FOCAL POINT

2017

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YOUTH, YOUNG ADULTS, & MENTAL HEALTH

JUSTICE AND RECOVERY

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INTRODUCTION

JUSTICE AND RECOVERY

A perfect storm surrounds young people with mental health conditions involved with the juvenile justice system. Research demonstrates that the prevalence of mental health conditions among justice system involved youth is alarmingly high[1] coupled with a strong likelihood of multiple traumatic exposures.[2] Unfortunately, while the need for appropriate and timely treatment is acute, the juvenile justice system seems challenged in meeting it.[3] The currents of justice and winds of recovery, it seems, are headed in opposite directions.

The authors of this year's issue make it clear that this does not have to be the case. Moreover, their writing demonstrates that justice and recovery should not – and cannot – be mutually exclusive ends. Our issue opens with a contribution from a parent of a young man of color who entered the justice system with mental health conditions. She recalls how his mental health was negatively affected by his experiences within the system. Viewing this issue through a wider lens, Spinney et al. offer evidence of racial disparities in behavioral health treatment in juvenile justice.

Hernan Carvente offers his perspective as a young adult with lived experience of the juvenile justice system. His story raises the question: how does the system respond to young people who are crying out for help? This issue includes a series of articles that explore possible answers to that question. Bilchik et al. address the need for responding to young people from a trauma-informed perspective. Kinscherff and Keator reinforce this need and consider the complexity of appropriately identifying the behavioral health needs of these largely traumatized young people.

All treatment is ultimately delivered though organizational structures. Yazzie discusses the organizational supports needed to implement evidence-based practices. Following her reflections are two articles discussing larger initiatives. Kretschmar et al. describe Ohio's behavioral health juvenile justice initiative that includes a perspective from the bench. Elkin presents evidence that the Reclaiming Futures model (emulating a "system of care" approach) is having a significant positive impact in many areas.

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This issue closes by considering the future in light of new research. An interview with Davis and Sheidow examines an emerging-adult enhancement to multi-systemic therapy that holds the promise of reducing recidivism. Mulvey et al. describe initial findings from the longitudinal Pathways to Desistence study. Their analyses consider how having a mental health condition may – or may not – effect a successful transition to adulthood.

I hope the reader finds within the following pages a breadth and depth of knowledge that will dissipate the clouds of the "perfect storm" and set a common course for justice and recovery – for *all* young people.

Editorial Note: The editors wish to extend a special thanks to William Feyerherm and Myrth Ogilvie for their assistance.

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Juvenile Justice 101: A Parent's Perspective

"The picture is a photograph I took in London outside of the Palace of Westminster, where Parliament meets. To me, it represents the strength and determination needed to keep fighting for what is right and true."

—anonymous author of this article

Being the adoptive parent of a young adult with a history of mental health issues who has become part of the juvenile justice system in our state, I have seen many challenges. When he was younger, I was able to navigate the mental health system to get him what he needed – be it crisis intervention, emergency counseling, medication adjustments or even psychiatric hospitalization and residential treatment. However, when his search for his identity as a seventeen-year-old black male living in a mainly white community with hidden racist undertones led him into the jaws of the juvenile justice system, I found all of the doors that led to the mental health system were slammed and locked shut to him for many months.

It has been extremely disconcerting to learn that in our state, which is the pride of so many advocates for those with special needs and alternative lives, the juvenile justice system is still so far behind when it comes to helping our children with mental health issues. The biggest area of dysfunction occurs during the detention phase. Kids are arrested and parents get notified – but they cannot always communicate with their kids right away. Kids are left in holding cells and transport vans for long periods of time, shackled hand and foot. There is little attention paid to basic necessities like food and water, never mind the psychological trauma of being held for many hours at a time with other sometimes violent adult offenders nearby.

Imagine that your child, who grew up with PTSD from early traumas and anxiety disorder, executive-functioning issues, and depression, now has to somehow stay sane and intact while dealing with his first exposure to the inside of a jail, a locked van, and being constantly restrained. My mind was completely overwhelmed with imagining how scared he was, how he was perceiving things, how he was reacting to people, and how little sleep he was probably getting. Of course, I was incredibly angry with him for his poor choices, but my heart was also trying to keep on being his mother and advocate. I knew that all of the hard work we had done to get him through some of the toughest traumas in his childhood was now in jeopardy. Without trusted mental health clinicians in place he was going down the tubes extremely quickly.

During the first few weeks of my son's time in detention we were in constant reactionary mode because so much information was coming at us. We heard from cli-

nicians and directors at various facilities about what our son would receive for support. He would have someone assigned to make sure that he could communicate with his lawyer and us, but that no counseling or therapy would be provided. He was moved from program to program due to various issues, some being in his control (arguing with peers) and others being completely out of his control (staffing issues, programs closing due to staff acting inappropriately). Each time I would see my son shutting down more and more, behaving erratically and having great difficulty thinking and processing. I would drive hours to and from locked units to see him for limited amounts of time, knowing that he would be strip-searched each and every time. My limited interactions with clinical staff showed that most barely knew my son. It took Herculean efforts and a chance message to a friend with connections to get a bit of informal counseling to him just as a way of keeping him treading water during this time. It was nine months before things changed for the better – when he was finally sentenced and committed to the Department of Youth Services until 21 years of age.

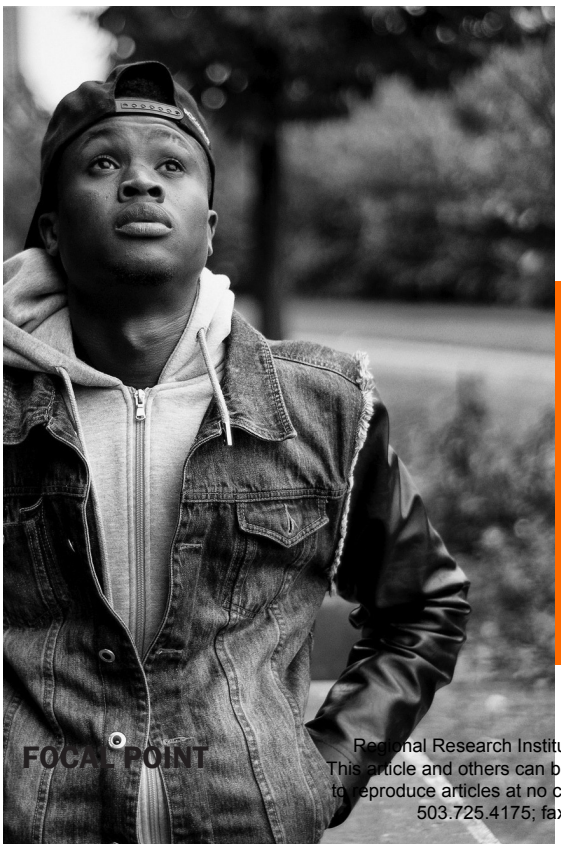
Once committed, therapeutic mental health counseling was put into place and I began to see gradual improvement in my son's mental health status. The damage was done, however. When he finally came home to us we saw a very stressed, changed young man who was prone to bouts of extreme anger and an inability to accept that people were there to be supportive of him. PTSD had really taken hold. Reactive Attachment Disorder, which had been simmering beneath the surface for years, was at full boil.

I am left to wonder, at this precarious stage in the game, if our son will ever fully recover from his experiences. He has admitted his mistakes and is having to live with the legal consequences of his actions, but I believe his mind is ravaged with the constant memories of things that happened to him while behind the walls of our juvenile justice system. We are living on a roller coaster of mood swings and rage. I wonder if some of this could have been prevented with more focus placed on assigning a skilled clinician who could do therapy with each and every juvenile as soon as they enter the system, rather than waiting for the rusty and inconsistent wheels of justice to expel the shattered minds of our children. Could this reduce the rates of recidivism? Could this improve the behaviors of more incarcerated individuals while they wait their turn? Could it keep more homes from being under strain when their children return?

Despite all he has been through, he continues to strive to be a better person. Our son was recently appointed to the Juvenile Justice Advisory Board by the governor. We hope that his personal experiences will help many others as time goes on.

AUTHOR

[anonymous parent] is an adoptive mother, photographer, and former special needs educator who now consults with other families and professionals on issues including special needs education, parenting, reactive attachment disorder, and mental health issues.



"I wonder if some of this could have been prevented with more focus placed on assigning a skilled clinician who could do therapy with each and every juvenile as soon as they enter the system, rather than waiting for the rusty and inconsistent wheels of justice to expel the shattered minds of our children."

Racial Disparities in Juvenile Justice Referrals to Mental Health and Substance Abuse Services

We know from recent research that juvenile justice populations frequently exhibit elevated rates of mental health and substance use disorders. To get a better understanding of how these needs are being met – and whether they are being met disproportionately by race and ethnicity – we reviewed and summarized the research literature examining referrals to mental health and substance abuse services from within the juvenile justice system.[1] This review was part of a larger review of research studies examining the racial and ethnic disparities that occur within the juvenile justice system at various contact points (e.g., arrest, referral to court, adjudication, secure confinement). We know that research over the past four decades on decision-making in the juvenile justice system has frequently shown evidence of racial and ethnic disparity. We also know that there are unmet mental health needs among youth in the juvenile justice system. What does the confluence of these two issues look like? The material that follows is drawn from our published article on this topic.[1]

MENTAL HEALTH NEEDS IN THE JUVENILE JUSTICE SYSTEM

We start with the observation that youth involved in the juvenile justice system frequently exhibit elevated rates of substance use and mental health disorders. Many of the studies examining this issue have found that over two-thirds of juvenile justice involved youth have a mental health diagnosis or need[2] and that over 20% have a mental health disorder that could be diagnosed as serious.[3] Common diagnoses include behavior disorders, conduct disorders, oppositional defiant disorders, antisocial behaviors, mood disorders, substance use disorders, anxiety disorders, and attention deficit/hyperactivity disorder. Many of these youth suffer from conditions resulting in more than one diagnosis.

