of Social Services.⁴⁶

Passports, which also include references to IEPs and past placements, are being used in many if not all jurisdictions across the state and are proving to be useful tools for collaboration, communication and information sharing among probation, health, mental health and education agencies.

An unanswered question is what happens to the Passport when a youth ages out of the juvenile system. Can this information be transferred to the adult system? If there is no well defined process, perhaps this is a gap that should be addressed legislatively.

A tangentially related question was raised with respect to the medical and mental health records for youth in DJJ. When asked if those records would be released to probation in the counties to which youth are being returned pursuant to realignment,⁴⁷ DJJ said its protocol is to send the records two months (60 days) prior to the youth's return to help the county develop a case plan before the required court hearing.

RECOMMENDATION 15: *Every effort should be made for health, mental health, education, and probation personnel to share relevant information in order to plan for and*

⁴⁶ WIC Section 16010

⁴⁷ Realignment is discussed further in the next section of this paper.

provide the most appropriate services to mentally ill youth in and transitioning out of custody.

DJJ ‘Realignment’: Even though CDCR’s Division of Juvenile Justice (DJJ) has been relied on to provide mental health treatment to serious juvenile offenders with mental health needs and has a number of good facilities and services to provide those treatments, decreases in its population and budget issues are causing significant changes in how – and potentially whether – DJJ operates. DJJ’s future is unclear; however, at the time this paper was written, it was anticipated that DJJ would be available to collaborate and/or contract with probation agencies to provide specified services, perhaps including acute or sub-acute care beds, for some mentally ill juvenile offenders.⁴⁸

The major realignment that occurred in October 2010, pursuant to AB 1628, moved responsibility for juvenile parole from DJJ to county probation departments, beginning in January, 2011, with all supervision to be transferred to the counties by July 1, 2014. AB1628 further authorized counties to establish Juvenile Reentry Funds,⁴⁹ through which probation departments are to “provide evidence-based supervision and detention practices and rehabilitative services” to youth discharged from DJJ.⁵⁰

This realignment means that young offenders who are mentally ill will be released from DJJ to their county of commitment’s probation department rather than paroled. As noted above, to help facilitate continuity of care for these youth, DJJ proposes to send their medical records and communicate their mental health needs to the respective counties at least two months prior to the youths’ actual release dates.

⁴⁸ DJJ’s mental health programs are described on the DJJ website as well as in the January 2009, State Commission on Juvenile Justice, Juvenile Justice Operational Master Plan, <http://67.199.72.34/php/Information/JJOMPFinalReport.pdf>

⁴⁹ A.B. 1628, Sec. 23, creating WIC §§ 1980 *et seq*

⁵⁰ WIC 1981(c)

DJJ also intends to send along necessary psychotropic medications with the releasee. Significant complications have already arisen about how this is being managed. Historically, DJJ had provided 30 days of medication and a 60-day prescription to youth going onto parole supervision. However, DJJ reports local facilities said their procedures required those medications to be disposed of if they accompanied released minors back to probation, so DJJ has altered its approach. What some counties that have received DJJ youth under the new procedures report is that DJJ is sending youth to probation with four days of medication and a 30-day prescription. Well intentioned as this may be, this makes it, virtually impossible to connect youth with a clinical practitioner before the medication runs out. Probation is having difficulty maintaining treatment gains under these circumstances. According to DJJ, meetings will be scheduled with probation agencies to work out these and other issues surrounding realignment.

RECOMMENDATION 16: *If discussions have not already occurred, DJJ is urged to contact CPOC, CAPIA and the counties to which youth are being returned immediately to clarify the conditions under which mentally ill youth will be returned to their committing counties under the AB 1628 realignment.*

VII. TRAINING

It bears repeating that training is central to everything that occurs in a correctional facility. Much of this paper has been about issues, ideas, directions and practices for which training is essential. Training creates the template for best practices and is the key to generating staff buy in. Training protects against liability. Training provides the background and understanding that enable custody staff to participate effectively on multidisciplinary teams. As contracting for mental health services goes forward, training for custody staff becomes even more important.

CPOC's "Costs" study, discussed early in this paper, recommends training facility staff "to improve conditions in facilities by increasing staff understanding of emotional disorders and reactions in youth, maximizing consistent communication among staff and providers, and maximizing the rehabilitative opportunities of detention facilities to improve social functioning and prevent subsequent recidivism."⁵¹ Training and retraining, as is done with firearms, is necessary to keep the workforce sharp and up to date on mental health service delivery issues and skills.

