The Juvenile Justice Diversion and Reintegration Project

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Promising Program Models for Diverting Youth with Mental Health and Co-Occurring Substance Use Disorders from the Juvenile Justice System

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Background

There are large numbers of youth who become involved with the juvenile justice system- an estimated 2.4 million youth under the age of 18 were arrested in the United States in 2000. Of this total, 71% were boys and 29% were girls (OJJDP, 2004). We now know, through existing research, that many of these youth have significant mental health and substance abuse problems and often end up in the juvenile justice system because their mental health and substance abuse needs are not identified early enough and services in the community are not available.

Many of these youth are detained or placed in the juvenile justice system for relatively minor, non-violent offenses but end up in the system simply because of a lack of community-based treatment options available to them. The placement of these youth in the juvenile justice system is part of a growing trend toward the "criminalization of the mentally ill"- placing individuals with mental health needs in the justice system as a means of accessing mental health services that are otherwise unavailable or inaccessible in the community. While this trend has been evident at the adult level for some time, it is now being observed at the juvenile level as well. Thus, the juvenile justice system is viewed as becoming the "public mental health system" for large numbers of youth who are referred there because there is no other place to get help.

On the adult level, the inappropriateness of relying on the justice system for mental health services for non-violent, low-level offenders has been recognized for years and has resulted in the establishment and evaluation of diversion programs for adults with mental health and substance use disorders. For youth in the juvenile justice system, virtually none of this exists. Instead, as a last resort, we are inappropriately placing large numbers of these youth into an ill-equipped juvenile justice system.

Research and practice have shown that these placements often do not lead to positive outcomes for youth, and may, in fact, worsen a youth's problems and impair their reintegration into their communities (National Institutes for Health, 2004). Given the needs of these youth, and the documented inadequacies of their care within the juvenile justice system, it is critical that we begin to better identify- across the juvenile justice and mental health fields- effective and promising models for the early identification and diversion of youth from the justice system to community-based treatment.

Project Overview

In 2003, the Substance Abuse and Mental Health Services Administration (SAMHSA) provided funding to the National Center for Mental Health and Juvenile Justice (NCMHJJ), based at Policy Research Associates, to undertake a comprehensive national survey to identify existing juvenile diversion program models that effectively respond to the mental health and co-occurring substance

use disorders of youth in contact with the juvenile justice system. This survey represented the first attempt ever to systematically identify the "state of juvenile diversion" in this country, and specifically identify diversion programs that target youth with mental health and substance use needs. The goal of this effort is to share this information with national, state and local officials across the country in order to foster the further development and implementation of comprehensive an integrated diversion and reintegration models that will successfully meet the needs of youth enhance their functioning and reduce recidivism.

Survey Methodology

An initial field survey, conducted by the NCMHJJ in conjunction with NASMHPD and CJCA and with support from the National GAINS Center, was performed to identify programs that divert youth from the juvenile justice system. The survey criteria indicated that the programs had to serve youth, operate as a formal program, reduce justice involvement and maintain linkages to community-based resources and services. Seven hundred and seventy-nine (779) programs responded to this initial survey.

Building on this initial effort, the NCMHJJ used the SAMHSA funding to collect additional and more in-depth information from the programs identified in the original survey. An in-depth survey was sent to each of the 779 programs requesting more specific information about the program, such as eligibility criteria, the point at which youth are diverted, how the program is organized and funded and the kinds of services provided by the program. Respondents were also asked to rate the program on the extent to which they serve youth with mental health or co-occurring substance use disorders using a seven-point scale. Of the 779 programs, a total of 230 programs responded to this survey.

Telephone interviews were conducted with those programs that self-identified in the mail survey has having an "above average" focus on serving youth with mental health or co-occurring substance use disorders. A total of 75 phone interviews were conducted. The purpose of the phone interview was to: 1) verify or clarify the survey information, 2) obtain program specific information about structure, services, youth served, perceived efficacy and evaluation data, and 3) to give program directors the opportunity to identify barriers to program implementation, strategies for overcoming barriers, and to provide advice to jurisdictions seeking to implement programs.

Guided by the telephone interviews, a subset of "promising programs" were identified. The first step in selecting these programs was to identify those programs that exclusively served youth with mental health or co-occurring substance use needs, or those programs that served a broader population but served youth with mental health issues routinely enough to have established procedures for linking or directly providing youth with mental health services (n=21). With this pool of programs, the following guidelines were used to identify the most promising models:

- ability to identify the needs of youth with mental health or co-occurring substance disorders,
- ability to provide services to youth with mental health or co-occurring substance use disorders,
- the level of collaboration,
- parental involvement, and
- evaluation data.

Programs did not have to meet all of these criteria; rather Center staff looked for strength in one or more. Based on strength in these areas, seven programs were identified and six of these programs were site-visited. During the site visit, Center staff met with the persons who oversee program administration and services, employees of the program, and representatives of outside agencies related to the program. The full group generally included administrators; direct service providers (employed by the program and those from outside service providers); agencies that refer youth to the program (justice representatives); collaborative funding and operating agencies; and youth.

Promising Program Models

The strengths of the program were confirmed during the visits and, as such, the Center has identified the following seven programs as promising models for diverting justice involved youth into community-based settings, especially youth with mental health disorders:

- The Special Needs Diversionary Program, Texas
- The Integrated Community and Home-Based Treatment Model (ICT), Akron, Ohio
- Mental Health Diagnostic and Evaluation Units, Jefferson County, Alabama
- Indiana Family Project, Monroe County, Indiana
- Family Intervention Specialists, Georgia
- Juvenile Court Liaison Program, Montgomery, Alabama
- Family Intervention Resource Services Team (FIRST), Owensboro, Kentucky

Brief descriptions of each of these programs is provided below. For more detailed information, please refer to the attached Program Summaries.

The Texas Special Needs Diversionary Program (SNDP)

The Texas Special Needs Diversionary Program (SNDP) is a jointly funded statewide initiative involving both the juvenile justice and mental health agencies that is designed to provide youth with mental health services. In Harris County,

Texas, the SNDP uses a team approach to provide case management, service coordination and supervision. Co-located Probation/Licensed Practitioners of the Healing Arts (LPHA) teams work together to staff cases and are responsible for jointly securing, providing or supervising the provision of services to youth on their caseload. These teams serve youth ages 10 to 18. There are multiple points of entry to a Probation/LPHA team, and referrals can be made from virtually all key juvenile justice processing points (from intake through post-adjudication). The state of Texas requires Probation to use the MAYSI (a mental health and substance use screening tool for use in juvenile justice settings) to screen all youth at Probation Intake. The results of the screen are passed to the Probation/LPHA teams, where youth then undergo a clinical assessment and family interview. Following these assessments, an individualized treatment plan is developed for the youth and family. All program services are based on a wraparound philosophy of team treatment planning. The Probation/LPHA teams strive to provide the majority of services in the home or school. Services includes benefit coordination, to assist with Medicaid or CHIP enrollment, psychiatric services including medication management, group and individual counseling, health care, parent and child support groups, and transition planning to prepare for discharge from the program.

The Integrated Community and Home-Based Treatment Model (ICT), Akron, Ohio

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

Mental Health Diagnostic and Evaluation Units, Jefferson County, Alabama

The Diagnostic and Evaluation Unit is a county program exclusively targeting youth with mental health disorders. There are four units in Jefferson county- two units in schools, one in the child welfare agency and one in the Family Court.

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

Indiana Family Project, Monroe County, Indiana

The Indiana Family Project serves youth in Monroe County involved with the juvenile justice system. This program serves youth under the age of 18. Eligible youth are diverted into the program from all points of the juvenile justice system, from initial contact with law enforcement to adjudication. Pre-adjudication referrals come from Probation and post-adjudication referrals come from the Family Court judge. To assess mental health needs, parents and youth complete a questionnaire similar to the Child Behavioral Checklist, which includes mental health and substance abuse subscales. Functional Family Therapy (FFT), an evidence-based intervention, is provided to all youth in the program. FFT proceeds in standardized phases: Phase 1 is the engagement and motivation phase, Phase 2 focuses on behavior changes, and Phase 3 emphasizes the generalization of skills learned in therapy.

Family Intervention Specialists, Georgia.

Family Intervention Specialists are a not-for-profit provider of intensive family intervention services. The program serves youth age 8 to 16 and a half who have a mental health disorder and who are referred from probation intake or the juvenile court. The county employs specialized probation officers who are trained to identify mental health and substance abuse disorders and who screen all youth referred to them using a standardized tool to screen for disorders. Upon referral to the program, all youth are administered the MAYSI-2 and the CAFAS. The Mauldin Pattern Assessment, which looks at the healthiness and strengths of a child and family, is administered to the youth and the youth's primary caregiver at the beginning and end of program participation. The program uses Brief Strategic Therapy as its core mental health service provided to youth to prevent out of home placement. The intervention provides families with the tools to decrease individual and family risk factors through focused interventions that improve problematic family relations and skill building therapies. The program

also provides parenting skills training, tutoring and anger management classes. Families are typically discharged from the program after three to four months. Aftercare services are available if needed, and program staff make three, six and 9-month follow-up phone calls with the family using a standardized outcome protocol to track family functioning.

Juvenile Court Liaison Program, Montgomery, Alabama

The Juvenile Court Liaison program is a statewide initiative that was created to provide a mental health presence in juvenile courts throughout the state. Court liaisons are master's level clinicians employed by the community mental health center who work exclusively with youth and families who come to the attention of the juvenile court. Youth can be diverted to the court liaison at any point in the juvenile justice process (from probation intake through adjudication) until the youth is committed to the Department of Youth Services. There is variation by county, but generally, liaisons provide case management services as well as direct therapeutic interventions, consultations and referrals for clinical evaluations and services, and reports to the court on a preferred course of action for the youth.

Family Intervention Resource Services Team (FIRST), Owensboro, Kentucky

The Family Intervention Resource Services Team (FIRST) is a county diversion program for first-time status offenders in grades 6th through 8th who have mental health and substance abuse problems and who appear for adjudication in juvenile court. The goal of the program is to connect these youth with effective, community-based interventions as an alternative to further (and more formal) court processing. The Court Designated Worker, who serves as the gatekeeper to juvenile court, makes referrals to the program based on referrals to the court from probation intake. The Court Designated Worker administers the POSIT to determine mental health status and shares the results of this evaluation with the FIRST program. The FIRST case manager then meets with the family (either at their home or at the court office) to do the formal program intake, to interview and meet the family and begin the development of a family service plan. The FIRST case manager provides referrals and linkages to a range of community services including mental health and substance abuse services, as well as case management to the family. The family case manager regularly reports to back to the Court Designated Worker on how the case is progressing, and if a youth meets the goals included in the individual service plan, the case is closed successfully. Typically, cases stay open 6 months, although the Court Designated Worker can ask the court to grant an extension if more time is necessary for a youth to meet the plan's goals.

Cross Program Review

This section of the report includes summary information on the seven identified promising programs. Included is the following:

- A review of the similarities and differences across the programs in several key domains;
- A summary of the issues identified by the programs as barriers to program development and service delivery; and
- A discussion of the elements identified by the programs as critical when developing a diversion program.

I. Program Similarities and Differences by Domain

Target Population. Each of the seven programs serves youth with mental health needs, though not all do so exclusively. The level of offender the program accepts and the number of youth served differs across programs.

Intake. Each program has a standard intake process which involves routine screening for mental health and substance use disorders and follow-up assessment and evaluation for youth whose screen indicates a need.