Unfortunately, the juvenile justice system does not consistently and sufficiently address these mental health needs. Numerous studies have found that a large percentage of youth with mental health needs go untreated during their involvement with the juvenile justice system. For example, in her study of juvenile courts in one state, Carolyn Breda found that fewer than 4% of juvenile offenders were referred for mental health services.[4] Additionally, a 2005 study of youth in another state found that only 23% of youth diagnosed with a mental health disorder received any treatment.[5] Finally, a 2006 study of juvenile justice facilities nationally found that only 10% of youth with a severe mental health disorder received any emergency mental health services.[6]

RACIAL DISPARITIES IN THE JUVENILE JUSTICE SYSTEM

In addition to youth with mental health needs, we also find that youth of color are overrepresented in the juvenile justice system. For example, in 2013 while the

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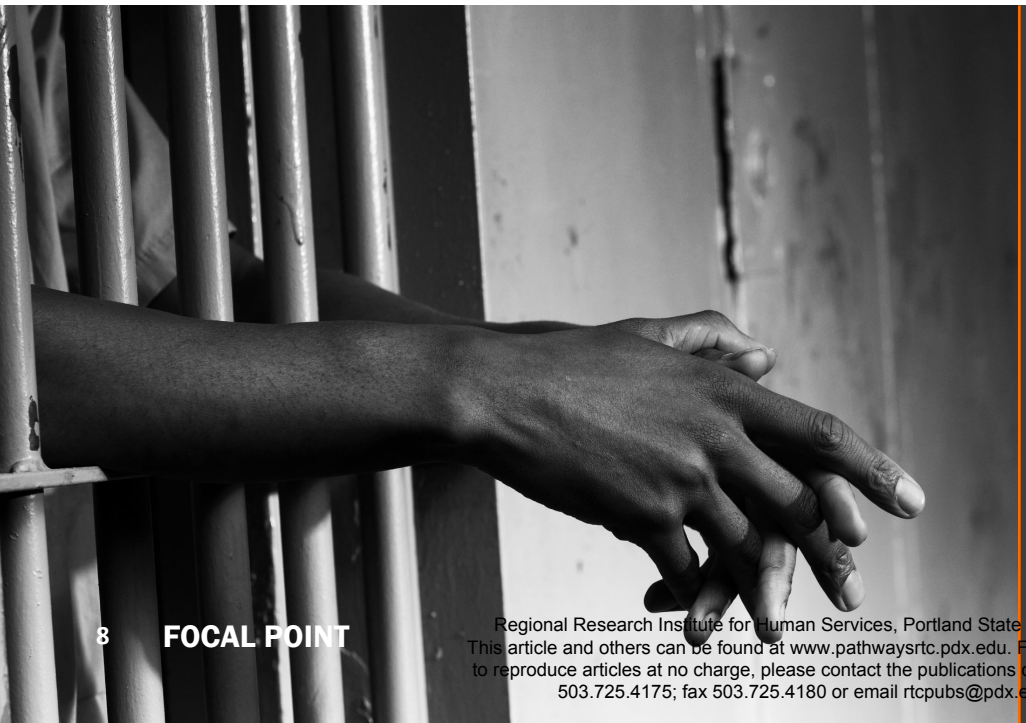
national arrest rate for white youth was 26.0 arrests per 1,000 persons in the population, the arrest rate for African American youth was 63.6, nearly 2.5 times higher.[7] Typically, national data shows that once youth of color are arrested and referred to court, they subsequently go deeper into the juvenile justice system than white youth and are less likely to be diverted or given more lenient dispositions such as probation. As another example, in 2013 the residential placement rate for African American youth was 4.6 times greater than for white youth.[8] Although not as stark, similar patterns of disproportionate contact with the juvenile justice system exist for American Indian youth, Hispanic youth, and smaller ethnic groups.

Several large-scale efforts have synthesized and analyzed the body of individual research studies on racial disparities in the juvenile justice system. Most of these studies examine whether disparities still exist after legal and extralegal factors are taken into account. In the first such study, Pope and Feyerherm identified 46 studies published between 1969 and 1989 and concluded that the majority of studies found some impact of race on decision-making.[9] They noted that the evidence suggested bias can occur at any stage of juvenile justice and, as minority youth progress further through the system, racial differences may accumulate and become more pronounced.

At least five subsequent reviews examined portions of the research literature between 1967 and 2014. Although each covered a slightly different set of research studies, the overall results were remarkably consistent. In the majority of well-designed research studies, racial and ethnic disparities may be found in many of the major decision stages in the juvenile justice system and cannot be fully accounted for by differences in the behavior of the youth involved: disparities in the handling of youth far exceed any differences in the behavior of these youth. It is also interesting to note that some research studies found no disparities and that the patterns of disparities appear to differ from one community to another and from one contact point to another.

RACIAL DISPARITIES AMONG REFERRALS TO TREATMENT

Given the disparities found in traditionally studied juvenile justice decision points (e.g., arrest, court referral, diversion, secure detention, petition, adjudication, secure confinement, probation, and transfer to adult court) and the fact that not all juveniles who need mental health services are treated in the juvenile justice system, are there also racial and ethnic disparities among referrals to mental health and substance abuse services? In our 2016 systematic literature review we found that a majority of studies published in the past 20 years found at least some race effect in the decision to refer youth to services.[1] Studies were included in our review if they examined the decision to provide juveniles with mental health or substance abuse services in the juvenile justice system, included race or ethnicity in the analysis, used quantitative methodology, and examined a sample from a state or local system in the United States. Of the 26 studies examined, 69% found at least some race effect disadvantaging youth of color while 31% found no race effect. To account for potential differences in mental health and substance abuse needs by race/ethnicity, 19 of these studies provided statistical controls for scores



Once youth of color are arrested and referred to court, they subsequently go deeper into the juvenile justice system than white youth.

Disparities in the handling of youth far exceed any differences in the behavior of these youth.

on screening and assessment tools, prior mental health or substance use treatment, or drug/alcohol-related offenses. Of these 19 studies, 63% found at least some race effect while 37% found no race effect.

For example, a study of detained youth in Indiana, which included statistical controls for gender, age, detention center site, and whether the youth had a positive score on a mental health screening instrument, found that both African-American and Hispanic youth were less likely than white youth to receive contact with a mental health clinician within 24 hours of detention center intake and to receive a referral to mental health services upon detention center discharge. A study of mental health treatment service delivery for youth in secure facilities in Maryland found that while only 11.9% of the African American youth who met the diagnostic criteria for a mental health disorder received treatment, 42.6% of the white youth who met the criteria received treatment. Another study of juveniles who were adjudicated delinquent in Pennsylvania found that the court was less likely to send African-American and Latino youth to a therapeutic program than white youth compared with a physical regime program or a traditional reform school.

Included in the 63% of studies that found at least some race effect were studies that reported mixed effects. For example, one study of a Missouri court found that although there was no race difference in the rates of referral for substance use disorders, white youth were more than twice as likely to receive a mental health treatment order as compared to African American youth. These researchers included statistical controls for gender, age, legal variables, parental history of substance use and mental health disorders, peer influence, mental health status, substance use problems, learning disorders, and other personal issues.

On the other hand, 37% of the studies that controlled for mental health needs found no race effect. For example, a study of a county court in South Carolina found that race was not a significant predictor of admission to drug court after accounting for gender, age, legal variables, family status, and mental health history. Similarly, a study of youth processed through a Midwestern circuit court found that once all control variables – including assault history, history of abuse or neglect, behavior problems, learning disorder, negative attitude, and social environment – were introduced into the final model, race was not a significant factor.

CONCLUSION

A preponderance of the literature finds that racial disparities in the juvenile justice system exist not only at traditionally studied juvenile justice system decision points such as referral to court and placement in a secure detention facility, but also among referrals to mental health and substance abuse services. While the rate at which mental health and behavioral health resources are used in juvenile justice settings is abysmally low in general, it is particularly low for African American youth and more generally low for all minority youth.

The net effect of these disparities in the operation of the justice system and in referral for mental health and substance issues is to push a greater volume of minority youth into punitive systems and a greater

volume of white youth into systems designed to deal non-punitively with their mental health and substance use problems. Resolving these inequities will require coordinated action from both sets of service providers: those in juvenile justice and those in the mental and behavioral health systems.

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Resolving these inequities will require coordinated action from both those in the juvenile justice systems and in the mental and behavioral health systems.

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ANSWERING THE CRY FOR HELP

I grew up in a household where alcohol use and violence were common. For most of my childhood, I was unable to talk about how I felt. I had to act tough and hide my feelings of anger, sadness, and fear. Bottling up all of these emotions led to me being a very angry young man. The anger and bitterness that I was unable to speak about caused me to act out in aggressive ways and led me to commit acts of violence that inevitably placed me in very bad situations. One of my worst acts of violence almost had me facing 18 years for the crime of attempted murder.

I was fortunate in that I only ended up having to serve four out of six years instead of 18. However, in those four years I was able to see how inadequate the juvenile justice system was when it came to addressing mental health needs of young people in state custody. A day in my life at the facility was a constant reminder of the fact that I did not have my freedom and that I was viewed as a "criminal." Throughout the day, I would hear automatic doors locking, witness fights between my peers, and I had to ask for permission for everything (including using the bathroom). Consequently, my mental health was not my first priority. Seeking help was the last thought on my mind. What I was most concerned with was making sure that I did not look weak and that I was aware of my surroundings, since things could easily go from two people peacefully talking to fists and chairs flying everywhere. I lived in a constant state of hypervigilance and had learned to adapt to the negative social environment around me in order to make it through each day.