Training Standards: As facilities and their custody staffs move in new directions, relevant Title 15 training standards may need to be changed as well. To that end, CPOC is working with CSA and its Standards and Training for Corrections (STC) Division to modify probation officer (PO) and juvenile correctional officer (JCO) core and annual training requirements. CPOC is advocating for training which provides staff with a balance of enforcement and best practices principles while also describing some of the benefits of using evidence based and best practice strategies and approaches.

CSA, STC and the Executive Steering Committee (ESC) that has been convened to produce the next iteration of training standards will take CPOC's and all other input into account. Acutely aware of existing fiscal limitations, they will also take pains to ensure revised standards do not set up unrealistic expectations likely to engender litigation against probation departments, juvenile facilities or staff.

Training for Custody Staff: As budgets are being cut, some juvenile facilities are experiencing reductions in staff and are looking for innovative, cost effective ways to continue providing services. Fresno County, for example, is using therapeutic college interns to help maintain treatment capacity in its Juvenile Hall, and is relying heavily on training to enable appropriate interactions with mentally ill youth in custody.

Some jurisdictions are reacting to budget cuts by reducing training. This may be the very essence of the saying "*penny wise, pound foolish*," since properly and fully trained

⁵¹ Costs of Incarcerating Youth with Mental Illness, pages 2 - 4

staff are the best buffer against unnecessary interventions, costly critical incidents and disruptive situations in custody facilities. What's more, just one lawsuit for failure to train will more than wipe out whatever savings might have been realized by not training staff.

The San Diego County Probation Department has recently completed a training needs assessment that identifies training for custody staff about how to manage juveniles with mental illness as the Department's number one training need. Some of the specific topics San Diego described as important for staff to be trained on included:

- Identifying the different levels and kinds of mental health issues youth bring into custody, such as those related to trauma, Post Traumatic Stress Disorder, Depression, Conduct, Oppositional Defiant, Personality Disorders, etc. and how those differ from psychoses;
- When and what type of questions to ask a detainee when you have a concern regarding their mental stability;
- What is psychotropic medication and how does it work?
- What best practice programs, therapy groups and individual counseling prove effective in working with violent and/or disruptive mentally ill individuals?

These issues are important in every facility in the state.

Noting that the mental health field could benefit from training about early, simplified assessment and screening, the Work Group recommended a host of additional topics for custody staff training including, but not necessarily limited to:

- Mental Health First Aid, i.e., the help provided to a person with a mental health problem or in a mental health crisis, and given until appropriate professional treatment is received or until the crisis resolves;⁵²
- Anti-stigmatizing training;

⁵² Mental Health First Aid, www.mhfa.com.au/cms/

- Collaboration training and training about multidisciplinary teams and conferencing teams;
- Training in strength based practice, including reattribution and reframing techniques to enhance engagement, improve behavior and reduce conflict;
- Training in family based thinking – to enable understanding that treatment shouldn't single out just the juvenile when there is a whole family system at work;
- Training on the role of evidence based practices, including the active engagement of youth, in facilitating behavior change;
- Training on trauma;
- Training on dual diagnoses / co-occurring disorders;
- Training on Motivational Interviewing (MI), and
- Training about specific interventions such ART, MST, Wraparound, and others.

In Santa Cruz County, the Juvenile Hall's child psychiatrist provides mental health training to all Juvenile Hall and Probation staff which includes an overview of the facility's most common psychiatric diagnoses as well as an overview of the medications used and their side effects to watch for. Some facilities suggested that custody staff might also benefit from training about resources available for mental health programs and services and some of the requirements and limitations of each.

The number and breadth of topics about which custody staff could or should be trained is extensive. Facilities will have to be selective about what they can provide and how best to provide it, i.e. in house, as briefing training, through outside providers, as courses staff are assigned to take, or etc. The bottom line is that custody staff must be properly trained to enable them to manage, supervise, and work with the mentally ill youth in their care.

Crisis Intervention Team (CIT) Training: Many correctional agencies and facilities provide training for trainers on mental health related treatments and programs and

some are taking the lead in providing interagency training in key topics. San Luis Obispo County Probation, for example, as mentioned above, has implemented Crisis Intervention Team Training (CIT), which is delivered to jail and juvenile hall staff together with people from County Mental Health and law enforcement. San Bernardino's Juvenile Halls use a 16-hour, scaled down CIT curriculum that is taught by teams of police and juvenile hall officers.