Services: Each program provides mental health specific services to youth but they differ in terms of whether the services are provided directly, the program brokers the services, or if provision is a mix of direct and brokered services.

Funding. The source of funding for selected programs varies. Some are funded by federal grants with or without local matches and others with state level funds. The programs also differ by their eligibility to receive Medicaid reimbursement. Additionally, two of the programs identified are funded as part of a statewide initiative while the remaining programs represent localized models.

Structure and Staffing. Five of the identified models are standalone programs with staff assigned to the diversion efforts. In one, the liaison program statewide in Alabama, the model is an individual person assigned to a court rather than an entire program with multiple staff.

II. Barriers to Development and to Service Delivery

The following areas were identified by programs as presenting difficulties in program development and service delivery.

Lack of information. As programs sought guidance in developing their program model they found a deficiency in the information available. There is information

available on adult diversion programs, but not all aspects of adult programs can or should be applied to juvenile diversion programs. One particular area where the transferability of information from the adult to the juvenile level falls short or may, in fact, be inappropriate is around treatment interventions and service delivery.

For example, the Integrated Co-Occurring Treatment Program (ICT) found limited information in the literature specific to youth with co-occurring disorders. There was no information to guide the optimal length of stay or what diagnoses should be included in identifying youth with co-occurring disorders. Also, the one co-occurring disorder treatment program that was considered effective was developed for adults and was not specific to the needs of youth.

Program Capacity. Several of the identified programs rely on intensive home-based service delivery which requires a low staff to client ratio. The programs are challenged with satisfying funding agencies requirements that are generally not supportive of programs serving relatively small numbers of youth versus the program's desire to maintain a low staff to client ratio and to provide effective treatment. Several programs structured their programs around specific treatment modalities, all of which call for low staff to client ratios. For example, the Family Interventions Specialists program is modeled around Brief Strategic Family Therapy, the Ohio Program structured the diversion program around the provision of an integrated co-occurring treatment model, and the Indiana program is modeled around the delivery of Family Functional Therapy. There is a growing body of research indicating intensive interventions are more effective than programs providing less specified treatments to greater numbers of youth.

Training. Programs had little guidance when deciding the content of training and the appropriate group to train. The absence of clear training curriculum was driven by the lack of clarity on program staff and partner agencies' roles and responsibilities. Program developers also faced broader training issues centered on what levels of staff to train at partner agencies and which partner agencies to involve in training in order to maximize buy-in.

Data collection and Evaluation. Most of the highlighted programs began with flexible or semi-defined goals. By virtue of that they had few prescribed outcome measures. Most programs collected data on the number of youth served and services provided but did little to evaluate the impact of the program on youth functioning. Securing continued funding commonly hinges on measures of efficacy so these programs have or are in the process of defining additional data elements to measure program impact.

Partner Agency Cooperation. These programs faced initial reluctance from partner agencies, primarily at the line-staff level. Most of the programs identified are structured so that a clinician or a clinical team has the lead in providing or coordinating services for diverted youth, but all either partner with or informally rely on justice agencies. Minimally, diversion programs must secure buy-in from

justice agencies to receive appropriate and timely referrals. The SNDP initiative in Texas represents a collaborative effort with equal buy-in from justice and mental health staff. The diversion program is structured around teams comprised of a Probation Officer and a therapist.

Regardless of the formality of the relationship between agencies, all of the identified programs succeeded in creating strong partnerships. The cooperation strengthened over time as staff from the different systems realized the relationships were mutually beneficial. For example, probation officers, parole officers, and judges realized that their own job was made easier and more effective by the efforts of the clinical diversion staff. Probation and parole officers can divide the number of home visits or appointments for youth under their supervision with diversion staff. Justice personnel come to rely on clinical staff for advice both at the individual case level and more generally for information on mental health disorders and optimal system handling of such cases. In turn, mental health providers benefit from the supervision role justice plays and from the specialized knowledge base of justice system practitioners.

Lack of Community Mental Health Services. All of the promising programs, as well as many of the programs the Center interviewed by telephone, identified the lack of available community mental health services as a continuing difficulty. This shortfall is salient to all programs but is especially prominent for specific diversion program models. Some diversion programs are structured so the program serves as a broker and links youth to mental health services provided in the community, providing no direct mental health and/or substance abuse services themselves. Another model is one where programs provide a limited amount of direct mental health services and broker for specific interventions. These two models need to have access to effective services in the community with available slots to link diverted youth. ICT and Family Intervention Specialists are examples of the third model identified. This model directly provides the intervention including the mental health component. Community mental health services are still utilized by the direct service models and all other programs. When youth are discharged from the program they should be linked to appropriate community services to maintain progress made while in the diversion program.

Fragmentation of Efforts: The youth involved in these programs are typically involved with multiple systems and the efforts of the multiple agencies involved are often fragmented. The multiple agencies with which youth are involved typically create their own case plans which are often duplicative or inconsistent. To overcome this, the justice and mental health agencies involved in the Harris County SNDP approved a single case plan document (provide in packet). The Jefferson County D & E program is in the process of developing a centralized assessment/intake/case planning process to more fully incorporate juvenile justice, mental health and substance abuse service needs into a comprehensive plan of action.

III. Elements Identified as Critical for Transferring to New Jurisdictions

Program staff were asked to identify elements of a juvenile diversion model that are critical for jurisdictions to address when improving or developing a diversion program.

Identification of Essential Stakeholders. Successful programs identify professionals in strategic positions at critical agencies. Staff at these selected programs stated that they were able to identify the individuals who held positions that put them in a position to pull people together and to secure cooperation. Judges were the professionals most commonly identified as essential to successful development and ongoing operation of programs.

Accessibility. Successful programs identify access to program staff as critical. For example, the D&E program and its staff are housed within the Family Court to maximize access for youth, family, and justice professionals. The Alabama Statewide initiative is a model that specifically seeks to create a mental health *presence* in the court by assigning mental health liaisons to courts. Accessibility promotes regular interaction and immediate follow-up to case specific issues that arise, increases program visibility which in turn increases the likelihood that appropriate, timely referrals are made, and reduces the burden of program involvement on youth and families.

Sustainability: Successful programs are forward thinking in their approach to funding. Due to the soft money environment in which they exist, successful programs are continually seeking new funding streams regardless of their current stability. For example, the Jefferson County D&E unit secured a federal SAMHSA/CMHS grant that required matching funds. The Family Court provided $2.00 for every $1.00 the federal grant provided. The group overseeing the program secured the Courts agreement to sustain the D&E unit at seventy-five percent of its current level once the federal money is removed. This pledge was secured far in advance of the end of the federal funds.

Capitalize on Partner Agency Expertise. Successful programs draw on the distinct skill sets that mental health and justice professionals bring to the endeavor. Rather than asking a professional in one area also to become a specialist in the other, these programs have staff learn from one another but do not expect specialized knowledge. Working in tandem minimizes unilateral decisions and balances the weight put on either supervision or treatment. For example, the SNDP in Texas promotes the blending of skills by structuring the diversion program as a team and diverted youth are assigned to a team comprised of a therapist and a probation officer.

Family Involvement. Successful programs go beyond nominal family involvement and incorporate families into the structure of the program. Most of the selected programs have family members on staff in various capacities including:

involvement in the intake process, running family groups, working as advocates for family members currently involved in the program, and providing feedback to clinical and justice staff.

Summary

This survey offers an important first look at diversion for juvenile offenders and provides an understanding of the key features of these programs - what they look like, how they are funded, how they select youth, what services they provide and more. While they vary, these programs are all similar in that they seek to identify and intervene early to prevent the unnecessary penetration of these youth further into the juvenile justice system, and to provide the community-based services necessary to improve the lives of these youth and their families. Despite these initial steps, our collective knowledge base on this issue continues to lag significantly. While 200 programs were initially identified through the survey, only a very small number (20) focus their efforts exclusively on serving youth with mental health and substance abuse problems. While some of these programs appear to be doing a good job, all of them are struggling with serious issues like:

- A lack of funding to support their programs;
- A lack of community-based mental health and substance abuse services available to divert youth to; and
- A lack of information on effective diversion models for youth with mental health and substance abuse needs.

There has been no wide scale investment in these types of programs. Consequently, there are many youth whose needs are simply not being met. It is hoped that the findings from this work will guide the next steps around the further identification, evaluation and implementation of diversion models that effectively respond to the mental health and substance use needs of youth.

References

National Institutes of Health, State of the Science Conference Statement. Preventing Violence and Related Health-Risking Social Behaviors in Adolescents. Draft Statement, October 15, 2004.

Texas Youth Commission. (2002) *Mental health presentation*. Council of Juvenile Justice Correctional Administrators, Best Practices Committee, San Antonio, TX.

Halbfinger, D. Care of juvenile offenders in Mississippi is faulted. *New York Times.* Sept. 1, 2003.

NATIONAL CENTER FOR MENTAL HEALTH AND JUVENILE JUSTICE

Juvenile Justice Diversion and Reintegration Initiative for Youth with Mental Health and Co-Occurring Substance Use Disorders

Special Needs Diversion Program
Texas Correctional Office on Offenders with Medical and Mental Impairments Initiative, Harris County, Texas

PROJECT OVERVIEW

The goal of the *Juvenile Justice Diversion and Reintegration Initiative for Youth with Mental Health and Co-Occurring Substance Use Disorders* is to identify programs and strategies that currently exist to divert youth with mental health and co-occurring substance use disorders from the juvenile justice system into community-based settings. The National Center for Mental Health and Juvenile Justice (NCMHJJ), operated by Policy Research Associates, received funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to better identify and assess, across the juvenile justice and mental health fields, effective and promising models and practices to divert and reintegrate youth with mental health and co-occurring substance abuse disorders. Results of this initiative are being shared with national, state and local officials across the country in order to foster the further development and implementation of comprehensive and integrated models that will more successfully meet the needs of youth, enhance their functioning, and reduce recidivism.

Building on an initial juvenile diversion survey that was completed by the NCMHJJ, in partnership with the Council of Juvenile Correctional Administrators (CJCA) and the National Association of State Mental Health Program Directors (NASMHPD), on-site and telephone interviews were conducted with seven of the most promising programs identified through the initial survey work. The program summary below highlights key information collected on one of these programs, the Special Needs Diversion Program, Texas Correctional Office on Offenders with Medical and Mental Impairments Initiative in Harris County, Texas.

HISTORY OF THE PROGRAM

The Harris County Juvenile Probation Department (HCJPD), the Texas Youth Commission (TYC) and the Mental Health Mental Retardation Authority of Harris County (MHMRA) collaborated to create the Juvenile Justice Mental Health Service program. The programs under the Juvenile Justice Mental Health Service program are

funded by the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI) and have two components: a program for diverting justice involved youth with a primary mental health diagnosis and a program designed to promote continuity of care and reintegration into the community for youth released from secure TYC facilities. The HCJPD teams began serving youth in 2001.

HCJPD, TYC and MHMRA joined forces in response to the needs of their community as well as to an RFP put out by TCOOMMI. Harris County has a history of collaboration among mental health, justice, and child welfare agencies which predates response to the TCOOMMI RFP. The program visited indicates they faced few barriers to program implementation since this was not the first time the groups had partnered.

The four Harris County Probation/LPHA teams serve approximately 60 youth annually. Each team has a caseload of 12-15 youth. The Teams provide diversion services to youth with a mental health diagnosis.