What was most troubling about being incarcerated was not being able to find people to talk to about the things I was feeling. In that space, I was either talking to people who were stuck in the same situation I was or staff who were often more concerned with keeping order than offering support. Although some frontline staff were very supportive, often times they were going outside of their job descriptions to provide support. And when it came to counseling, well, I could come out of a session feeling happy only to find myself locked in my room later on because a fight broke out or because staff didn't want to let us out. When I did seek counseling, it was only to get out of my room for a period of time. Out of the few times I did seek counseling, I remember being offered Seroquel on more than one occasion. I was told it would "help me relax and sleep better." I saw many of my peers take Seroquel as if it was some kind of tranquilizer. Medical staff would come to the unit and staff would jokingly say, "Come get your Skittles!" More than half of the guys would get up to get their meds. I never gave much thought to it then but I now question why medications or restraints were always the answer. I remember once having a bad phone call with my family and losing my mind in my room. I started yelling and punching the walls. In that moment, staff came into my room to restrain me, fearing that I was getting ready to commit suicide. What I needed in that moment was a hug, an ear, a shoulder to cry on. I needed compassion.

I came into the justice system after having experienced a number of traumatic experiences which hampered my ability to think through my actions and

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PROJECTS AND STAFF

PROJECT FUTURES: FOSTERING UNITY TOWARDS UPLIFTING RESILIENCE, EDUCATION, AND SUCCESS tests an approach to enhancing self-determination and community participation to help young adults with a history of mental health challenges to build skills to navigate the university system and increase postsecondary success and engagement.

Jennifer Blakeslee, Principal Investigator; Shannon Turner, Project Manager; Marin Henderson Posther, Graduate Research Assistant; Trhona Johnson & Rebecca Miller, Coach-Student Mentees; Anthony Abshire & Miriam Montes, Student Interns; Sarah Geenen & Laurie Powers, Project Consultants.

EASA CONNECTIONS brings together young adults who have been part of Oregon's early psychosis initiative to develop and test a peer-delivered series of web-based decision support tools for new individuals entering into early psychosis services.

Tamara Sale & Ryan Melton, Co-Principal Investigators; Dora Raymaker, Project Manager; Christina Wall, Young Adult Coordinator.

TEC-PD: TECHNOLOGY-ENHANCED COACHING FOR POSITIVE DEVELOPMENT tests a workforce intervention using state-of-the-art technology to implement high-quality coaching and supervision with practitioners employing the Transition to Independence Process intervention with emerging adults with serious mental health challenges.

Janet Walker, Principal Investigator; Celeste Seibel, Project Manager; Caitlin Baird, Research Assistant; Mary Beth Welch, Peer Support Trainer; Esther Manea, Student Research Assistant.

S/PAC: SYSTEM/POLICY ASSESSMENT AND CHANGE PROJECT documents and analyzes processes, strategies, and outcomes by which organized groups of young adults engage in policy analysis and action relevant to transition, and develops knowledge about key systems factors at the state level affecting transition services.

Nancy Koroloff & Barbara Friesen, Co-Principal Investigators.

AMP+: DEVELOPING THE YOUNG ADULT PEER SUPPORT WORKFORCE tests a workforce intervention focused on training and coaching peer support providers who work with emerging adults with serious mental health conditions, and prepares agencies to supervise and support them.

Janet Walker, Principal Investigator; Celeste Seibel, Project Manager; Caitlin Baird, Research Assistant; Mary Beth Welch, Peer Support Training Specialist.

MENTEE-NOMINATED MENTORING adapts and tests a promising mentoring approach – youth-initiated mentoring – for young people who are living in residential treatment settings after stepping down from more acute psychiatric care.

Jennifer Blakeslee, Principal Investigator; Celeste Seibel, Project Manager; Caitlin Baird, Research Assistant; Janet Walker & Tom Keller, Project Consultants.

THE PATHWAYS TRANSITION TRAINING PARTNERSHIP has formed partnerships with service provider organizations that are participating in testing the effectiveness of an online training program, will survey service providers regarding their training needs and preferences, and develop new training materials in response.

Eileen Brennan & Pauline Jivanjee, Co-Principal Investigators; Leigh Grover, Project Manager; Claudia Sellmaier, Project Collaborator.

regulate my emotions. What I came to realize while incarcerated was that the environment was not going to change – it was going to remain violent and unsafe, because that is what the culture and structure of the facility promoted. I needed to keep busy and find positive outlets to release what I was feeling and internalizing. Unfortunately, the opportunities for outlets and safe spaces were limited and I was often left to my own devices. For some of my peers, being in this space only caused them to act out more because they were constantly being viewed as having "behavioral" issues rather than as young men in need of support.

I want to convey to the reader that young adults do not always need psychotropic medication to address their mental health needs. When young people act out it does not mean that they are mentally unstable; it may just be a cry for help. Also, mental health and juvenile justice professionals must bear in mind that each system thinks about, and deals with, behavioral issues in different ways. Not all staff know how to deal with and address trauma, so proper training on how to respond is important when it comes to the mental health of young people in the justice system. A cry for help should not always be met with medication. A cry for help should not be met with physical restraints. A cry for help should be met with dialogue, compassion, and love – no matter how difficult a young adult's behavior may seem.

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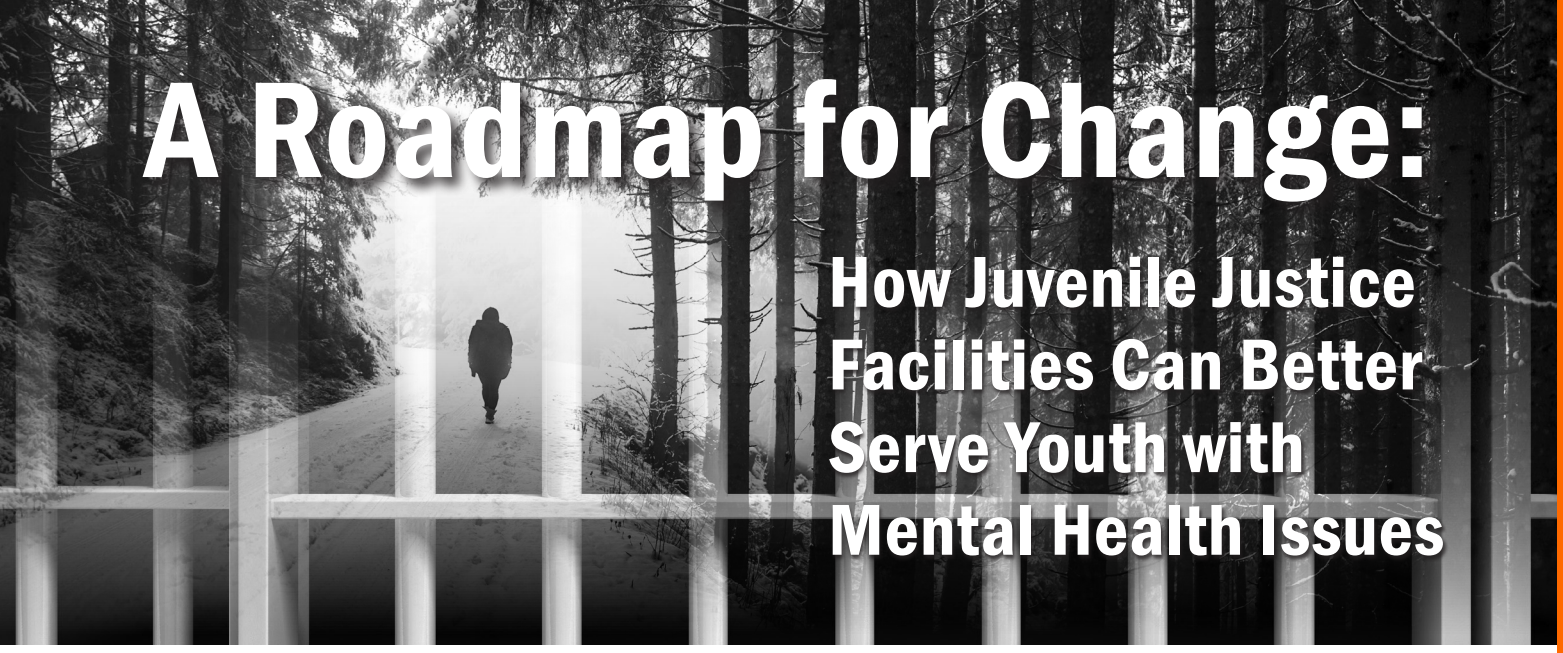
Hernan Carvente is a program analyst for the Vera Institute of Justice's Center on Youth Justice, where he works on improving the conditions of confinement, including efforts to support the incorporation of youth voices in facility-based and statewide juvenile justice policy reform.