CIT training is valuable in that it provides law enforcement and custody personnel "understanding and skills to identify and provide the most effective and compassionate response to ... situations involving people in a mental health crisis."⁵³ Information about CIT training is available from a variety of sources, including the National Alliance on Mental Illness (NAMI) CIT Technical Assistance Resource Center.⁵⁴

RECOMMENDATION 17: *To ensure the safety and security of youth in custody, of staff and of facilities, it is essential for all juvenile facility staff to be trained about mental health issues, services and interventions. Whenever it is possible, custody, mental health, and other treatment personnel should be trained together to present multidisciplinary perspectives, facilitate information sharing and ensure that all those who interact with youth deliver the same message.*

Training for Bench Officers: It is important that judges and other court officers be aware of the relationship between the timing of placement orders and the ability to offset placement costs through MediCal. In some instances, delays mean youth will get no treatment, whereas once placement is ordered, probation can proceed with post-disposition assessments and other prerequisites to getting youth into appropriate treatments. The Work Group was advised that the AOC Task Force for Criminal Justice Collaboration on Mental Health Issues is recommending training for bench officers on such matters as expediting court orders related to placement and TBS, using MediCal and SSI and encouraging collaborative treatment and service planning and delivery.

⁵³ www.portlandonline.com/police/index.cfm?c=30680

⁵⁴ <http://www.nami.org/template.cfm?section=CIT2>

VIII. FUNDING ISSUES

This is a perilous time for money and financial resources. So much is up in the air; so much is uncertain. Probation departments, state and local mental health departments, social services, education have all taken big hits in the past year or so and most are facing the very real possibility of additional cuts in the days and months ahead. Non-mandated services are in danger of being eliminated, and mandated services are being considered for reductions. Nonetheless, treatment and services must still be delivered to juveniles in local custody. Jurisdictions like Santa Cruz County, which has the longest running children's system of care, and also the highest rate of mental health expenditure per capita in the state, will have to become even more creative as well as cost efficient to make the best use of every available dollar.

The strategy most likely to maximize existing resources is to move beyond existing silos and pool resources. Our current, fragmented funding approach talks about 'medical money,' 'mental health money,' 'child welfare money,' 'probation money,' 'education money' as if all those services weren't related, as if each part of the safety net has separate responsibilities for serving clients. That is clearly not working.

A more unified, cross-systems approach abandons those silos, prioritizes services and collaboratively blends money to accomplish what are in fact common goals. A unified approach acknowledges that child welfare is good crime prevention; so are really good school programs. It recognizes that putting money into treating children's early conduct disorders helps schools, helps keep children out of the foster care system and helps prevent delinquency. A systems view, moving from silos to community thinking, will help move all involved toward cost effectively taking care of young people while maintaining the public good.

Collaboration in funding is not without precedent in California. The Children's System of Care (CSOC) is instructive as it cobbles together multiple funding streams. The Mental Health Services Act (MHSA), Mental Health Realignment, the Prop. 10 Commission and Title IV-E are additional examples of collaborative funding with synchronized planning across multiple agencies. Incentive-driven efforts such as the innovative Title IV-E Waiver projects in Los Angeles and Alameda Counties that got minors out of group homes have saved millions of dollars, which the counties have been able to reinvest in other programs. Wraparound incentives have also given rise to cost effective and outcome effective services across systems for youth and families.

Health care reform may help break down additional silos relative to mental health care, since health insurers will have an incentive not to let mental health disorders go untreated. Seeking to create parity, health care reform may result in cost shifting if not cost saving, and, although this is not yet certain, may well engender strategies for making health and mental health care more accessible for youth in and after custody,.

Especially in the current environment, it is crucial to make prudent use of existing sources of funding⁵⁵ and be on the lookout for grant opportunities such as those offered by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) or CSA's CalGRIP and Best Practices initiatives, among others. Of course, probation agencies must continue to maximize Title IV-E and MediCal funding as well.

Local juvenile facilities doubtless are aware that CPOC continues to actively seek funding for mental health services for youth and adults in the justice system. Its 2011 platform commits CPOC to:

- Support legislation and funding for supervision strategies and evidence based practices that consider the treatment and service needs of probationers with mental illness in order to improve outcomes for this population.