PROGRAM OVERVIEW

Program Structure and Staffing

The Probation/LPHA team consists of one therapist (employed by MHMRA) and one probation officer (employed by HCJPD). There are four teams within Harris County. Each team works together on the same caseload of 12-15 probationers. The gatekeeper to the teams is a specialized service coordinator employed by MHMRA. The service coordinator approves all referrals made to the Teams. Collaboration between County Mental Health and Juvenile Probation is required by the funding agency.

Funding Sources and Program Costs

Probation/LPHA teams are funded through the statewide Special Needs Diversion Program initiative, and revenue collected from Medicaid, CHIP, or Third Party Payers. In this initiative, the legislature provides the TCOOMMI funds to support localized diversion programs. The program's yearly revenue collected through Medicaid, CHIPS, and Third Party Payers was $110,000. The TCOOMMI is responsible for funding initiatives throughout the State. The State places several contractual requirements for those sites receiving TCOOMMI special needs diversion funds.

SERVICES PROVIDED

Overview of service configuration

The program service plan is based on a wraparound philosophy of team treatment planning. Program services are founded on intensive case management and multi-disciplinary team treatment models. The team is responsible for securing, providing, and or supervising the provision of services. Teams strive to provide the majority of services in the home or school. The mental health services that are not directly provided by the team are primarily available through the MHMRA. Teams must provide or secure services that at least include: medication related services, group and individual

counseling, health care, job training services, continuum of care services, court resource services and other services included in individual treatment plans.

The two team partners are co-located to stay in close contact with one another regarding individual youth's progress, but also meet with the child individually. Three times a week the Probation Officer assigned to the youth makes an unscheduled home visit and the LPHA therapist makes one scheduled visit per week. Participant families have three to five program contacts per week; a minimum of two are in the home. The services are available at flexible times to minimize interruption of work and school schedules and translators are on-call and available at all family sessions.

Referral Process

There are multiple justice and non-justice points of entry to a Probation/LPHA team. All referrals are sent to the Service Coordinator who acts as the gatekeeper to the program and determines eligibility. Referral points include:

- Probation Officers housed in courtrooms

  Probation officers staff the courtroom and if they hear a case that meets program requirements they can refer a youth to the service coordinator (Rare point of entry).
- Pending adjudication

  Detention hearings are the primary referral mechanisms for youth pending adjudication. The program is voluntary, but once youth agree to participation at the detention hearing then participation becomes a condition of probation.
- Post adjudication

  Youth can be referred from a Probation run assessment center. Youth are held here post-adjudication pending an assessment and determination of the appropriate placement. The majority of youth referred to the probation/ LPHA team come from the assessment center.
- Mental Health and Mental Retardation Authority clinics
- Family
- Other community agencies

Intake process

- Screening for mental health disorders

  Texas requires Probation intake officers to use the Massachusetts Youth Screening Inventory (MAYSI) to screen all youth that are not released at intake. The results of the Probation screen are passed to the program.
- Clinical assessment

  A clinical or psychiatric evaluation is completed by MHMRA staff for all youth referred to the Probation/LPHA teams.
- Family Suitability Interview

  After the clinical assessment is completed and it is determined that the youth is part of the priority population, a family suitability interview is conducted. The Probation/LPHA team meets with the legal guardian and youth and conducts an interview during which program requirements and the responsibilities of the Probation Officer, LPHA, legal guardian and the youth are explained. If a family

declines participation but the Team feels they are appropriate clients, the Team contacts a Family Advocate. The Family Advocate approaches the guardian and youth to secure cooperation.

Direct Services

- Benefit Coordination

The program has a Benefit Coordination component. All clients accepted into a Probation/LPHA team are referred to a benefit coordinator within five days of admission. The benefit coordinator assists with the Medicaid/CHIP paperwork. If the youth does not have insurance, the coordinator completes the Medicaid/CHIP application within 5 days of enrollment.

- Team Treatment Planning

The Probation/LPHA team is responsible for pulling together the team that devises an individual treatment plan (Team Staffing). The team that staffs the treatment plan is made up of, at a minimum, a licensed clinician, child and adolescent psychiatrist, a service coordinator, and a guardian (when applicable). Cases are staffed monthly by the teams. To reduce overlapping or conflicting requirements on youth and their families, the Harris County Probation Department and the Mental Health agency developed one case plan that meets the needs of both agencies. Individual case plans are developed together and jointly signed.

- Psychiatric Services

Psychiatric services are dependent on the initial psychiatric assessment. A client will be seen a minimum of one time per month and more frequently if necessary. Psychiatrists provide office based services and join each team once every three weeks on a home visit to provide home-based medication follow-up. The psychiatrist communicates regularly with all treatment team members to insure coordination of care.

- Parent support groups and Child support groups

As part of participation with a Probation/LPHA, parents are required to attend a parent group which meets one time a week. The parent group provides an opportunity for parents to meet other parents and is facilitated by a Family Advocate. The Probation/LPHA teams have four family advocates who are from the National Alliance of Mental Health. The weekly parent support groups are held at the same time and location as the required weekly child group sessions. Both the parent and the child groups are flexible and cover a variety of issues with the overarching goal of rehabilitation and skills training.

- Community-based services

Teams have a broad knowledge of the services available in the community and, beyond the direct services the Teams provide, they link clients or family members to these services. To maximize Team awareness of community resources, the Program divided the County into quadrants and each Team is responsible for a particular area. Teams attend Wraparound training; the County produces a Service Resource book; and Teams can access a United Way helpline.

- Transition planning

Transition planning begins two months prior to planned discharge (2-4 months into the program). During the larger monthly case staffings the full team involved

in the treatment plan is responsible for developing a transition plan. The Probation/LPHA team is responsible for making referrals or connections developed in the transition plan. If a client declines referrals and any planned continuum of care the Probation/LPHA team must provide the client with an emergency psychiatric number to call if immediate services are needed.

Barriers related to services and steps to overcome

When Probation and Mental Health began jointly serving youth, each agency had their own treatment plan. To streamline the process and limit unnecessary burden on youth and their families, the agencies chose to approve a single case plan document. The primary obstacle in developing a single plan was related to each agency struggling to have their own interests addressed in the plan and failing to understand the importance of the other agencies interests and requirements for inclusion. For example, Probation did not understand the MHMRA's emphasis on Medicaid eligibility. Many other sites funded by TCOOMMI SNDP funds continue to struggle with the development of a single case plan.

CHARACTERISTICS OF YOUTH AND FAMILIES

In order for youth to be eligible for Team services they must be Harris County residents ages 10-18 years old with a primary mental health diagnosis (DSM IV, Axis I-MH) **AND** have at least one of the following:

- GAF score of 50 or below
- Classified as Seriously emotionally disturbed (SED) in Special Education
- At risk of removal from home/living environment due to psychiatric reasons

Factors related to the youths' justice involvement are not used to restrict youth from the program. However, since the Teams can only serve 60 youth annually they must turn youth away. The common clinical override is chemical dependency and the most common justice overrides are a history of noncompliance with probation or multiple runaways.

Teams provide services to youth and their families from four to six months. Transition planning begins two months into the program. At the individual family level there is required involvement. The legal guardian of the youth involved in the Team must attend weekly parent groups and be available for some of the home visits made by the Team members. To offset the burdens of weekly participation, the Family Sessions are structured to empower families and to maximize the benefits of involvement. Family Advocates state that sessions are geared toward empowering parents to ask questions and be active voices in developing their child's treatment plan.

LEVEL OF INTERAGENCY COORDINATION

Collaboration is fostered through the monthly case staffing when teams and ancillary providers meet to review case plans. The state representatives believe coordination can be sustained by mandating collaboration as a requirement of funding. Buy-in from

individual team members is not perceived as sufficient for sustainability; their must be agency-wide buy-in to promote a culture of change.

DEMONSTRATED OUTCOMES OF PROGRAM

The State requires locally funded programs to collect specific data elements to measure outcomes. These elements include:

- Number of arrests
- Number of absconders
- Number of revocations
- Number of detention admissions
- Number of psychiatric inpatient stays
- Number of institutional admissions

The Legislature has directed Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), Texas Juvenile Probation Commission and other State agencies involved in the initiative to submit a report on a three year recidivism study of the Juvenile Justice initiative in January 2005.

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NATIONAL CENTER FOR MENTAL HEALTH AND JUVENILE JUSTICE

Juvenile Justice Diversion and Reintegration Initiative for Youth with Mental Health and Co-Occurring Substance Use Disorders

Integrated Co-Occurring Treatment (ICT) Program
Akron, Ohio

PROJECT OVERVIEW

The goal of the *Juvenile Justice Diversion and Reintegration Initiative for Youth with Mental Health and Co-Occurring Substance Use Disorders* is to identify programs and strategies that currently exist to divert youth with mental health and co-occurring substance use disorders from the juvenile justice system into community-based settings. The National Center for Mental Health and Juvenile Justice (NCMHJJ), operated by Policy Research Associates, received funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to better identify and assess, across the juvenile justice and mental health fields, effective and promising models and practices to divert and reintegrate youth with mental health and co-occurring substance abuse disorders. Results of this initiative are being shared with national, state and local officials across the country in order to foster the further development and implementation of comprehensive and integrated models that will more successfully meet the needs of youth, enhance their functioning, and reduce recidivism.

Building on an initial juvenile diversion survey that was completed by the NCMHJJ, in partnership with the Council of Juvenile Correctional Administrators (CJCA) and the National Association of State Mental Health Program Directors (NASMHPD), on-site and telephone interviews were conducted with seven of the most promising programs identified through the initial survey work. The program summary below highlights key information collected on one of these programs, the Integrated Co-Occurring Treatment (ICT) Program in Akron, Ohio.

HISTORY OF THE PROGRAM

The ICT program is a treatment model specifically designed to serve justice involved youth with co-occurring mental health and substance use disorders. The model is an integrated treatment approach using an intensive home-based model of service. The ICT program is both a reintegration program and a diversion program, serving youth on Probation and Parole. Approximately two thirds of the youth served are on Parole and the remaining youth are on Probation.

Since receiving a residency and training grant in 1987 from the Ohio Department of Mental Health, the University of Akron, Center for Family Studies has been providing home-based intervention training for undergraduate and graduate students and on-site home-based intervention training for professionals in the community. In 1999 the Center for Family Studies staff began to focus on more specific applications of home-based intervention and embarked on the development of an integrated community/home-based treatment model for adolescents with co-occurring disorders of substance abuse and mental health.

The ICT model was collaboratively developed with support from the Ohio Department of Mental Health. The model development was based on several steps which included: a review of the literature; analysis of current effective treatment programs designed for dual diagnosis; a series of focus groups with adolescents, their families and their service providers from mental health, substance abuse, education and juvenile courts; and convening a task force of psychologists, psychiatrists, drug and alcohol counselors, consumers, parent advocates, and juvenile justice representatives, who met monthly to guide the development of the model. The original focus of the model was youth with co-occurring disorders, but was later adapted to include youth with juvenile justice involvement in response to receiving a juvenile justice diversion grant. The model was piloted in 2001, utilizing funds from a Juvenile Accountability Incentive Block Grant (JAIBG) administered by the Ohio Department of Youth Services.

A private community mental health agency was contracted to implement the model and evaluation components were built in. In 2003, the piloting of ICT continued utilizing Byrne grant funds made available through Ohio's Office of Criminal Justice Services. The team continues to meet with service providers for feedback and ongoing modification of the model.