A Roadmap for Change:

How Juvenile Justice Facilities Can Better Serve Youth with Mental Health Issues

Over the past decade, the juvenile crime rate has dropped significantly and the number of youth in the "deep end" of the system (i.e., those committed to correctional agencies and placed in residential facilities) has decreased. These positive advances in the juvenile justice system are bringing a vulnerable population into sharp focus: adolescents suffering from mental illness. System officials around the U.S. report that what was once a mix of low-, moderate- and high-risk youth placed in juvenile correctional facilities is now a population of mostly high-risk youth. Studies consistently find that 65 to 70% of youth in such placements have at least one diagnosable mental health issue.[1]

In many jurisdictions, juvenile facilities fail to meet the needs of youth with mental health issues. Despite residents' histories of trauma and victimization, facility staff continue to utilize traditional punitive correctional approaches proven to be ineffective, as opposed to strength-based, therapeutic interventions. In the face of research showing that half of all suicides in juvenile facilities occur while youth are held in isolation, 46% of juvenile correctional facilities still report using room confinement for more than four hours to control behavior.[2] Many facilities also lean on the use of force as a behavior management strategy, physically restraining youth and applying chemical agents (e.g., pepper spray) to resolve incidents rather than adequately engaging in de-escalation and conflict resolution techniques. These practices aggravate residents' trauma-based disorders and damage relationships between staff and youth.

The reality for youth of color in residential placements is even starker. A population already overrepresented in the juvenile justice system, youth of color are more likely to be diagnosed with conduct disorders or antisocial behavior than their white counterparts.[3] Youth of color needing treatment for mental health issues are half as likely to be screened into treatment as white youth, and their diagnoses may be more likely to be impacted by racial differences in presentation or clinician biases. This disparity leaves many youth of color placed in facility "Special Management Units" designed to control their behavior, often lacking access to mental health treatment services. Youth of color in custody typically have less access to formal outpatient services and are less likely to take advantage of those services post-release.[4] Even if youth are inclined to resume services, practical and cultural factors like transportation costs and community stigma around mental illness often prevent youth from utilizing services after release.[5]

Unfortunately, the primary experts on any given youth – their families – are often not adequately encouraged and supported to engage in the youth's treatment process at the facility and upon community re-entry. Across the board, family engagement in juvenile justice is linked to better youth outcomes. One study even found a correlation between family visitation at facilities and youth's positive behavior and educational progress.[6] Yet system staff and providers often drive treatment planning and service delivery without ensuring that families have a meaningful role at the table. This practice has especially negative consequences for youth with mental health issues. Family engagement helps ensure that the full context of an adolescent's behavior is available for consideration in treatment planning, raising the likelihood that services are tailored to the youth's unique needs. It also empowers families and gives them the skills to support the youth upon re-entry.

Despite these significant challenges, there is hope. Over the years, the field has developed a number of

tools, resources, and approaches that can enhance the way youth with mental health issues are served in residential settings. Validated screening and assessment tools such as the Massachusetts Youth Screening Instrument (MAYSI-2, http://www.nysap.us/MAYSI2.html) and the Global Appraisal of Individual Needs (GAIN, http://gaincc.org) have become a standard part of intake and ongoing assessments that greatly inform case planning and service delivery. The impact of trauma on youth and staff is now better understood, and many facilities are reshaping their practices – through staff training and multi-disciplinary collaboration – to better address the needs of youth and staff. Re-entry planning and support have also gained national attention as practice areas necessary to a youth's long-term success.

Structural frameworks that actively support practices that address mental health issues are also becoming more prevalent, such as the Youth in Custody Practice Model (YICPM),[7] an evidence-based framework for residential juvenile facilities. Developed and operated by the Council of Juvenile Correctional Administrators and the Center for Juvenile Justice Reform, the YICPM provides agencies with guidance to develop blueprints to create more comprehensive methods of care for youth in custody.

The largest challenge still remains: shaping an approach in our residential care facilities that is sensitive to the needs of youth with mental health issues, from initial contact to community reintegration. Following are some strategies and recommendations to assist in making that vision a reality.

1. Strengthen programming and policies around evidence-based practices aimed toward rehabilitation and positive youth development.

The general purposive shift in juvenile justice from being a primarily punitive system to a primarily rehabilitative one has proved to be tremendously successful. The philosophy is there, and the structural and operational elements have begun to follow. This often takes the shape of policies that put a comprehensive case planning system front and center for staff and youth alike, providing transparency as well as a sense of engagement and care. Further building and supporting staff capacity and efficacy around the practices that bring these policies to life to a greater degree is essential.

This move from punitive to rehabilitative practice is most readily seen in jurisdictions like Oregon, Massachusetts, and Missouri that have embraced core tenets of positive youth development. The highly regarded "Missouri Approach" to juvenile treatment, for example, includes a continuum of mental health services that is responsive to youths' needs, and "group systems" that incorporate therapeutic intervention techniques and experiential group projects into programming (http://missouriapproach.org).

2. Engage and empower families to play an active role in their children's treatment.

Family engagement and empowerment must be a fundamental element of juvenile justice practice. Staff should support youth to define for themselves who constitutes family, including "fictive kin" who may not be related by blood or through marriage but nevertheless support the youth. Facility visitation policies must accommodate family members' schedules, and staff must regularly encourage families to participate meaningfully in treatment planning (even by videoconference if in-person attendance is not possible). Staff's interactions with families should be strength-based, and families should have opportunities to receive needed services, voice their concerns, and share their insights on how to enhance service delivery and approaches.

3. Create facility environments that are safe and conducive for learning and personal growth.

The facility's physical environment can play a big role in creating an atmosphere for learning and personal growth. Physical plants that evoke a correctional feel (e.g., sterile hallways and common areas, concrete beds, little natural light) send a message to youth about how they are valued and the type of behavior that is expected from them. For all youth, including those with mental illness, we must craft a different message. Even in challenging physical plants, staff can take relatively simple and low-cost measures to enhance the environment, such as hanging artwork, painting walls calming colors, installing carpet and area rugs to reduce noise, and adding more comfortable furniture to common spaces and visitation rooms.

4. Break down "staff silos" and encourage information-sharing and cross-training opportunities.

Bridging the informational and logistical gaps between different staff groups is crucial to create a more integrated mental health approach within the juvenile justice process. In institutional settings this requires creating case planning teams with all staff groups represented, laying broad communication lines across silos, and providing training and educational opportunities for all staff at the facility. Offering cross-training on topics such as mental health can create a more well-rounded workforce that understands colleagues' needs regarding how to best assist youth with mental health issues.

5. Provide staff with training on adolescent development, cultural competency, and trauma sensitivity, and create environments of staff wellness.

Facilities must ensure that staff are well-equipped and empowered to do their jobs. Serving youth in custody is undoubtedly challenging, particularly given staff's regular exposure to the behaviors and emotions of youth with trauma histories and mental health challenges. Creating environments of wellness and support are critical to prevent burnout and secondary traumatic stress. In addition to training all staff on adolescent development, mental health, cultural competency, and trauma, facilities should ensure that staff receive excellent supervision, have opportunities for regular breaks, and are regularly recognized for their good work. Training on conflict management also helps staff develop skills to deescalate potentially dangerous situations non-violently.

6. Track mental health data within facilities and develop targeted strategies to address deficiencies.

What gets measured gets managed and improved. Facilities should be tracking key process and performance indicators, including those pertinent to the administration of mental health services (e.g., practices related to screening/assessment, treatment planning/service delivery, and continuity of care). Whether conducted with internal resources (i.e., data/quality assurance staff) or with the assistance of initiatives like Performance-based Standards (http://pbstandards.org), systems should be regularly collecting and utilizing data to improve approaches. This includes conducting routine analysis of practices and outcomes by race and ethnicity to identify any existing disparities and develop targeted strategies to address them.

7. Create a model of transition for the re-entry process to ensure stability for youth and to discourage recidivism.

For youth struggling with mental health issues, continuity of care is especially important for successful community re-entry. Ensuring access to services outside the facility before release is critical, as is guaranteeing that youth have the material tools they need to make re-entry as successful as possible. Creating a model of transition for youth returning to their communities that links the youth's key support systems, especially those of facility mental health staff, mental health service providers in the community, parole/re-entry field staff, and family, can help ensure that youth do not fall back on unhealthy and delinquent behavior. Professionals should be working together early and often while the youth is at the facility to plan for re-entry and ensure that the youth will leave the program with all necessary medication and community-based services in place.

In summary, for the thousands of youth and their families involved with the juvenile justice system who have mental health needs, the time for action is now. Working together, we can create a comprehensive, equitable, rehabilitative juvenile justice system that places young people with mental health issues in a position to thrive. As described above, this will take a strong set of policies and practices and a concentrated effort that is measured on an ongoing basis to ensure its effectiveness.