⁵⁵ See Appendix II for an overview of the kinds of funding available for serving mentally ill youth in the justice system

- Support programs (such as the former Mentally Ill Offender Crime Reduction (MIOCR) grants and Proposition 36 for drug related offenses) that provide mental health, alcohol and drug and related services for offenders.
- Maximize federal funding opportunities such as Title IV-E and MediCal Administrative Activity (MAA) / Targeted Case Management (TCM).⁵⁶

Facility administrators might be interested in two pieces of legislation, SB 695 and AB 396, making their way through the state legislative process as this paper was being written. Both of these measures seek to reduce one of the largest roadblocks to providing services to mentally ill youth in custody – the rules prohibiting counties from billing MediCal. While neither would totally eliminate the barriers against using MediCal dollars for youth in local custody, each and both of these bills, if passed and signed, will help counties offset some of the costs of providing medical and mental health care.

SB 695 (Hancock) permits MediCal benefits to be provided to an individual awaiting adjudication in a county juvenile detention facility if the individual is eligible for MediCal at admission or is subsequently determined to be eligible to receive MediCal benefits. Benefits would be required to be paid until the date of the individual's adjudication. The county would have to agree to pay the state's share of MediCal expenditures and administrative costs, and federal financial participation (FFP) would have to be available.

AB 396 (Mitchell) requires the Department of Health Care Services (DHCS) to develop a process to allow counties to receive any available federal financial participation for health care services provided to juvenile detainees who are admitted as inpatients in a medical institution. It would declare that a juvenile detainee who is an inpatient in a medical institution shall not be denied MediCal eligibility because of his or her status as a detainee of a public institution.

⁵⁶ Chief Probation Officers of California 2011 Platform, www.cpo.org

RECOMMENDATION 18: *Mentally ill juvenile offenders will continue to be part of the juvenile justice system for the foreseeable future and will continue to require treatment services to enhance public safety, promote rehabilitation and reduce recidivism. Given the extraordinary fiscal limitations currently facing correctional, mental health and other human service agencies, the Work Group strongly recommends maximizing existing resources through collaboration and employing data collection and ongoing evaluation to ensure the maintenance of cost effective, as well as programmatically effective, programs and services. Under all circumstances, and especially in times of economic pressures, it is imperative that juvenile justice facilities seek innovative ways to provide necessary mental health services. Facilities are encouraged to work with service providers and other agencies to blend funding streams and to maximize the use of such resources as Title IV-E and MediCal dollars to the full extent allowed by federal and state laws.*

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ADDITIONAL RESOURCES

American Academy of Child and Adolescent Psychiatry (AACAP)	www.aacap.org
California Association of Probation Institutions Administrators (CAPIA)	www.cpoc.org
California Department of Developmental Services	www.dds.ca.gov
California Department of Corrections and Rehabilitation, Corrections Standards Authority (CSA)	www.cdcr.ca.gov/CSA
California Department of Corrections and Rehabilitation, Division of Juvenile Justice (DJJ)	www.cdcr.ca.gov/Juvenile_Justice
California Department of Education, Special Education	www.cde.ca.gov/sp/se
California Department of Mental Health	www.dmh.ca.gov
California Department of Social Services	www.dss.cahwnet.gov
California Endowment Healthy Returns Initiative	www.calendow.org
California Institute for Mental Health (CIMH)	www.cimh.org
Cathy Wright Center for Technical Assistance to Children’s System of Care, Newsletters on Juvenile Justice Mental Health, available at the CIMH website – /About/ Newsletters/Other-Newsletters.aspx#cwtac	www.cimh.org
Chief Probation Officers of California (CPOC)	www.cpoc.org
Forensic Mental Health Association of California (FMHAC)	www.FMHAC.org
Healthy Returns Initiative	www.healthyreturnsinitiative.org
Justice Research Center	www.thejrc.com
Mental Health Association in California	www.mhac.org

National Alliance on Mental Illness	www.nami.org
National Center on Institutions and Alternatives (NCIA)	www.ncianet.org
National Commission on Correctional Health Care (NCCHC)	www.ncchc.org
National Implementation Research Network (NIRN)	www.fpg.unc.edu/~nirn
National Institute of Corrections Information Center (NICIC)	www.nicic.org