Barriers to Development

When developing the model, the initial barrier was the limited amount of information available in the literature specific to youth with co-occurring disorders. For example, there was no information available to guide the optimal length of stay in the program or what diagnoses should be included in identifying youth with co-occurring disorders. Secondly, the one integrated treatment program that was considered effective (Integrated Dual Diagnosis Treatment; IDDT), was developed for adults (Mueser, Noordsy, Drake, & Fox, 2003) and was not specific to the needs of youth. The developers also faced barriers in finding and training clinicians to provide both substance and mental health treatment.

SERVICES PROVIDED

Overview of Service Configuration

The program is grounded in System of Care service principles and utilizes resilience-guided treatment interventions. An array of services including individual and family therapy, case management, crisis response, and advocacy are provided by Masters level

dually trained clinicians who provide integrated treatment for the youth's mental health and substance abuse disorders. Weekly staging meetings are held with the clinician and the youth's parole officer in order to better facilitate collaboration and service coordination.

The clinicians are employees of the Child Guidance and Family Solutions, a non-profit community mental health agency, though their salaries have been paid through grant funds from JAIBG (2001 and 2002) and from a Byrne grant (2003 and 2004) . Child Guidance and Family Solutions was initially approached because of its history of supporting and providing innovative programming.

Referral Process

Youth are referred to the program in one of two ways: 1) a judge can refer youth to the program as a condition of probation (in Summit County, this occurs through Crossroads, an innovative Juvenile Court program that was developed to comprehensively address mental health and substance abuse issues of court-involved youth); and 2) youth can be identified by staff at Department of Youth Services (DYS) facilities prior to release on Parole. For incarcerated youth, if the packet prepared prior to release indicates a youth has both a mental health (cannot be only conduct disorder) and substance use diagnosis and is being discharged into the region served by the program, the DYS staff can refer youth to the program. When a youth is referred, the youth's participation in the program is typically mandated in the youth's probation or parole case plan. The Program meets with DYS on a weekly basis to keep them aware of the program and to update staff on availability of program slots.

Intake Process

- Screening for mental health and substance use disorders

The program uses assessment instruments that draw on multiple perspectives (youth, parent and provider). The instruments include: the Child Adolescent and Functional Assessment Scale for level of functioning; CALOCUS for determination of level of care; SASSI-adolescent version for substance abuse; and Ohio Scales-Youth, Parent, and Worker versions.

Direct Services

The program clinicians are available to each family on their caseload 24 hours a day, 7 days a week. Clinicians meet with the client 2-4 times per week, averaging 3-6 hours per week. Assessment and intervention services are delivered in the home, school and community. Services are delivered using a stage wise treatment approach and are geared toward meeting the youth and family's primary presenting needs prior to proceeding to more complex needs. A family need hierarchy is used to prioritize the youth and family needs (Shepler, 1991; Shepler & Cleminshaw, 1999). The clinicians utilize individual and family therapy interventions to effect change with the youth and family. Individual treatment focuses on skill and asset building, while simultaneously focusing on risk reduction. Family interventions include building parenting skills, and rebuilding family hierarchy and relationships. Finally, the clinician works with the larger community to

increase positive community connections, as well as community readiness to embrace the youth (back into school or to hire a youth, for example).

The services provided include:

- Cognitive behavioral therapy
- Family therapy
- Skill building
- System advocacy
- Resource linkage
- Crisis management and stabilization
- Random drug screening is administered by the Probation or Parole officer assigned to the youth
- Relapse prevention

Relapse prevention is incorporated into ICT and includes assisting parents in increasing parental monitoring and supervision, teaching youth self-regulation skills, and linking youth with pro-social peers and activities. In addition, aftercare planning addresses the services and supports that are necessary for the youth's ongoing success. The typical aftercare recommendations focus on maintenance and relapse prevention and include:

- Mentoring
- Supportive counseling
- Education and work skill development
- Linkage to community supports and resources
- Pro-social activities and contributions

Barriers Related to Services and Steps to Overcome

When the model was developed, the decision was made to use a computerized structured diagnostic assessment, but based on feedback from the service providers this assessment was discontinued. The clinicians found that this type of assessment was not conducive to use in the field, partly due to the length of time involved and partly due to concerns about the ability to detect co-occurring disorders. The computerized assessment did not identify disorders as sensitively as did independent assessments by the ICT providers and the DYS pre-referral assessment. The program now uses a team diagnostic approach (including the psychiatrist when available) to make and confirm the diagnoses of the youth.

The low staff to client ratio is considered an integral component to effective service delivery, but is also identified as a barrier because of the limited number of youth that can be served. The program also cited the difficulty in identifying and hiring professionals with sufficient training and credentials as a barrier to service delivery. Additionally, there is a general lack of psychiatrists who serve youth. Ideally, the program would like a psychiatrist to be part of the ICT team, but since child psychiatrist availability is limited, the model focuses on encouraging increased access to the available agency or community psychiatrist.

Child Guidance and Family Solutions, the agency that employs the clinicians who deliver the services, had early reservations about the financial implications of being the agency to pilot the model. The administrative staff stresses the importance of using a case rate funding mechanism that reflects the needs of the families instead of basing funds on categories of services. The agency can be reimbursed at a case rate because the JAIBG grant gives the University this flexibility.

Probation and Parole officers, who have youth on their caseload who are involved in the ICT program, stated that it was difficult for them to buy in to letting the service providers take the lead on the youth. However, most justice personnel have embraced the program over time as they learned that either having the clinicians to discuss problems with or handle problems has proved to make their own jobs easier.

The service teams meet with the youth more often than the Probation or Parole officers so the Probation or Parole officer often calls the team to get information.

CHARACTERISITCS OF YOUTH AND FAMILIES

Since the current team began serving youth in 2001, the program has served 84 families. The age of youth served ranges from 13-18 years of age. The mean length of stay is 6 months. The program serves youth who have a long history of being involved with multiple child-serving systems, but who have not been successful previously. In addition to the youth struggling with substance abuse, mental illness, and juvenile justice concerns, these youth also experience significant difficulty with school success and functioning.

To be eligible for the program, youth must have specific substance use and mental health diagnoses. To be included in the program the mental health criteria include: Mood disorders, Psychotic disorders, or Anxiety-related disorders (having *only* a Behavior Disorder coupled with a substance abuse disorder would not make a youth eligible). The substance abuse criteria include meeting the DSM IV criteria for Abuse or Dependency.

LEVEL OF INTERAGENCY COORDINATION

Clinicians and justice staff both identified the weekly staging meetings as beneficial tools in taking each system's perspective into account when dealing with each youth and family. Because services are delivered in the community, the providers have greater access to coordinating services with other systems where the youth lives and functions, such as the school. In addition, the ICT provider further coordinates positive connections for the youth in the community, by facilitating linkages with pro-social activities, mentors, and age appropriate twelve-step programs.

One of the barriers to interagency coordination identified by Child Guidance and Family Solutions' administrators was the traditional separation of child-serving systems such as, Mental Health, Substance Abuse and Juvenile Justice. This poses a problem for not only the funding of co-occurring treatment for juvenile justice involved youth, but also for the

communication across systems. The administrators also added that HIPAA regulations further complicate the communication across agencies.

DEMONSTRATED OUTCOMES OF PROGRAM

The program developers have conducted an initial evaluation of ICT, with some promising results. The outcomes tracked include mental health, substance abuse, and juvenile justice outcomes, and functioning in relevant life domains. The recidivism and commitment rates at discharge from ICT average 25% which is significantly lower than the recidivism rate for usual services in the same community. In addition, youth showed improvement in functioning and behaviors, but the small sample size and lack of randomization limits the conclusions that can be drawn at this time. The program systematically collects data and has an evaluation component built in so more in-depth analysis is underway.

PROGRAM RELATED REFERENCE MATERIAL

Mueser, K.T., Noordsy, D.L., Drake, R.E., & Fox, L. (2003). Integrated treatment for dual disorders: A guide to effective practice. New York: Guilford.

Shepler R. (1991). Integrating home-based practice: A transdisciplinary model for treating multi-need families. In P. Cibik, S. Gwatkin, C. Pastore, & R. Shepler (Eds.), *A Practitioner's Guide to Home-based Services: A Resource Manual* (pp. 311-331). Akron, OH: The Center for Family Studies, The University of Akron.

Shepler, R. N. & Cleminshaw, H. (1999). Community-based intervention for families. In L. VandeCreek and T.L. Jackson (Eds.) *Innovations in Clinical Practice: A Source Book* (pp.413-430). Sarasota, Florida: Professional Resource Press.

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NATIONAL CENTER FOR MENTAL HEALTH AND JUVENILE JUSTICE

Juvenile Justice Diversion and Reintegration Initiative for Youth with Mental Health and Co-Occurring Substance Use Disorders

Mental Health Diagnostic and Evaluation Units
Jefferson County, Alabama

PROJECT OVERVIEW

The goal of the *Juvenile Justice Diversion and Reintegration Initiative for Youth with Mental Health and Co-Occurring Substance Use Disorders* is to identify programs and strategies that currently exist to divert youth with mental health and co-occurring substance use disorders from the juvenile justice system into community-based settings. The National Center for Mental Health and Juvenile Justice (NCMHJJ), operated by Policy Research Associates, received funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to better identify and assess, across the juvenile justice and mental health fields, effective and promising models and practices to divert and reintegrate youth with mental health and co-occurring substance abuse disorders. Results of this initiative are being shared with national, state and local officials across the country in order to foster the further development and implementation of comprehensive and integrated models that will more successfully meet the needs of youth, enhance their functioning, and reduce recidivism.

Building on an initial juvenile diversion survey that was completed by the NCMHJJ, in partnership with the Council of Juvenile Correctional Administrators (CJCA) and the National Association of State Mental Health Program Directors (NASMHPD), on-site and telephone interviews were conducted with seven of the most promising programs identified through the initial survey work. The program summary below highlights key information collected on one of these programs, the Mental Health Diagnostic and Evaluation Units in Jefferson County, Alabama.

HISTORY OF THE PROGRAM

The Diagnostic and Evaluation unit (D&E) also referred to locally as Children Overcoming Problems Everyday (C.O.P.E.), is a county level program exclusively targeting youth with mental health disorders. There are four D&E units overseen by the Jefferson County Community Partnership (JCCP): two units in schools, one in the Department of Human Resources (Child Welfare) and one housed in Family Court. NCMHJJ Staff visited the Family Court unit, which was established in May 1999. The

court D&E unit is housed in the Family Court of Jefferson County, the largest juvenile court in Alabama.

The Jefferson-Blount-St. Clair Mental Health Authority (JBSMHA) is a regional, public, non-profit corporation. In 1990 this organization, with money from the State Department of Mental Health, began providing community-based in-home therapy and case management services to children with serious emotional disturbance who were at high risk for removal from the home. After successful demonstration of the in-home and case management model with 132 families in the tri-county catchment area during the first two years of operation, the JBSMHA was given additional funds by the State Department of Mental Health to expand to 4 teams and 4 case managers. By using these early successes, the JBSMHA also sought to increase interagency system of care collaboration for children and families in Jefferson County by establishing formal interagency contracts and agreements for direct service provision. In 1993, the Jefferson County Department of Human Resources (Child Welfare) was the first agency to contract with the JBSMHA to provide a specialized in-home team and case manager to serve their families. Local coordination efforts like this led to the formation of the Jefferson County Community Partnership (JCCP) in 1997.

The JCCP, under the guidance of the JBSMHA, applied for a SAMHSA/CMHS grant and was awarded $5.9 million dollars to more formally establish Jefferson County's system of care. Partnering with 17 local child-serving agencies and families, the JCCP has established D&E Units at family court, the child welfare agency, and designated city and county-based schools.