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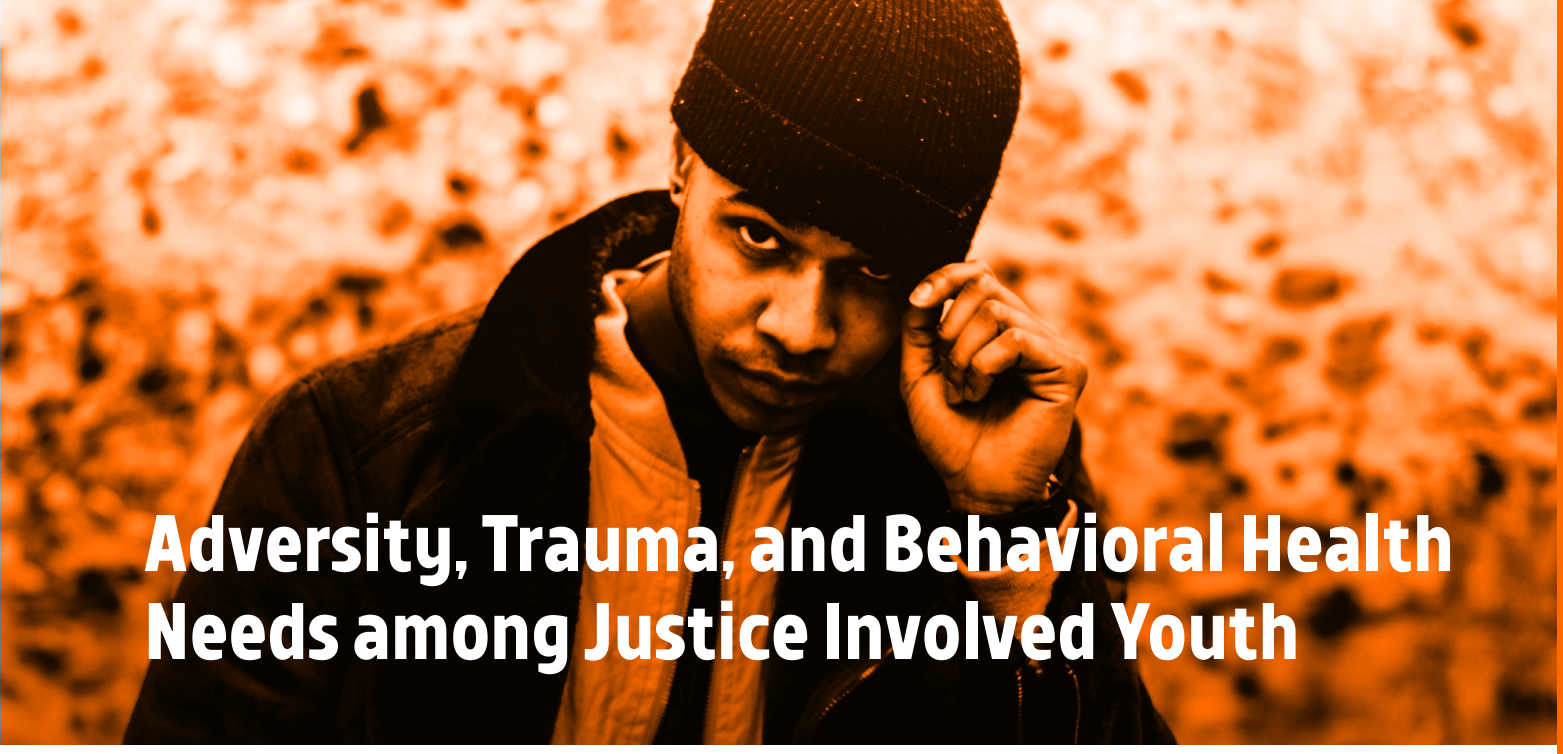


Adversity, Trauma, and Behavioral Health Needs among Justice Involved Youth

Nearly 1 million youth under the age of 18 are arrested each year in the United States.[1] These youth disproportionately have trauma-related and behavioral health conditions that have not been sufficiently identified or addressed in the community. As a result, they are at elevated risk of entanglement in the juvenile justice system.

Youth in contact with the juvenile justice system disproportionately experience mental and substance use conditions, and bear the burden of exposures to violence and traumatic stress. More than 90% of these youth experience at least one trauma in their lifetime, and the average youth has experienced 4.9 different types of trauma exposures.[2,3] Exposure to traumatic violence in childhood increases the risk for drug and alcohol use, depression, and anxiety, and has numerous additional long-term consequences including increased likelihood of stroke, diabetes, cardiovascular disease, cancer, and early death.

Multiple, or co-morbid, conditions are the norm for youth in the juvenile justice system. The presence of these co-morbid conditions presents unique challenges for juvenile justice and behavioral health care service systems and practitioners alike. These youth present with the greatest impairment in individual and academic functioning, have elevated risk of suicide, and consistently have the poorest treatment outcomes.

Co-morbid mental health, substance use, and traumatic stress conditions interact in ways that tend to intensify one another. For example, a youth suffering from anxiety arising from PTSD may develop a substance use problem from efforts to self-medicate. To increase community safety, and support recovery and long-term success for these youth, it is essential that juvenile justice and community behavioral health care systems and practitioners develop a common understanding of the complex needs of these youth. Both systems should adopt practices that are collaborative in nature, designed to identify and quickly respond to the needs of these youth and their families, and that are trauma-informed and evidence-based.

"BAD" OR "VULNERABLE" YOUNG PEOPLE?

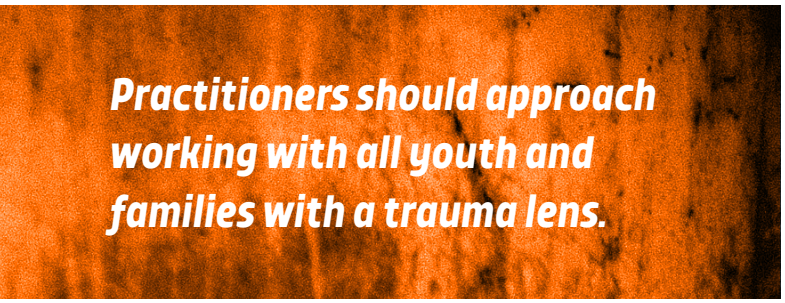
Not all exposures to adversities result in traumatic symptoms or persisting post-traumatic adaptations. For example, youth may have personal characteristics that support resilience, or family and other supportive relationships that buffer the impact of adversity. However, youth exposed to chronic and/or extreme adversities commonly do develop symptoms and adaptations arising from those experiences. Some of these young people will behave in ways that bring them into contact with police and courts. If their behavior is not viewed through a trauma-informed lens, their misconduct may prompt responses that make matters worse, lessen the prospects for rehabilitation, and increase the likelihood of deeper penetration into the juvenile justice system.

The variability of adaptations following exposures to adversities results in a kind of "clinical chameleon." Many youth will present with some features of PTSD but not meet enough diagnostic criteria to warrant that diagnosis. As a result, clinicians may attempt to capture the clinical presentation through assigning two or

more other diagnoses. Or, if the origins of symptoms in adversity exposures that have yielded trauma symptoms are not recognized, the youth may be misdiagnosed. Diagnosis will drive treatment and misdiagnosis runs a substantial risk of failure since it will not directly address symptoms and problematic behaviors that originate in adversity and trauma.

Young people whose problematic behaviors arise – at least in part – from traumatic exposures may elicit punitive rather than rehabilitative responses. For example, some whose exposures to violence have resulted in hypervigilance may respond aggressively when they feel they are threatened. Punishing the aggression without addressing the underlying problem with threat perception is likely to worsen the problem rather than resolve it.

Young people with significant histories of exposure to adversity are overrepresented in special educational, behavioral health, and juvenile justice settings. The kaleidoscope of diagnoses, supports, treatments, and other interventions they receive reflects both their vulnerability and a failure to consistently recognize the role of adversity and trauma in their development and, therefore, their problems with learning and behavior. As a result, practitioners also fail to consistently implement evidence-based practices to detect and respond to the array of behavioral health needs, identify their resiliencies, and support normalizing positive youth development.



AN INTERVENTION FRAMEWORK

Whether and how these needs are identified, understood, and addressed will greatly impact how juvenile justice systems react to these youth and their families. This, in turn, will deeply shape the outcomes for them and their communities. Juvenile justice practitioners and others will rely on different models for intervention based upon how they understand the behaviors resulting from developmental adaptations to adversity and symptoms of trauma.

It is essential for healthy development that youth be held progressively accountable for their decisions and behaviors as they mature. Accountability can be punitively imposed through correctional practices likely to exacerbate their vulnerabilities. However, accountability can be a component of broader rehabilitative strategies that include explicit instruction in emotional regulation, managing perceived threat, decision-making, building upon resiliencies, and addressing explicit symptoms of behavioral health and trauma conditions. Juvenile justice policies and practices that properly address behavioral health needs and that include trauma-informed, evidence-based clinical and organizational practices increase the prospects for rehabilitation, positive youth development, and community safety.

There are a number of approaches and interventions that practitioners in juvenile justice and behavioral health care can adopt to support better outcomes for these youth. Broadly, practitioners can rely upon a Risk-Needs-Responsivity (R-N-R) model to: (a) identify *risk* factors but also protective factors and resiliencies; (b) identify "criminogenic" *needs* (i.e., needs likely to result in criminal behavior) such as affiliation with delinquent peers, unsafe homes or neighborhoods, family substance use, and other factors related to delinquent misconduct which need to be addressed as part of a comprehensive intervention plan; and, (c) craft an individualized plan that takes into account "*responsivity*" factors such as a youth's learning style, culture, interests and competencies, family engagement, and other factors. These factors need to be taken into account to optimize the match between interventions and a youth and family.

The R-N-R model must be trauma-informed and responsive to behavioral health needs at each point to optimize selection, planning, and implementation of interventions. Youth with a history of significant exposure to adversities and indications of post-traumatic adaptations or symptoms must be seen through a trauma-informed R-N-R assessment. For example, substance use that is an effort at self-medication is a risk for misconduct, while engaged, positive parents are a protective factor; ongoing affiliation with delinquent peers or unsafe streets are conditions that need to be addressed, and recent immigration or other cultural factors would be responsivity factors that may require treatment in their language of origin, or adapted to respect cultural norms.