APPENDIX I

AGENDA TOPICS

DEVELOPED FOR DISCUSSION

BY THE MEMBERS OF THE

MENTALLY ILL JUVENILES IN LOCAL CUSTODY WORK GROUP

AGENDA TOPICS

- I. **TREATMENT AND SERVICES** including but not limited to:
 - A. Defining kinds and levels of mental illness
 - B. Role of Custody Staff
 - C. Intake and Assessment
 1. Information for Decision Making
 2. Getting Information to the Court and PO
 - D. Best Practices Interventions – What's in Place Where?
 - E. Program / Intervention Issues, including:
 1. Staffing considerations
 2. Continuity of care from custody to supervision
 3. More community based programming needed
 4. More MH beds and placements needed
 5. Juvenile Sex Offender treatment
 6. Dual Diagnosis Treatment
 7. Dealing with Disruptive Behavior
 8. Protocols for Safety
 9. Special MH Units
 10. MHSA for probation youth
 11. Oversight / Monitoring
 - F. Medication Issues, including
 1. Forced medication
 2. Formularies
- II. **AFTERCARE/REENTRY** including but not limited to:
 - A. What Has Worked and What Hasn't
 - B. Family Involvement in In-Custody Treatment and Aftercare
 - C. 18 year olds Aging Out
- III. **TRAINING** including but not limited to:
 - A. Interagency cross training
 - B. MH Medications training
 - C. Training re special ed., and other related issues
 - D. Training re Motivational Interviewing
 - E. Training in Cross Cultural / Cultural Competence Issues
- IV. **INTERAGENCY COMMUNICATION & COORDINATION** including but not limited to:
 - A. Meetings for Coordination and Continuity of Care
 - B. Interactions with Courts
 - C. Continuity of Care Issues, including:
 1. Kids in 'Wrong System'
 2. Medical Records
 - D. Creating Cohesive Systems

APPENDIX II

FUNDING FOR MENTAL HEALTH SERVICES

FOR

YOUTH IN THE JUVENILE JUSTICE SYSTEM

**FUNDING FOR MENTAL HEALTH SERVICES
FOR YOUTH IN THE THE JUVENILE JUSTICE SYSTEM**

Name	Description	Eligibility	Source
Therapeutic Behavioral Services (TBS)	Therapeutic behavioral services are a one to one therapeutic contact between a mental health provider and a youth for a specified short term period of time which is designed to maintain the youth's residential placement at the lowest appropriate level by resolving target behaviors and achieving short term treatment goals.	These services are available to those youth who are full scope MediCal eligible living in the community, or are in a post disposition status in custody.	51/49/00 (Fed/State/County sharing ratios)
Wrap Around Case Management Services (WRAP)	Wrap provides intensive services to families with the goal to keep the minor living in the home setting. These services are available to youth in the community who are at risk of out of home placement. The family must be willing participants and the county must have such a program in place		State General Fund/County share
AB 3632	Mental health services for special education students that could include assessments, individual and/or group therapy, medication monitoring, intensive day treatment and case management.	Students who have an Individual Education Plan and have been determined to require mental health services to benefit from public education are eligible to receive appropriate services. These services typically occur within the school setting and home or foster home setting. These services could be provided in juvenile hall.	100% State General Fund
Early, Periodic, Screening, & Diagnosis Treatment	Mental health assessments, plan development services, medication support services, day rehabilitation, crisis residential and crisis intervention and stabilization, targeted case management.	Full scope MediCal for eligible children and adolescents up to age 18 years of age who are living in the community or in a post disposition status in juvenile hall.	51/49/00 (Fed/State/County share ratios)
The Mental Health Services Act, Proposition 63	Each County Mental Health / Behavioral Health Department receives an allocation of funding from Proposition 63, the Mental Health Services Act and is required to develop a countywide spending plan for this funding. At the discretion of individual county's plans, children/youth in the juvenile justice system may be eligible for programs or services under this funding.		

Additional Possibilities for Funding

County Mental Health / Behavioral Health Departments can provide general outpatient and inpatient services for MediCal eligible children/youth and others depending upon their individual budgets.

Probation Departments receive state funding from programs including **Juvenile Probation and Camp Funding (JPCF)**, the **Juvenile Justice Crime Prevention Act (JJCPA)**, and the **Youthful Offender Block Grant (YOBG)**. Any or all of these funds could be used to assist in the treatment of mentally ill youth in local custody.