Barriers to Development

In preparing the SAMHSA grant, the JCCP was required to secure cross-agency cooperation to provide matching funds. The earliest barrier the JCCP faced was getting local providers and agencies to contribute funds. During the early 1990s, each agency tended to take the approach that multi-needs children were not their problem. This improved during the subsequent years as the state allocated funds for each county multi-needs child facilitation team to access treatment for higher risk children. In addition, the chair of the multi-needs facilitation team pushed each agency head to get on board with forming a true partnership to address multi-needs youth in Jefferson County. The team held full-day retreats where they worked on building cooperation and addressing actual and perceived constraints to cooperating.

PROGRAM OVERVIEW

Program Structure and Staffing

As the lead agency for the SAMHSA/CMHS grant, JBSMHA oversees the supervision of the units and monitors and reimburses the subcontractors that provide services. The units offer a full continuum of services at the primary ports of entry (court, child welfare and schools). The court unit staff is housed in Family Court so that services can be provided directly to youth and so that information can be provided to court staff in a timely

manner. The units evaluate youth and provide case management, psychiatric, outpatient therapy and access to additional wraparound services.

Funding Sources and Program Costs
The four D&E units began with a Federal SAMHSA/CMHS grant that required matching funds. For the court unit, the Family Court provides $2.00 for every $1.00 provided by the Federal grant. Any projected Medicaid reimbursement is backed out of the contract based upon billing trends in the past with clients served at Court. Local sustainability begins in FY 2005 and the Court has pledged money that will sustain the unit at 75% of the current level. The FY 2004 budget for the Court D&E unit was $370,000, of which $54,604 was covered by Medicaid revenue, $158,000 from the Jefferson County local revenue, and $157,866 from the Federal grant.

SERVICES PROVIDED

Overview of Service Configuration
The court unit provides services on-site. The court D&E unit employs: a Master's level Diagnostic and Evaluation Specialist, a Juvenile Court Psychiatrist (Child and Adolescent Board Certified), a Psychologist, two Case Managers, an Outpatient Therapist, and a parent/family advocate.

In addition to these on-site staff, the JCCP contracts with 17 additional providers to whom youth can be referred. The on-site staff is responsible for: screening all referrals, assessing and informing the judge of the least restrictive and most appropriate mental health and social service needs, developing an individualized service plan, and coordinating and accessing mental health and related social services with assistance from the case manager, parent advocates, and other community supports. The overall goal of the court unit is to complete an assessment in a timely manner and, in conjunction with the family, develop an individualized service plan.

Referral Process
The Family Court judge and probation officers can refer a child to the court unit for an initial screening and assessment (intake). Probation intake is the most common referral source. A probation intake officer can refer cases in which charges will be filed as well as those cases that are diverted at probation intake and charges are not filed in court. Through intake, the D&E specialist determines eligibility for program services, and if the child does not meet eligibility criteria the evaluation specialist will "refer out" by helping the family access service providers in the community.

Intake Process
- Screening for mental health and substance use disorders

Each unit is staffed with a Master's level mental health professional known as a D&E specialist whose job is to perform an initial screen and determine which youth need to be referred for a further evaluation. A family advocate is often present for the initial screen and intake. The D&E specialist is also responsible for providing mental health consultation to teachers, other school personnel, probation officers, and social

workers; brokering initial services within the target community, and promoting family education and involvement. The D&E specialist makes initial service recommendations with family input and then steps out and transfers to the case manager.

- Assessment for mental health and substance use disorders

The D&E specialist either conducts the mental health assessment or refers youth to a licensed psychologist from the University of Alabama at Birmingham (UAB) or Glenwood, with whom the court contracts to provide in-depth assessments. An assessment is only completed on youth whose initial screen indicates likely mental health issues. Substance abuse screening and assessment is conducted through an on-site court provider separate from the COPE unit.

Direct Services

- Diagnostic and Evaluation services

The Master's level D&E specialist is a full-time position responsible for evaluating and assessing those youth referred to the unit who present initially with mental health symptoms or who are already diagnosed and need more services. D&E specialists consult with probation officers and judges regarding least restrictive, most appropriate services for youth referred.

- Psychiatric assessment/consultation

The Juvenile Court Psychiatrist is a part-time professional who is on-site to assist with diagnosing juvenile court youth. The Unit also contracts with PhD level psychologists from the UAB who evaluates youth to aid in treatment planning.

- Medication monitoring

The Juvenile Court Psychiatrist is on-site part-time to provide medication consultation and monitoring once a diagnosis is assigned/confirmed and medication is recommended.

- Crisis Intervention

The Juvenile Court Psychiatrist is on call within 2 hours for crisis situations and the rest of the court D&E unit staff provide crisis support and intervention as needed. A 24-hour emergency phone access service is provided to families who are involved with the in home therapy program (for the 12-16 week service period).

- Case management

The 2 full time case managers are on site at the court and provide brokering/linkage services to mental health and social/recreational services as well as advocacy at the school and court. Case Managers monitor progress and collaborate with other providers to ensure continuity of care.

- Individual/family/group outpatient therapy

The Unit has 1 full time therapist who provides outpatient therapy at the court and takes referrals from the D&E specialist.

- Parent advocacy and support groups
- Family advocate

A family member/advocate is present to participate during initial screenings and intake and is also accessible to families throughout the work week and on weekends through special arrangements. Program staff report that family members are more

likely to broach difficult issues with the family advocate present at some point during the screening/intake process.

- Referral and linkage to non-mental health services

Discharge from the Program

Once the individualized service plan goals have been met, the child/family can be considered for discharge from the program if they have completed the terms of their probation. In fact, the majority of youth who were referred to the program as a condition of their probation often choose to remain with the program even after probation has ended. Parents are usually receptive to continuing with the program because of its accessibility and flexibility. The average length of involvement is eighteen months (1 ½ years).

Barriers Related to Services and Steps to Overcome

The units all have paid family advocates on staff but the program would like to see more positions filled with family members and more volunteer family involvement. Also, the program has created and utilizes an individualized service plan that covers the domains of mental health, safety, legal, educational, spiritual, family, and basic needs according to each child/family's specific needs. However, the program is in the process of developing a centralized assessment/intake/case-planning process to more fully incorporate the juvenile justice, mental health and substance abuse service needs into a comprehensive plan of action that will best meet the complex needs of the juvenile- involved youth and their family.

CHARACTERISTICS OF YOUTH AND FAMILIES

The court unit serves approximately 170 youth per year. The target population is children ages 5-21 (average age is 12.5) who reside in Jefferson County and who meet Alabama State Department of Mental Health's definition for Serious Emotional Disturbance. Criteria for enrollment include having a DSM-IV diagnosis and **either:** previous separation from family due to emotional and/or behavioral disturbance or significant functional impairments at home, school and/or in the community **and** is considered at risk for placement if services are not received.

LEVEL OF INTERAGENCY COORDINATION

The program was developed in Jefferson County, which has a long-history of attention to youth with mental health needs, and was developed by agencies that had a long-standing history of collaboration. County-wide collaboration began in the early 1990's, with the provision of home-based services to youth with mental health needs. The people involved in these early efforts are many of the same people involved in the D&E program both as direct supervisory staff and as staff of agencies in the larger network of partners. The multi-agency collaboration is also fostered through the Jefferson County Community Partnership. The County currently has a multi-needs facilitation team that meet once a month to discuss youth they are serving. Furthermore, the individuals who are on the multi-needs facilitation teams tend to be the same people involved in the JCCP initiative.

Collaboration specific to the D&E program is fostered by the fact that the JCCP oversees the SAMHSA grant and matching funds and uses the money as a tool to drive cooperation. Also, there is a symbolic pledge where all involved agency heads sign a document agreeing to their pledge to collaborate.

Proximity and daily contact also fosters collaboration. The probation officers and program staff are housed in the court building, so collaboration between justice and mental health is fostered through daily contact. Also, for youth who are on probation, the program case manager who is serving the child goes to court and talks regularly with that child's probation officer and the case manager attends all court hearings and prepares a written report for the judge and probation.

Barriers to Collaboration

The constant change at the Director level of one partner agency has occasionally been a barrier to local collaboration efforts. Since the inception of the D&E program, the Jefferson County Department of Human Resources has been through eight different administrations. However, the fact that a single juvenile court judge has remained involved and has served as a driving force in local collaboration efforts since 1990 greatly contributes to the program's ability to keep partner agencies interested.

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NATIONAL CENTER FOR MENTAL HEALTH AND JUVENILE JUSTICE

Juvenile Justice Diversion and Reintegration Initiative for Youth with Mental Health and Co-Occurring Substance Use Disorders

Indiana Family Project (Functional Family Therapy) Bloomington, Indiana

PROJECT OVERVIEW

The goal of the *Juvenile Justice Diversion and Reintegration Initiative for Youth with Mental Health and Co-Occurring Substance Use Disorders* is to identify programs and strategies that currently exist to divert youth with mental health and co-occurring substance use disorders from the juvenile justice system into community-based settings. The National Center for Mental Health and Juvenile Justice (NCMHJJ), operated by Policy Research Associates, received funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to better identify and assess, across the juvenile justice and mental health fields, effective and promising models and practices to divert and reintegrate youth with mental health and co-occurring substance abuse disorders. Results of this initiative are being shared with national, state and local officials across the country in order to foster the further development and implementation of comprehensive and integrated models that will more successfully meet the needs of youth, enhance their functioning, and reduce recidivism.

Building on an initial juvenile diversion survey that was completed by the NCMHJJ, in partnership with the Council of Juvenile Correctional Administrators (CJCA) and the National Association of State Mental Health Program Directors (NASMHPD), on-site and telephone interviews were conducted with seven of the most promising programs identified through the initial survey work. The program summary below highlights key information collected on one of these programs, the Indiana Family Project (Functional Family Therapy) in Bloomington, Indiana.

HISTORY OF THE PROGRAM

The Indiana Family Project (IFP) is a county-wide program for youth involved with the juvenile justice system in Monroe County. Five years ago, there was community interest in bringing an evidence-based program for youth to Monroe County, Indiana. The community "champions" were the probation department, community corrections and the juvenile court. At the same time, the Indiana University School of Education was showing an interest in becoming more of a part of the community by providing "cutting-

edge" training opportunities to students in counseling psychology. This shared interest of helping adolescents and families in need led to a partnership between the two to improve the lives of youth and families and to stop the spiral of delinquency. Dr. Thomas Sexton, professor at Indiana University and creator of an evidence-based treatment program, approached the juvenile court judge at the time, Judge Taliaferro, who was looking for ways to divert youth coming through her court. As a result of more than a year of relationship building and hard work on the part of the community "champions" to build support and obtain funding, the Indiana Family Project (IFP) was created. The agencies now meet on a monthly basis and undergo ongoing reevaluation and expansion.

IFP is a non-profit provider of intensive family intervention services. The program uses Functional Family Therapy (FFT) which is a family model intervention created by Dr. Thomas Sexton and Dr. James Alexander. FFT is being used in 148 sites around the country and internationally.

PROGRAM OVERVIEW

Program Structure and Staffing

The diversion program is run under the auspices of the Center for Adolescent and Family Services (CAFS) at Indiana University, of which Dr. Sexton is the clinical director. The staff consists of a team of five therapists (all doctoral students), a project leader, and an office administrator.