Optimal behavioral health and juvenile justice interventions are more likely to achieve positive outcomes if a trauma-informed R-N-R model is used to create a common understanding and coordinated efforts to address the needs of juvenile justice involved youth. Specifically, systems and practitioners should:

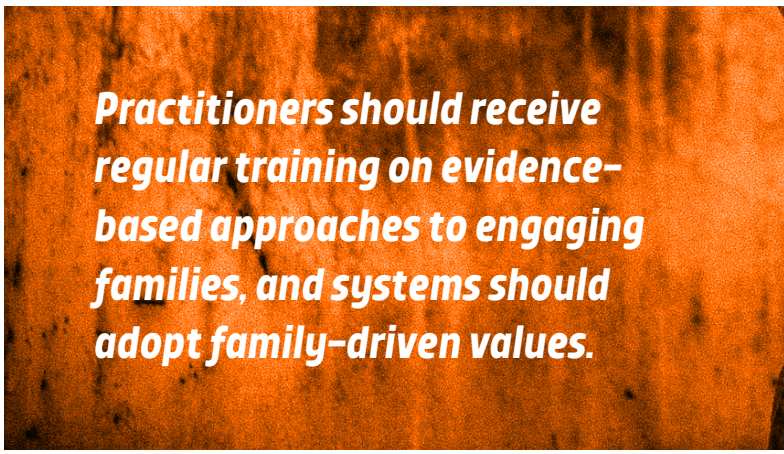
- Develop a common understanding of adolescent development and the behavioral manifestations of

common diagnoses or developmental adaptations to adversity. This usually occurs through regular cross-systems training efforts, alignment of mission or values statements, and implementation of policies that support rehabilitative rather than punitive responses.

- Practice trauma-informed care as the norm rather than the exception. Given the prevalence of exposure to violence and resulting traumatic stress, practitioners should approach working with all youth and families with a trauma lens.
- Engage and involve families in juvenile justice and behavioral health systems given the important role they play in supporting youth. Practitioners should receive regular training on evidence-based approaches to engaging families, and systems should adopt family-driven values.
- Use research-based tools to identify mental health, substance use, and traumatic-stress related conditions. For juvenile justice practitioners, this requires adoption of behavioral health and trauma screening procedures at all points of contact with the juvenile justice system. Given the prevalence and nature of co-occurring conditions, it is important that screening procedures target all conditions. When youth screen in, juvenile justice practitioners must be able to refer youth to community-based, clinical service providers who can conduct an in-depth assessment.
- Increase the community capacity to provide a comprehensive continuum of trauma-informed, co-occurring, or integrated care for youth. Too often services are segmented and treatment is offered by different practitioners that do not coordinate care or cover the wide range of treatment needs. Services that are rooted in an adolescent framework should be available for those with emergent needs, and to the most severely affected young people.

RESOURCES FOR RECOVERY AND REHABILITATION

Over the last decade, strategies and innovative models with demonstrated success have been developed by and for juvenile justice practitioners who work with these youth. These include operationalization of the R-N-R framework for identifying and responding to risk factors while building on and strengthening those factors that promote resilience. Toolkits, guidebooks, and training programs are available to support local adoption of this framework. Similarly, there are training curricula and cross-systems models for effective collaboration and coordination of services to support practice that is trauma-informed, engages and involves families, and is rehabilitative rather than punitive. There are screening tools, validated for juvenile justice settings, which can identify mental health needs, substance use, and trauma-related stress among youth in contact with the juvenile justice system, and new evidence-based treatments and integrated approaches to meeting their behavioral health needs. Consult the National Center for Mental Health and Juvenile Justice (https://www.ncmhjj.com) for specific resources. Juvenile justice practitioners, now more than ever, have resources to support adoption of interventions that lead to better outcomes for youth with behavioral health and traumatic-stress conditions.



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What Organizational Factors Influence Mental Health Treatment Allocation?

In a major national survey, Young and his colleagues explored substance abuse and access to intensive treatment services for both adult and juvenile offenders.[1] They found rates of substance use to be over 50% in both adult and juvenile incarcerated populations. In their discussion of evidence-based practices (EBP), they highlighted issues such as organizational climate and culture, resources, training opportunities and administrator attitudes as factors influencing the use of known EBP in adult and juvenile settings. Of importance in recent years is the adoption and implementation of EBP in both public and private organizations. Farrell, Young, and Taxman assert that existing research documents the importance of organizational context in the adoption of EBPs in substance abuse, mental health, and as of late, correctional agencies.[2] Concern for both the need to access services, and the need for effective treatment, makes it vital to understand what aspects within the organization or setting impact the allocation of treatment to individuals in custody.

Organizational factors including agency leadership, staff training, climate, and culture have all been identified by Glisson and Green as aspects which affect service quality, service outcomes and staff attitudes in both child welfare and the Juvenile Justice System (JJS).[3] Specifically, Green, Albanese, Cafri and Aarons highlight the many ways in which the role of leadership may influence mental health services and treatment offered to individuals involved with JJS.[4]

Still the question remains: what organizational factors influence treatment allocation for youthful offenders? As a way to explore this question specifically, a series of focus groups was held with staff from a juvenile justice organization in the Pacific Northwest. Using a qualitative approach, staff attitudes were explored as an integral part of organizational climate and culture. Primarily, staff were asked to discuss the agency and facility interactions that they believed influenced whether or not a young person received treatment. Preliminary findings from the focus groups revealed facility leadership, training and culture, as well as staff participation in making treatment recommendations as major elements.

This study included four separate focus groups facilitated across the agency. Focus groups were asked nine questions targeted at various organizational factors including aspects of decision-making, participation in treatment recommendations, perceptions about staff training, and agency leadership. A total of 28 staff members participated and were representative of six of the agency facilities. Participants were 47 years of age on average, and had just over a decade of agency work experience. Among the participants, 22 (79%) were male and six (21%) were female. The majority (29%) were classified as front line supervisory staff, with the next largest group of participants being mental health professionals (25%).

KEY ORGANIZATIONAL FACTORS

The following relevant themes emerged from the discussions. Staff believed that individuals' level of training directly impacted their ability to recommend treatment for a young person. Availability and frequency of training was important, along with ensuring training included specific content related to mental health disorders and

treatment approaches. Staff discussed the utilization of "on the job" training as their primary exposure to knowledge of mental health and effective practices. One staff member stated he first learned about mental health treatment "on the job as to what [the agency] had to offer." He went on to add that some of his knowledge came "from previous positions working in residential treatment for ten years." Participants noted other staff with previous work experience, who were more familiar with mental health service needs, helped to develop their understanding of reasons to prioritize treatment for youth.

Staff also believed frequent *agency change* and *turnover in leadership* affected their support of treatment recommendations for youth. Specifically, leadership changes and rotating philosophical approaches impacted staff attitudes towards the importance of treatment. In reference to setting priorities, one staff clarified "leadership sets the tone." Another staff member mentioned organizational issues influencing *staff turnover*, such as staffing changes, alterations in shift schedule, and lack of communication among staff, as barriers to offering consistent treatment to youth. In regards to the effect of change on staff and youth, one staff member mentioned, "Staff has a hard time with change. The mental health population needs consistency." Aspects of *organizational climate,* including team cohesiveness, adjustment to constant agency change, and ability to engage in collaborative working relationships, were all identified as elements that staff believed improved the direction and prioritization of treatment resources. Finally, although discussed with less frequency and intensity, staff indicated *individual staff factors* such as personality traits and voice in the decision-making process as influencing whether or not a young person is referred for treatment. One staff reported traits such as "patience, understanding and a willingness to learn new things" as key staff qualities.

Since the work of many has clearly documented the high mental health needs of young people across child welfare and the JJS, it is essential these systems include avenues to ensure timely access to services.[3] In order to accomplish this, the JJS and its vast number of correctional facilities, both long- and short-term, should evaluate the organizational context in which services are provided. Organizational factors including leadership, decision-making, and mental health-specific staff training and knowledge appear to be highly influential in the allocation of treatment to juveniles in custody.

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A Decade of Diversion: Ohio's Behavioral Health Juvenile Justice Initiative

Researchers report that between 65-75% of juvenile justice-involved youth experience mental health or substance abuse problems,[1,2] as well as elevated levels of violence exposure and trauma.[1,3] Due to the complex needs of these young people, jurisdictions have developed detention alternatives that allow for more complete behavioral health assessments and provide more comprehensive and evidence-based treatment services than are available in most juvenile justice facilities.

In the late 1990s, Ohio's juvenile court judges met with representatives from the Ohio Departments of Mental Health and Addiction Services (Ohio MHAS) and Youth Services (ODYS). The judges discussed the increasing number of youth appearing in their courts with significant mental health or substance use issues. Although these young people would have benefitted from behavioral health treatment, diversion options were simply not available throughout the state.

One recommendation that arose from this meeting was to develop alternatives to detention for juvenile justice-involved youth with behavioral health concerns. In lieu of detention, youth would be diverted into community-based behavioral health treatment. This alternative to detention came to be known as the Behavioral Health Juvenile Justice (BHJJ) Initiative.

OHIO'S BEHAVIORAL HEALTH JUVENILE JUSTICE INITIATIVE

The BHJJ program was created to provide detention alternatives for juvenile justice-involved youth with behavioral health concerns. The program targets young people ages 10-18 who have at least one psychiatric diagnosis. Participating counties were required to use evidence-based or promising treatment models, although each county was free to select the model(s) that best met the needs of their residents. Juvenile courts were required to partner with their local alcohol, drug, and mental health board and identify local behavioral health treatment agencies that would provide the identified treatment. Six projects were funded in the first cohort, and the first young person was enrolled in January 2006. Since then, eight additional projects have been funded.

The entry point into BHJJ is the local juvenile court. A young person charged with a crime is screened for behavioral health issues.[4] If the screening indicates a potential issue, a full diagnostic assessment is given by a local treatment provider. If the young person meets the eligibility criteria and agrees to participate in BHJJ, a recommendation is made to the judge. In the vast majority of cases, the recommendation is accepted, the family is enrolled, and the court refers the family to the treatment

A central tenet of BHJJ is to provide services in the least restrictive environment possible.

provider to begin services. A central tenet of BHJJ is to provide services in the least restrictive environment possible, and thus most treatment services are provided in the home.

Since 2006, more than 3,500 young people have received BHJJ services. More males (60%) and young people of color (52%) have participated, and the average age at intake is 15.5 years old. Participants presented with an average of 2.5 psychiatric diagnoses, and common diagnoses include Attention Deficit Hyperactivity Disorder (ADHD), Cannabis-related disorders, and Oppositional Defiant Disorder (ODD). Over half report problems with alcohol or drugs, most commonly alcohol, marijuana, and painkillers.

Trauma and violence exposure is common – especially among females. Twenty-seven percent of girls and 7% of boys have a history of sexual abuse. Girls are more likely than boys to talk about (50 to 30%) and attempt suicide (24 to 9%). The majority have family members who experience behavioral health issues. Many report elevated levels of anger and depression.

Results of a recent 10-year outcome evaluation indicated that program participation led to significant improvements in general functioning and problem severity.[4] Youth reported reductions in trauma symptoms and substance use. Grades improved, and school suspensions and expulsions were greatly reduced. Two out of three participants completed treatment successfully, and over 96% were not sent to a state-run youth prison following participation in the program.

The BHJJ program is also a cost-efficient alternative to detention. The average cost per young person enrolled in BHJJ services was approximately $5,000.[5] This figure includes direct state contributions to the program but does not include additional local or federal dollars used to supplement the program. In comparison, it costs approximately $200,000 to house a young person in a state-run youth prison for the average length of stay of 12.5 months.

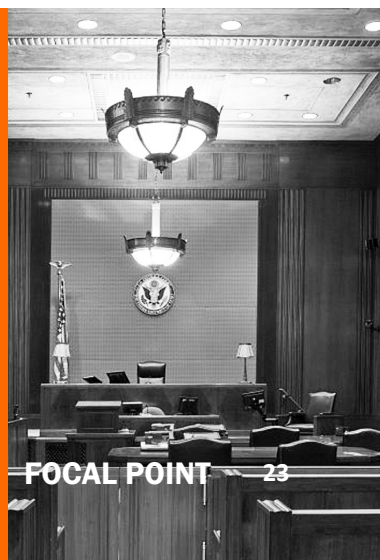
LESSONS LEARNED

The effectiveness of BHJJ can be tied to several factors. Any court applying for funding must partner with its local Alcohol, Drug, and Mental Health (ADAMH) board and local treatment providers. This helps to ensure the necessary partnerships and services exist before program implementation. Next, while the state requires each site to use an evidence-based or promising practice, each site is free to choose the treatment model or models that best serve the needs of its clients. Treatment is not a one-size-fits-all experience. Young people bring with them varied and complicated treatment needs, and BHJJ allows counties to populate their menu of treatment services with the best options for their clients.

Another reason for success has been the state's investment in quality assurance and evaluation services. The state funds an independent evaluation of BHJJ and has used its results to advocate for additional funding at the local, state, and federal levels, and counties use the results to track program outcomes and identify gaps in services. The state also offered funding for collaboration with implementation and fidelity experts, which improved the likelihood of successful implementation and positive programmatic outcomes.

Finally, the program would not work without judges and magistrates who are willing to divert young people away from detention and into community-based behavioral health treatment. Over the past decade, there has been a shift in attitudes regarding the incarceration of

Treatment is not a one-size-fits-all experience.



Views from the Bench: Judge Anthony Capizzi Reflects on BHJJ

The BHJJ initiative began in Montgomery County, Ohio in 2005 with a focus on developing evidenced-based behavioral health services for violent female offenders. We decided that Functional Family Therapy (FFT), a home-based behavioral health intervention,[6] would be ideal for our youth and families. The Court partnered with South Community, our local community mental health provider, to provide the FFT services. FFT has since become a significant part of the menu of services offered to youth involved with the Montgomery County Juvenile Court (MCJC).

Over the past eight years, the MCJC and South Community Inc. have expanded the use of BHJJ and FFT to allow both females and males and their families from every area of our court to access this valuable resource. For example, in 2012, South Community expanded the FFT service to include FFT-Contingency Management (FFT-CM)[6] for youth and families with substance abuse issues. The addition of FFT-CM has been invaluable for the young people I see in our Drug Court program. The availability of FFT-CM allows me to ensure the entire family is being treated, which leads to better outcomes. In 2015, we were able to serve 335 young people and their families though the BHJJ program.

As a juvenile court judge, I feel confident referring youth and their families to a program that has such empirical support behind it. With FFT, I have the opportunity to allow youth to be treated in the community. This approach is fiscally responsible and allows our community to treat young people in their own homes with their families rather than removing them for placement in expensive environments that often show little success.

our nation's youth. Programs like BHJJ have demonstrated that youth can be safely and effectively served in this manner without compromising public safety.

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New Lessons and Evidence from Reclaiming Futures

Reclaiming Futures is a national public health and juvenile justice reform organization developed nearly 17 years ago at a time when the terms public health and juvenile justice were seldom uttered in the same breath. We offered a different lens on juvenile justice – one that focused on the systems that serve youth as well as the relationships between these systems – rather than the youth themselves.[1]

Our model was resonant with the emerging "system of care" approach that is now consensus best practice in behavioral health for adolescents and adults alike. Reclaiming Futures, however, was ahead of its time to suggest shifting the focus of intervention to the systems that serve youth, and making the building blocks of a public health approach – screening, assessment, triage, and community reinforcement – standard practices at the front door of juvenile justice. Today, treatment-focused alternatives in juvenile justice are more commonplace and there is growing consensus and consistent research evidence supporting the notion that community-based alternatives should form the core of youth justice practices.[2]

Along with a greater focus on the community and more systematic consideration of treatment need, the field has also seen greater sensitivity to the role played by trauma and neuro-developmental factors in delinquent behavior. Further, the field has finally begun to take seriously the persistent racial and ethnic disparities in the ways that youth are handled by the system.[3] Still, many jurisdictions continue to overuse detention and incarceration, don't track disparate outcomes by race and ethnicity, and don't properly screen, assess, and refer young people for substance use and behavioral health treatment need. The Reclaiming Futures model offers a blueprint and national peer learning community to support jurisdictions around the country in bringing these reform principles to life in their communities.

THE RECLAIMING FUTURES NATIONAL COMMUNITY

Reclaiming Futures (RF) has now implemented our model in 42 jurisdictions across 20 states. After the launch of the original ten sites, The Robert Wood Johnson Foundation teamed up with the federal Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to fund a series of 15 additional sites that were concurrently implementing a juvenile drug treatment court. Between 2008 and 2012, 14 counties in North Carolina joined the initiative with a blend of funding from the NC Governor's Crime Commission and the Kate B. Reynolds Charitable Trust. Later, two additional NC counties were able to join the Reclaiming Futures initiative with funding from the Conrad N. Hilton Foundation, and most recently a consortium of three counties in rural Northwest Ohio tapped into state justice reinvestment funds to join the initiative. All RF sites convene for regular national meetings, webinars, and conference calls to maintain close collaboration, peer-to-peer exchange, and coaching and technical support from the Reclaiming Futures national program office.

OPERATIONALIZING AND TESTING THE RECLAIMING FUTURES MODEL

In 2009, at a point when Reclaiming Futures had fine-tuned its approach and established a consistent

implementation strategy, the federal government funded a multi-site longitudinal evaluation of the effectiveness of the RF model. A research team at the University of Arizona's Southwest Institute for Research on Women (SIROW) led by Sally Stevens, along with Kathryn McCollister from the University of Miami, was awarded the multi-year research grant administered by the US Library of Congress and funded by OJJDP. The SIROW team studied nine Reclaiming Futures sites that combined the RF model with a juvenile drug treatment court over a five-year period and compared outcomes for these sites with a matched comparison sample of jurisdictions that had implemented a juvenile drug treatment court, but did not use the Reclaiming Futures approach.[4]

The Reclaiming Futures model and systems integration strategy were found to have significant impact in a number of areas, including improving a jurisdiction's ability to connect youth with needed treatment services, and to do so in a way that matched the severity level and specific treatment needs of youth. Sites employing the RF model showed significantly stronger outcomes – most notably, reductions in substance use and criminal behavior for youth with relatively more severe substance use and behavioral health problems. Similarly, RF sites had greater success with youth whose delinquent behavior was more serious at baseline.

Perhaps the strongest finding, and most significant from a policy standpoint, is that the Reclaiming Futures approach results in a dramatic drop in recidivism (repeat criminal offending) compared to sites that do not use the RF approach. These reductions in recidivism generate significant cost savings. Health economist Kathryn McCollister reports that the Reclaiming Futures sites produce an average one-year net cost savings of roughly $84,000 per child.[5] These savings are over and above the cost of implementing Reclaiming Futures at a local jurisdiction and represent savings that could be reinvested to sustain and expand the approach.

According to McCollister: "Our analysis did not isolate the specific factors contributing to the reduction in criminal activity that generated the greatest savings from juvenile drug courts implementing the Reclaiming Futures model. My impression, however, is that the coordination of care and interagency collaboration that Reclaiming Futures adds to juvenile drug courts may be a key factor in reducing crime and delinquency among this group."

Jeffrey Butts and his colleagues of the John Jay College of Criminal Justice Research and Evaluation Center also released a report with the findings of a follow-up study they conducted.[6] This evaluation examined the quality and consistency with which RF sites around the country implemented our model as a predictor of how local jurisdictions perceived the level of coordination and the quality of the treatment service delivery for the youth served in their juvenile justice systems. Their findings clearly suggest that consistent engagement in a peer-based and professionally-coached national learning collaborative like Reclaiming Futures allows local jurisdictions to implement and sustain important practice reforms and to establish effective treatment systems for youth.