Funding Sources and Program Costs

It is estimated that the treatment costs about $2250 per family. The Project is funded by the Indiana Department of Corrections (DOC) through a four-year grant for diversion programs. This funding is directed from the DOC to Community Corrections or Family Court. The Family Court contracts with the Indiana Family Project to be the service provider. The funding is expect to continue, but if it ends the University will sustain the program.

SERVICES PROVIDED

Overview of Service Configuration

A youth is diverted by the Monroe County Juvenile Court. An intake Probation Officer performs a risk assessment and an intake assessment team assigns a risk level. A family preservation team identifies resources and oversees case management. The youth is referred to the Indiana Family Project and the project leader assigns the case to a trained FFT therapist. Services are delivered under the guidance of the FFT clinical supervisor, and are monitored by the probation officer. Upon discharge, the youth is referred back to the family preservation team at the Monroe County Juvenile Court. When issues arise, additional support is provided by a family support team composed of the FFT therapist, clinical supervisor, probation officer, and probation supervisor.

Referral Process
Referrals come from the Probation Department if the youth is diverted pre-adjudication, and from the Family Court Judge if the youth is diverted post-adjudication. A fax is sent to IFP referring a youth. The therapist will contact the family to set up an appointment, either in the home or at the CAFS. Most sessions occur in the home (60%) and in the office (40%), which is open late and on weekends to accommodate the family's schedule. Once a determination is made about who will be involved in treatment, the therapy begins.

Due to the program's popularity, referrals are increasingly coming from other youth-serving systems such as schools and behavioral health care.

Intake Process
Probation intake screens all youth who come before them for both substance use and mental health disorders. Intake officers use a standardized tool developed by Robert Barnoski, Ph.D. (Washington State Juvenile Court Pre-Screen Risk Assessment) to determine risk and protective factors. Those at low risk are referred to community service. Those at extremely high risk are referred to a Serious Habitual Offenders Comprehensive Action Program (SHOCAP). Those who are at high to moderate risk are referred for the Indiana Family Project using Functional Family Therapy (FFT) or Aggression Replacement Training (ART).

Once in the FFT program, the National Assessment Protocol is administered, which looks at the youth's behavior and the family's functioning. Also, the parent and youth each fill out a Youth Outcome Questionnaire (similar to the Child Behavioral Checklist). It has subscales for both mental health and substance abuse.

Direct Services
- Functional Family Therapy (FFT)

FFT is an integrated system for clinical assessment and successful family-based treatment of at-risk adolescents. The target group is youth age 18 and under and their families, whose problems range from acting out to conduct disorder to alcohol/substance abuse. A family preservation team is assigned to work with the family as they progress through three stages: Phase One – engage and motivate; Phase Two – change behavior; Phase Three – generalize change. Mental health services are included in FFT and not referred to an outside mental health service provider.

Discharge from the Program
Discharge is based on therapist criteria. A typical program lasts about 12 – 14 sessions. Phase Three determines whether the family has gained the capacity to utilize multisystemic community resources and to engage in relapse prevention. Reintegration planning begins on day one so a plan is in place upon discharge. Probation officers step up their involvement and serve as a resource to the family. The officers and therapists stay in frequent communication during this period. If necessary, the therapy team intervenes with the other systems (school, community, etc.) in which the youth is

involved to help facilitate a smooth transition. The entire process is usually spread over a 3 to 6 month time frame.

There are no continuing services, but if the family needs to return or if the youth re-offends and is again referred to FFT, they meet with the same therapist and pick up in Phase Three – generalization.

Barriers Related to Services and Steps to Overcome

The largest barrier was establishing credibility with the community corrections agencies who were skeptical at the outset of the program. Fortunately, the Juvenile Court Judge was an avid child advocate who believed in the program and was able to establish some positive relationships within the community. Staff from the IFP met weekly with Probation staff (brought food, talked and listened) to nurture those relationships. As a result, the IFP was able to demonstrate that they were competent, available and responsive in order to gain the trust of their partners. From the initial point of contact with the judge, it took a year to train the therapists and design the project.

CHARACTERISTICS OF YOUTH AND FAMILIES

Most youth in the program:

- are between 14 and 15 years old, but must be under age 18
- have been in trouble more than once
- have a diagnosis of oppositional defiant or conduct disorder or some other mental health issues
- have used substances, bordering on or including substance abuse
- have trouble in school and have a non-social peer group
- have high family conflict
- are very well known to the juvenile court system

Most youth are referred to the program as part of their disposition (60%) and the rest are referred pre-adjudication (30%). It does not have to be their first offense and the program will work with any type of offender that is referred except for true sex offenders.

LEVEL OF INTERAGENCY COORDINATION

Due to its program structure, the IFP has created partnerships and collaboration that did not previously exist. Program staff developed a relationship with the courts through the juvenile court judge, and subsequent contacts with the probation department and community corrections staff. As mentioned earlier, other youth-serving systems (such as schools and behavioral health) have begun referring juveniles to the IFP for treatment as a way of preventing contact with the juvenile justice system.

The IFP also provides a unique training opportunity for doctoral students who will later move into a similar community setting. The university provides research opportunities which add to the knowledge base.

DEMONSTRATED OUTCOMES OF PROGRAM

A major requirement of FFT is fidelity to the model since poorly done therapy can actually cause outcomes that are worse than no treatment at all. All FFT programs are connected by a computer database that provides quality assurance. The model has been successfully replicated in six separate sites in Indiana, and 140 more sites around the world. The therapy is currently delivered in eight languages using multi-cultural standards. It is also being used solely as a reintegration program in several locations including Idaho, Washington, and New York City. The three major benefits that FFT delivers are: it keeps kids in the community, keeps families together, and doesn't pathologize kids and make them worse.

FFT has demonstrated positive outcomes across a wide range of youth and communities:

- Significant and long-term reductions in youths re-offending and violent behavior
- Significant effectiveness in reducing sibling entry into high-risk behavior
- Very low dropout and high completion rates
- Positive impacts on family conflict, family communication, parenting and youth problem behavior
- Long-term savings to taxpayers per youth in reduced victim and criminal justice costs

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NATIONAL CENTER FOR MENTAL HEALTH AND JUVENILE JUSTICE

Juvenile Justice Diversion and Reintegration Initiative for Youth with Mental Health and Co-Occurring Substance Use Disorders

Family Intervention Specialists
Douglas and Paulding Counties, Georgia

PROJECT OVERVIEW

The goal of the *Juvenile Justice Diversion and Reintegration Initiative for Youth with Mental Health and Co-Occurring Substance Use Disorders* is to identify programs and strategies that currently exist to divert youth with mental health and co-occurring substance use disorders from the juvenile justice system into community-based settings. The National Center for Mental Health and Juvenile Justice (NCMHJJ), operated by Policy Research Associates, received funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to better identify and assess, across the juvenile justice and mental health fields, effective and promising models and practices to divert and reintegrate youth with mental health and co-occurring substance abuse disorders. Results of this initiative are being shared with national, state and local officials across the country in order to foster the further development and implementation of comprehensive and integrated models that will more successfully meet the needs of youth, enhance their functioning, and reduce recidivism.

Building on an initial juvenile diversion survey that was completed by the NCMHJJ, in partnership with the Council of Juvenile Correctional Administrators (CJCA) and the National Association of State Mental Health Program Directors (NASMHPD), on-site and telephone interviews were conducted with seven of the most promising programs identified through the initial survey work. The program summary below highlights key information collected on one of these programs, Family Intervention Specialists in Douglas and Paulding Counties, Georgia.

HISTORY OF THE PROGRAM

Family Intervention Specialists (FIS), founded by Cynthia Bass, is a non-profit provider of intensive family intervention services. Dr. Bass was originally a consultant for the County Juvenile Court hired to provide psychological evaluations and to oversee the courts mental health unit. While working as a consultant for the court, the founder focused court and other county agency attention on the seriousness of the issue of youth with mental health needs involved in the justice system. Building off the momentum created, Dr. Bass sought funds from state and county agencies and received money from

the local county welfare agency, the regional mental health agency (which covers seven counties) and the state juvenile justice agency. Using this money, Dr. Bass provided MST in one county from 2001 to 2003.

In 2003, at the urging of the regional mental health department, Dr. Bass began her own non-profit organization, Family Intervention Specialists. FIS provides Brief Strategic Family Therapy (BSFT), which is a SAMHSA Model Program, to youth who are referred to them. FIS is the only provider of BSFT in Georgia. By creating a non-profit organization, Dr. Bass was able to get her own Medicaid number to bill Medicaid for clients, rather than relying solely on the grant money. FIS continued providing MST for a time but decided to switch to BSFT for a number of reasons which include: they believed MST only allowed them to focus on a very narrow client population, the program was too expensive, and it had weak quality assurance. On the other hand, they liked that BSFT allowed them to serve a more diverse clientele, was less expensive, used a "train the trainer" model so FIS does not have to pay additional licensing fees, and BSFT staff provide constant consultation. FIS only serves justice involved youth with mental health needs.

PROGRAM OVERVIEW

Program Structure and Staffing

The diversion program is operated by a not-for-profit agency, FIS, that employs a clinical director, a supervisor, six therapists, twenty-two para-professionals, a quality assurance manager and an office administrator. The services are provided directly by program staff and those costs that are not covered by Medicaid reimbursement are covered through grants. Staff is hired as consultants to save the agency money on insurance. FIS also finds that this arrangement is helpful because the number of youth served fluctuates, and they are not forced to pay staff salary when caseloads are low.

Funding Sources and Program Costs

Most clients are Medicaid eligible so the program bills Medicaid for services. For those clients that are not Medicaid eligible, FIS has funding from the Douglas County court (who reimburses them only for youth referred by that county court) and from the regional mental health department. Operating the diversion program through a non-profit has saved the court money because so many clients are Medicaid eligible. The program originally received money from the State Juvenile Justice agency and Child Welfare, but once they got their own Medicaid number they no longer received this state-level funding.

SERVICES PROVIDED

Overview of Service Configuration

The program provides the majority of services directly using BSFT as the only intervention. While they are a direct service provider, they always work to incorporate providers that are already involved with the family. At the earliest stages of treatment, the program sets up a team meeting with any providers that are already working with the

family. This is one reason the program founder switched to BSFT over MST, MST required that families stop meeting with outside professionals with whom they were involved. After the youth and family are referred to the program, the program makes contact within 48 hours. Families are initially contacted by telephone to schedule a visit. The youth's probation officer accompanies the program therapist for the initial home visit. Typically, the program makes 3 family contacts per week: the therapist meets with the family one time and the paraprofessional meet with the family on the remaining two visits. The therapist's visit focuses on providing counseling. The para-professional works on life skills and linking the family to needed resources outside the program. They are also responsible for weekly school visits, during which they complete a behavior checklist on the youth and gather information for case notes on the youth's school progress.

Beyond the 3 weekly contacts, a senior clinician completes weekly reviews of all charts. Staff all meets together and the senior clinician provides feedback. The weekly reading of progress notes is required by BSFT to assure fidelity.

Referral Process

The bulk of referrals come from Juvenile Court (either the judge or probation intake). The county court employs specialized probation officers who are trained to identify mental health and substance use needs and who know how to refer youth to the program. Probation intake officers and the judges are aware of the program because the program staff have been in the courts in different capacities for many years and because the program does presentations and trainings to keep referring sources up to date on procedures.

Intake Process

- Screening for mental health and substance use disorders

Probation intake screens all youth who come before them for both substance use and mental health disorders. Intake officers use a standardized tool developed by a Professor at Georgia State.

Upon entry, the program uses the MAYSI-2 and CAFAS on all youth. They also perform The Mauldin Pattern Assessment which looks at the healthiness/strengths of a child and family. The Mauldin is given to the primary caregiver and the youth at the beginning and end of program participation.

Direct Services

- Brief Strategic Family Therapy (BSFT)

BSFT is a problem-focused approach to the prevention of out-of-home placement. The intervention provides families with tools to decrease individual and family risk factors through focused interventions that improve problematic family relations and skill building strategies.

Discharge from the Program

Seven weeks into the program the program staff meet to discuss how the family has progressed in meeting the goals of their treatment plan. From this, the team leader guides the development of a step-down plan. While discharge is individualized and the treatment plan for each family is driven by their unique needs, there are Medicaid restrictions on the length of stay in the program. On average, families are discharged after three to four months.

Staff stated that most families are reluctant to leave the program because the level of services they've grown accustomed to is very intensive. To make the program departure more smooth, community services are put in place for all family members who need it. Additionally, the program makes 3 month, 6 month, and 9 month telephone calls with the family and relies on a standardized outcome protocol to track family functioning.

Barriers Related to Services and Steps to Overcome

- Regional board of the Northwest Region

The Georgia regional mental health boards were identified as major obstacles to service delivery. In Georgia, these boards control which private providers are given Medicaid waivers and are, therefore, eligible to bill Medicaid. The program and the courts indicate there is a shortage of providers to serve youth with mental health needs, yet the regional boards will not grant more waivers.

- Lack of community mental health services

Medicaid will not allow Family Intervention Specialists to provide intensive services beyond a certain time period. Intensive Family Intervention, which BSFT is part of, is the most expensive outpatient service funded by Medicaid. Medicaid strictly regulates the length of stay and urges the program to step clients down to less expensive mental health services provided by the community service boards. But, the community service boards do not employ child adolescent psychiatrists and do not provide mental health services specific to youth. So the program sends youth to private providers which is problematic for Medicaid and the regional mental health boards. Family Intervention Specialists is trying to close the gap in available services by providing group therapy on a sliding fee scale to clients who have completed the intensive BSFT intervention.

- Community Service Boards

The community mental health providers were cited as a major barrier to service delivery because they are seen as "hoarding" Medicaid money by claiming to provide intensive services. Yet they have a Medicaid waiver for them so other providers are unable to get Medicaid waivers through the Regional boards to provide intensive services.

- Referral to program

In one of the counties the program serves, the probation intake officers are not completing the referral packet accurately or comprehensively. The repercussion of this is that the therapists makes the initial home visit unprepared which places the therapist and program staff in potential physical danger.

CHARACTERISTICS OF YOUTH AND FAMILIES

The following criteria must be met in order for youth to be eligible for the program.

1) The primary client has to be Medicaid eligible, 8 – 17 years old.
2) Client has to have known or suspected mental health or substance abuse (ASAM Level II.5) diagnosis.
3) Treatment at a lower level of care has been attempted or given serious consideration.
4) Consumer is at risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent.
5) There is at least one competent adult residing with the client.
6) Family has stable living arrangement; families living in extended stay motel or frequently moving will have to be approved by clinical director first.
7) FIS cannot accept clients that are actively suicidal or homicidal or otherwise direct threat to the community.

Typically, clients receive 12-15 sessions over 3 months with the sessions averaging about 60-90 minutes. Medicaid specifies that a therapist can carry a maximum caseload of 12 families. The typical youth has a diagnosis of ADHD. There is some variation by county in terms of the characteristics of youth served.

Most youth are referred to the program are involved with the justice system for status offenses, typically "unruly complaints". For most youth it is not their first time involved with the justice system or their first time receiving mental health services. The program seeks to serve youth with multiple non-violent priors *and* a history of unsuccessful episodes of mental health services. In one county the program serves, the youth referred tend to be more serious offenders because the program is used by the court as a last resort.

LEVEL OF INTERAGENCY COORDINATION

Program staff has a long history of collaboration with the courts. The courts want to collaborate because it makes decision-making in these cases easier and it gives court staff a sense of efficacy. The court has tried a few companies that provide in-home interventions but has dropped them all except for FIS.

Collaboration at the staff level is fostered through contact between the program and justice partners. The FIS staff accompanies clients to court, completes progress reports for the court, and talks with probation officers. Probation officers want to collaborate with the program because it cuts down on the home visits they complete themselves. Probation officers rely more on the reports about visits completed by program staff since FIS provides intensive home-based therapy. In one county the court employs a full-time case manager who, in addition to other duties, serves as a link between probation and the program and insures that treatment plans are completed. The judge signs off on all cases before the program ends and/or probation is terminated.

DEMONSTRATED OUTCOMES OF PROGRAM

In order to be designated a SAMHSA Model Program, BSFT had to have proven outcomes contrasting study and comparisons groups. In terms of this diversion effort, because the program relies on BSFT, there is emphasis on data collection and outcome study. These data are maintained by BSFT staff. Once families are discharged from the program, BSFT requires providers to hold 3 month, 6 month, and 9 month follow-up calls with families to track family functioning by asking a series of standard questions. Additionally, Family Interventions Specialists works with the Department of Juvenile Justice to track recidivism.

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NATIONAL CENTER FOR MENTAL HEALTH AND JUVENILE JUSTICE

Juvenile Justice Diversion and Reintegration Initiative for Youth with Mental Health and Co-Occurring Substance Use Disorders

Alabama Juvenile Court Liaison Initiative
Tuscaloosa and Walker Counties, Alabama

PROJECT OVERVIEW

The goal of the *Juvenile Justice Diversion and Reintegration Initiative for Youth with Mental Health and Co-Occurring Substance Use Disorders* is to identify programs and strategies that currently exist to divert youth with mental health and co-occurring substance use disorders from the juvenile justice system into community-based settings. The National Center for Mental Health and Juvenile Justice (NCMHJJ), operated by Policy Research Associates, received funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to better identify and assess, across the juvenile justice and mental health fields, effective and promising models and practices to divert and reintegrate youth with mental health and co-occurring substance abuse disorders. Results of this initiative are being shared with national, state and local officials across the country in order to foster the further development and implementation of comprehensive and integrated models that will more successfully meet the needs of youth, enhance their functioning, and reduce recidivism.

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HISTORY OF THE PROGRAM

The juvenile court liaison program is a statewide initiative that funds the creation of a single position in multiple counties across Alabama. The liaison position is a partnership between the Alabama State Department of Mental Health and Mental Retardation (DMH/MR) and Community Mental Health Centers. The DMH/MR provides money to fund 22 liaisons positions throughout the state. Each liaison serves a catchment area, which can be anywhere between one and five counties depending on population. The goal of the initiative is the development of a mental health *presence* in the juvenile

courts. The State encourages and supports local determination in what the program or specific duties of the liaison entail. The state initiative is modeled after a liaison position developed in Jefferson County Alabama and funded by local county court funds.

The liaisons work with the courts to identify youth with mental health needs that the DMH/MR has responsibility for. These include youth with Serious Emotional Disturbance, co-occurring substance use disorders, and youth with mental retardation. The State initially funded 10 sites which began services in September 2001. In June 2002, 12 more sites were funded. The original 10 counties were chosen because they had a history of collaboration and reflected active counties or courts with respect to youth involved in the court system. The liaisons were hired to move youth with mental health needs into more appropriate resources, but there was little guidance on how they should do that. The liaisons we met with described their position and duties as having evolved since inception. The liaisons define their goal as meeting both the justice and mental health systems needs by screening, evaluating, and diverting youth.

PROGRAM OVERVIEW

Program Structure and Staffing

All liaisons are, at a minimum, masters level clinicians employed by the community mental health center and work exclusively with youth and families who come to the attention of the juvenile courts and have mental health needs. The juvenile court liaisons are also trained and certified as case managers. While some provide direct clinical services, the typical liaison serves as a link between juvenile justice and mental health agencies by identifying needs, explaining issues to the court and brokering the provision of services. The liaisons are employees of the community mental health agencies but their position is primarily funded by the state. The liaison serves as a link between the courts and the mental health community. There is variation across the state as to whether or not the liaisons are housed directly in the court or have an office in the local mental health agency.

Funding Sources and Program Costs

The state provides up to $35,000 to fund one liaison and the local mental health center pays for any other costs. The DMH/MR will reimburse the county mental health center for the categories listed below up to $35,000, net of federal Medicaid revenue received for services rendered and any other sources of revenue available for the following services:

- Salary
- Benefits
- Travel
- Office Expenses
- Administrative Expenses
- Training

Some counties bill Medicaid and others do not. In some counties the liaison has a therapeutic role and can bill Medicaid or other third party (i.e. SCHIP). In counties where

the liaison is more of a *presence* and mostly brokers services and provides information, they are unable to bill Medicaid or the SCHIP program.

SERVICES PROVIDED

Overview of Service Configuration

The liaisons can provide case management services as well as direct therapeutic interventions, consultation and referrals, and report to the court on a preferred course of action for the youth. While all liaisons are masters-level clinicians, the extent to which they provide direct therapeutic services versus primarily brokering these services varies by county. The liaison who covers Walker, Fayette, Lamar Marion and Winston Counties, for example, is a PhD level psychologist and covers these rural counties with limited services available to refer youth to, so he provides some direct counseling. In Tuscaloosa, a more urban county, the liaison is a Masters level clinician and provides very little direct counseling services. Liaisons are on call 24 hours a day seven days a week. Liaisons screen youth and then link them to community mental health centers for the bulk of direct services.

Referral Process

There are multiple points at which youth can be referred to a liaison, though all are from the justice system. Referrals can be made from Probation and Intake up to and including post adjudication. Whether entries more commonly come from Probation, Intake or from a Judge varies by county and hinges on how each county has defined the role of the liaison.

- Detention Hearings

  In Tuscaloosa County most referrals come after Probation Intake has determined that an offense is detainable and a hearing is set. If anyone involved in the hearing, either before or after it is held, has concerns about mental health issues they call the liaison.

- Liaison in courtroom

  Liaisons spend a lot of time in the court house and often participate in the work of the court by being present during hearings. Youth are sometimes identified during court proceedings and referred to the Juvenile Court Liaison for evaluation or services. Probation officers also identify youth on there caseload that may be appropriate for the mental health liaison to review and meet with the liaison informally or as needed.

- Detention centers

  Some liaisons have trained detention center staff to identify youth that are being held either pending or post adjudication who may be appropriate for liaisons services. Youth in detention centers have been referred to liaisons for evaluations/ assessment or crisis intervention.

Intake Process

- Screening for mental health disorders

  There is no uniformity across the state in terms of tools used. For the most part, however, it does not appear that objective tools are used. Liaisons do not screen all

youth for mental health disorders, they screen only youth referred to them. The liaison in Tuscaloosa does not use any standardized objective testing because he doesn't feel that any tools are effective. There is no clear flag that would indicate when a Probation officer, legal guardian or judge might refer a child to a liaison. They would refer if they see something in the child's file or history that indicates a diagnosis, if they "have a feeling or a sense" there is an issue, or the liaison may pick up on an appropriate case simply by sitting in court and listening to proceedings. Most liaisons do hold trainings for Probation officers to teach them what signs to look for to identify youth with mental health issues. Due to the availability of this service, the Probation Officer can consult with the liaison if they have any question or concern.

- Clinical assessment

  In most counties the liaison refers youth to either a public mental health center or to a private psychologist for a full evaluation. In 1 or 2 counties, the liaison is a PhD level psychiatrist and can do the evaluation themselves.

Direct Services

There is no prescribed document explaining how the liaison should carry out the job. In fact, one liaison who serves multiple courts stressed that his job looks different across the courts and the actual job of the liaison is often driven by individual judges. Some courts like the liaison to be in court during proceedings while other courts do not interact as openly and the liaison works behind the scenes with appointed guardians and probation prior to and after the hearings. In the rural counties where access to mental health services is limited and more challenging, the liaison provides direct therapy, while in counties where there are community providers who do this the liaison simply refers the youth to them.

A survey of the Juvenile Court Liaison services by the DMH/MR shows that the community mental health center and the court are the typical settings in which services are provided though the setting is flexible and also includes: homes, probation offices, schools, detention centers, and hospitals.

The services to be provided by the liaison as outlined by the DMH/MR include:

- Intake/Evaluation
- Individual/ Group Counseling
- Case management and coordination

All liaisons are trained as case managers but a survey administered by the State shows that only 16% of liaisons indicate they regularly provide case management services.

- Interpret psychological reports for the courts and probation
- General presence in the courts-visibility so that law guardians or probation officers are more likely to approach them on a child they are unsure about and not just the ones they know for a fact have mental health issues
- Crisis intervention
- Pre-Hospitalization Screening/Court Screening
- Family Support/Education
- Community Education and Consultation

Barriers Related to Services and Steps to Overcome

The State and localities experienced barriers, most associated with early startup issues that included: a lack of clarity on the mission or the services that should be provided, no predefined data elements to capture for later use in evaluating the program, and no standardized protocol for training liaisons. The DMH/MR now provides at least two trainings a year in which all the liaisons across the state meet and receive training from DMH/MR and other child-serving agencies such has Child Welfare, Youth Services, Multiple Needs Child Office, Administrative Office of the Courts, and Special Education. Also, the State ran into hesitancy from some counties where the local mental health centers and courts where unsure if they wanted therapists assigned to the court full time. To get the initiative off the ground the state purposefully chose the original 10 funded counties because the counties had a history of collaboration and there was little or no hesitancy from county mental health or their respective courts.

CHARACTERISTICS OF YOUTH

The target population is youth with mental health needs who are involved with the juvenile justice system. The 22 liaisons combined serve an estimated 1981 youth last year. There are a total of 27 liaisons, 23 are full-time employees and 4 are part-time. The average caseload is 31 youth but ranges from 2-120. The majority of youth served are boys (61% vs. 39% in FY 2003), nearly evenly split between African American and Caucasian. Youth were also nearly evenly split between testing on their grade level and below their grade level and the majority were involved with multiple systems within their community.

LEVEL OF INTERAGENCY COORDINATION

The liaisons interviewed both felt that collaboration was very strong and the justice officials in the rooms stressed how integral the liaisons have become to daily decisions. The two liaisons interviewed and the justice partners felt that liaisons are more like court staff than outsiders.

Collaboration with Probation officers is fostered through daily informal contact and regular trainings that liaisons hold to help probation officers look for signs indicative of potential mental health needs. Collaboration among agencies is supported by monthly staffing of County Service Facilitation Teams (Multi-Needs Teams), which bring multiple agencies together to discuss how to handle individual cases of youth who are at risk of more intense services or removal from the home. To foster collaboration among liaisons, the sate sends liaisons to bi-annual training.

Collaboration with liaisons is supported because the liaisons have reduced the burdens that used to fall on other peoples shoulders. For example, Probation officers stress that before the position existed they were overwhelmed trying to identify mental health needs and then navigate the service delivery system; having a mental health liaison, they feel, makes them more effective. Justice professionals and liaisons have

found that parents respond positively to liaisons and are typically willing to work with liaisons primarily because they ease the expectations placed on parents. Specifically, parents used to be told, either by probation or a judge, to make an appointment for their child with the mental health center, but now the liaison makes the appointments and helps parents negotiate the system. Also, one liaison surveyed parents about the services and found that parents felt that working with a liaison was less stigmatizing than working directly with the mental health center. The District Attorney's staff likes to work with the liaison because it relieves the burden on them for determining if a youth should be punished or treated, and the liaisons backing gives the DA's recommendations for diversion or treatment more credence with the judge.

DEMONSTRATED OUTCOMES OF PROGRAM

Outcome Measures Used to Assess Program

The State is in talks with locally funded agencies regarding ways to better track services provided. The State has indicators showing that the number of youth served and volume of services continues to increase; tracking numbers show that consultation services with education and outside agencies is on the rise suggesting that collaboration is increasing; and more courts are reporting improved relations with mental health agencies. The state does not have impact data statewide but some liaisons seem to track functional improvement, though it seems to be mostly subjective evaluations. Another area needing closer review is situations in which youth are being diverted from involvement in the juvenile justice system by referring youth to liaison services prior to the court accepting a complaint. This is significant in that these youth (diversions) never appear on the courts database and thus are not technically considered mental health diversions.

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NATIONAL CENTER FOR MENTAL HEALTH AND JUVENILE JUSTICE

Juvenile Justice Diversion and Reintegration Initiative for Youth with Mental Health and Co-Occurring Substance Use Disorders

Family Intervention Resource Service Team (F.I.R.S.T) Owensboro, Kentucky

PROJECT OVERVIEW

The goal of the *Juvenile Justice Diversion and Reintegration Initiative for Youth with Mental Health and Co-Occurring Substance Use Disorders* is to identify programs and strategies that currently exist to divert youth with mental health and co-occurring substance use disorders from the juvenile justice system into community-based settings. The National Center for Mental Health and Juvenile Justice (NCMHJJ), operated by Policy Research Associates, received funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to better identify and assess, across the juvenile justice and mental health fields, effective and promising models and practices to divert and reintegrate youth with mental health and co-occurring substance abuse disorders. Results of this initiative are being shared with national, state and local officials across the country in order to foster the further development and implementation of comprehensive and integrated models that will more successfully meet the needs of youth, enhance their functioning, and reduce recidivism.

Building on an initial juvenile diversion survey that was completed by the NCMHJJ, in partnership with the Council of Juvenile Correctional Administrators (CJCA) and the National Association of State Mental Health Program Directors (NASMHPD), on-site and telephone interviews were conducted with seven of the most promising programs identified through the initial survey work. The program summary below highlights key information collected on one of these programs, the Family Intervention Resource Service Team (FIRST) in Owensboro, Kentucky.

HISTORY OF THE PROGRAM

In Kentucky, several district judges have jurisdiction in each county. They each have a day set aside for hearing juvenile cases. In 1995, a local district judge created a committee to discuss the alarming number of young offenders coming into his court and was concerned that youth were being directed to the court without accessing any of the already available community services. The goal of the committee was to develop some workable solutions. Committee members included: the mayor, heads of the three local school boards, the court administrator, court designated workers, education personnel, the

local cabinet for Human Resources, local court personnel, police, health, county governing board, parents, housing authority, alternative school personnel and the local community services agency (Audubon Area Community Services). The original group planned and met for a full year before a grant was written. A proposal was submitted to the State Commissioner of Mental Health and the group was awarded a total of $254,000 for the first year (1996) from several agencies. The Family Intervention Resources Services Team (F.I.R.S.T.) grew out of this collaboration.

PROGRAM OVERVIEW

Program Structure and Staffing

FIRST is operated by Audubon Area Community Services, Inc., which is an "umbrella" agency that operates many projects under one organizational structure. The agency functions like several "businesses" under the unified management of an Executive Director. Audubon Area is a Community Action Agency (CAA), one of 23 Kentucky CAAs, and now Kentucky's largest. FIRST works with the Court Designated Workers (CDW) at intake to develop a family service plan and set goals for the youth to reach. The only direct services provided by FIRST are home visits, school visits, and monitoring compliance with the treatment plan. The purpose of the program is to decrease the number of middle-school children who display mental health and substance abuse problems who appear in juvenile court by increasing the number and the effectiveness of interventions available as alternatives to formal court appearance.

Funding Sources and Program Costs

For the first few years, the program was funded by four sources: $100,000 from state mental health; $100,000 from state substance abuse; $30,000 from state education; $24,000 from local donations. Now the sources have diminished to two: a total of $80,000 from state mental health and private donors. The overall cost to operate the program is $80,000.

SERVICES PROVIDED

Overview of Service Configuration

FIRST is a county diversion program that is privately operated with money from the state mental health agency and private donations. Youth are referred by CDWs pre-adjudication. A service plan is created for each youth and family that includes life skills, home and school visits and compliance monitoring. The service plan builds on the family's strengths, which is learned through the family history. When youth complete the program, their record is expunged. The program staff consists of two full time case managers (MSW level) and the Program Director. FIRST serves approximately 70 youth per year.

Referral Process

Referrals come from the CDW who acts as the gatekeeper between the police and the court. They make the decision to file the petition.

Intake Process
The youth must be charged with a status offense (usually a "beyond control" charge brought by the parent or the school). The case then goes to the CDW who administers the POSIT (Problem Oriented Screening Instrument) to the youth and the family. If they receive a warning score of 7 or 8, the CDW diagnoses the child with a mental health/substance abuse problem, which, along with other criteria, makes them eligible for FIRST. The youth and the parents are sent to the program for intake. This can take place either in the home or in the ACC offices. The program case manager meets with the family, collects information on family history, and then meets with the service plan team to draw up a treatment plan.

Direct Services
No direct services are provided by FIRST. The only services provided by the two full-time staff are monitoring of the treatment plan, intake, home and school visits. Mental health and substance abuse treatment is brokered to a multi-agency service team. The case manager regularly reviews compliance and reports back to the CDW. The program can then send the case back to the CDW or to court for a formal disposition. The CDW makes that determination.

Discharge from the Program
The youth are ready for discharge when they fulfill the treatment plan. The CDW cannot hold the case open for longer than 6-8 months. If the CDW determines that the youth needs additional services, they can appeal to the judge for permission to keep the case open. There is no community reintegration program at this time.

Barriers Related to Services and Steps to Overcome

- High staff turnover – difficulty keeping family service workers due to low salaries
- Services provided by the county agency (while low-cost or free) have changed their availability by trying to link youth to private providers at reduced fees. The county agency is still used for further mental health assessment that is unaffordable elsewhere.

CHARACTERISTICS OF YOUTH AND FAMILIES

The program serves 6-8th graders with substance abuse and/or mental health problems who appear for adjudication in the juvenile court. Youth must also be first time, low-level status offenders in middle school. Most are "beyond control", which is a status offense in Kentucky. The program has served 560 families since 1996.

LEVEL OF INTERAGENCY COORDINATION

FIRST formally collaborates with the court and with other agencies. These agencies sit on a program advisory board. When the original grant was written, the heads of key

agencies sat on a governing board and they rotated the director position. The governing board has its own bylaws, specified budgets, and procedures. Now, the governing board has become an advisory board. In terms of a formal fee agreement for services, they originally signed Memoranda of Agreement, but the arrangement is now more informal. The advisory board meets regularly and reports to the state on a regular basis.

DEMONSTRATED OUTCOMES OF PROGRAM

FIRST has a 75% success rate based on evaluation data going back to 1996. A program study is conducted yearly by the University of Louisville. A recent study concluded that children who were referred but declined services were three times more likely to have additional charges compared to children who completed the program. The likelihood of incarceration for additional charges is directly related to the level of compliance in the program. The author of the study stated "the program is highly successful in meeting the summary goal of preventing further court involvement. Even when some clients do have further charges, the impact of the program is still evident in that the better the performance in the program, the longer before the child gets into trouble."

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