Taken as a whole, the findings of these two studies offer strong validation for the Reclaiming Futures approach that we hope will allow us to sustain and expand our impact on the field and continue to innovate for years to come.

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Note: Reclaiming Futures is supported by grants from the Office of Juvenile Justice and Delinquency Prevention and the Conrad N. Hilton Foundation.

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A Comprehensive In-home Intervention to Reduce Justice System Involvement

An interview with Maryann Davis and Ashli Sheidow

Focal Point (F.P.): *Could you give us a little background about why you are conducting this research?*

Maryann Davis (M.D.): Research done in the mid-2000s revealed a high rate of justice system involvement up to age 25 among youth who were adolescent clients of the Massachusetts state mental health system. In fact, between the ages of 15 and 25, when these youth were arrested they had a 35–50% risk of being re-arrested on a new charge within the next year. Clearly, there was a need to reduce reoffending among young people who were involved in the mental health system. At the time we started developing our intervention (around 2007), there were numerous evidence-based practices to reduce justice system involvement in juveniles, but no evidence-based practices (EBPs) that would work with young adults – with or without serious mental health conditions. We considered a modification to Multi-systemic Therapy (MST), as it was an established EBP with a strong track record of reducing recidivism among adolescents. We focused the initial adaptation of MST-EA (Multisystemic Therapy for Emerging Adults) on 17-21 year olds because those ages are the first following the age covered by standard MST.

F.P.: *Please briefly introduce us to MST-EA – what is involved in treatment? How is it different from MST?*

M.D.: Both emphasize recidivism reduction, through a comprehensive, ecological method. In standard MST, therapists promote behavior change by empowering parents/guardians and working with the ecosystem surrounding the young adult. Our modification focused on empowering young adults to be decision-makers when it came to changes in their lives. MST-EA still leverages family support to help the young person make changes whenever appropriate, but also leverages the broader social network of young adults. Like standard MST, MST-EA is an intensive, home-based treatment provided by a team of 3 or 4 therapists. Coaches are added to the MST-EA therapy team, and MST-EA works extensively with other providers in the community. The coach works on developing independent living, wellness, school, and work skills. The focus on independent living and work, key life domains for this age group, are another key distinction of MST-EA. Like MST, MST-EA employs empirically based clinical techniques from cognitive behavioral therapy (CBT) and other behavioral therapies. Motivational interviewing is also a fundamental technique. Finally, MST-EA treatment is longer than standard MST – averaging 7 months. (You can also see our articles published on MST-EA for more details.[1,2])

F.P.: *What are the goals of MST-EA?*

M.D.: There are a number of goals, but first and foremost is to reduce reoffending. MST-EA also targets the symptoms of mental illness. Although reducing mental health symptoms doesn't equate directly with reducing reoffending, it does promote involvement in pro-social relationships and activities (which reduces the risk of reoffending). The explicit focus on mental health distinguishes it from standard MST. When present, which is common, reducing substance use is always a goal. Another goal is for young people to be positively engaged in school, work, or both – and have secure housing and positive social relationships.

Regional Research Institute for Human Services, Portland State University.
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F.P.: *Thanks. I'd like to turn our attention to your research on MST-EA. I understand that MST-EA has gone through some feasibility testing. Could you tell me a little about it?*

M.D.: Sure – I should tell you that our feasibility study was an open trial with no control group and a small treatment group. However, our initial results were very encouraging! First, we found a significant decrease in re-arrests, as well as decreases in mental health symptoms and anti-social peer involvement that can result in reoffending behavior. While we did see positive changes in substance use and school and work engagement, these were not statistically significant. All in all, our findings were promising enough for us to be awarded two grants for studies with randomized control that will measure the effectiveness of MST-EA.

F.P.: *That's great! Before we focus on future research, could you tell me about any challenges you faced implementing MST-EA?*

Ashli Sheidow: It's important to recognize that this population finds themselves in a perfect storm. Where they have the highest needs, supports seem to be slipping away as they age out of one system and into another. These young people are also most likely to drop out of therapy because they've already had experiences with therapy that didn't work. Because of all this, MST-EA therapists need to develop strong motivational interviewing skills and creativity when engaging young people.

Another complexity actually arises from a strength of MST and, thus, MST-EA. On a positive note, both are highly individualized interventions, so community and cultural contexts are leveraged as strengths to support a young person's recovery. (MST-EA is based on MST, which shows promise of being efficacious across cultures.[3]) However, being individualized means understanding that no two young adults have the same set of circumstances. An MST-EA therapist needs to be very flexible because each case can present complex challenges unique to an individual's situation.

Lastly, the elephant in the room: paying for the treatment. In our initial work, we were lucky to find champions in the child welfare system who saw that this program could reduce long-term personal and system costs. Many thanks are owed to Anne McIntyre-Lahner, Sara Lourie, and Tere Foley, with the Connecticut Department of Children and Families. This is an expensive program, but it aims to reduce even more expensive outcomes like incarceration, medical and psychiatric emergencies, homelessness and unemployment, suicides and homicides.

F.P.: *Could you please tell us about your future directions with this research?*

M.D.: Currently, we are working on two funded studies. Our NIMH grant will allow us to replicate our prior study with a control group. The control group will get a masters-level facilitator who can provide appropriate referrals, talk to young people about available services, and provide travel vouchers to get to services. This 4-year study will involve 240 participants, with 120 of those being treated by MST-EA teams. Our NIDA grant will test MST-EA's effectiveness in individuals who have substance abuse disorders. Both grants will include individuals with co-occurring mental health and substance use disorders, and both aim to find out what factors are making the treatment actually work. We want to know if our positive behavioral health model will help with mental health conditions, substance abuse disorders, or both. Both studies are effectiveness trials that will be delivered in communities by community providers – so they will be a real world test of MST-EA. We hope to have preliminary results available in the next couple of years.

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For a blog posting describing an MST-EA case study, please visit http://info.mstservices.com/blog/population-at-risk-young-people-aging-out-of-juvenile-justice-system; for an in-depth discussion of MST-EA, please visit Pathways' 2017 webinar archive at: https://www.pathwaysrtc.pdx.edu/webinars-2017.

INTERVIEWEES

Maryann Davis is Research Associate Professor of Psychiatry, Director of the Systems & Psychosocial Advances Research Center, and Director of the Learning and Working during the Transition to Adulthood Rehabilitation Research and Training Center, University of Massachusetts.

Ashli J. Sheidow is a senior research scientist with the Oregon Social Learning Center. With her colleague, Dr. Michael McCart, she has developed MST-EA and studies treatments for mental health and substance abuse problems in adolescents and emerging adults, particularly those who have co-occurring problems.

The Impact of Mental Health Problems and Antisocial Behavior on Education and Employment

Workforce participation is generally recognized as an indicator of a successful transition into adulthood for adolescents and is a marker of positive well-being and good health throughout the life course. Working steadily, with increasing income, is a marker that someone is "doing well." Educational experiences and the skills developed in these experiences provide the foundation for, and substantially contribute to, workforce success in terms of both economic gains and status. Employment and education work together to fuel positive development.

We do know some things about how these patterns of educational attainment and employment usually unfold in adolescents and young adults. However, the overwhelming proportion of this research is done with high school / college samples; much less is known about these experiences in the lives of disadvantaged youth. Yet these are exactly the youth for whom these positive experiences may mean the most for launching productive adulthoods.

There are two groups for whom these experiences might be particularly salient for their positive development – adolescents with mental health problems and those with juvenile justice involvement. For adolescents with mental health problems, successful employment experiences can provide the stability and resources needed to address the challenges of "fitting in" as a well-regarded young adult. For those adolescents with justice system involvement, increased training and stable employment can provide the path out of a criminal lifestyle.[1]

The challenge of promoting these positive outcomes seems even more daunting, and the potential impact even greater, for those adolescents confronted by both mental health issues and criminal involvement. Understanding and addressing the needs of these adolescents at "double jeopardy" is a critical challenge for both juvenile justice and mental health professionals.[2] We have been conducting preliminary data analyses recently on the patterns of education and employment in serious adolescent offenders with and without mental health disorders in an effort to address this gap in our understanding.

THE PATHWAYS TO DESISTANCE STUDY

Looking at the factors related to these outcomes in these high-risk youth is part of our ongoing analyses of data from the Pathways to Desistance study (see http://www.pathwaysstudy.pitt.edu). We used a comprehensive longitudinal design to follow a sample of serious adolescent offenders (N = 1,354) from adolescence into early adulthood. We know that a large proportion

of serious adolescent offenders decrease their criminal involvement as they enter adulthood, but we know little about the factors that promote this widely-observed pattern. This study, therefore, set out to examine the effects of changes in developmental capacities (e.g., impulsivity), social contextual factors (e.g., living arrangements), and intervention-related experiences (e.g., being placed in an institution) on future criminal offending, with the goal of informing justice-related interventions to promote positive outcomes.

The adolescents followed in the study were at least 14 years old and less than 18 years old at the time they were found guilty in court of committing a serious offense (almost exclusively felonies). Half of the sample was from Phoenix, AZ and half was from Philadelphia, PA; 84% were males; and the sample was ethnically diverse. The adolescents were, on average, 16 years old at the beginning of the study. A large proportion of the sample (93%) was included in our analyses of education and employment outcomes.

The youth participated in a baseline interview and a series of ten follow-up interviews (at six-month intervals for the first three years and yearly thereafter through seven years). These interviews were very comprehensive, using a variety of established measures, including the Composite International Diagnostic Interview[3] to assess the presence of major depression; dysthymia; mania; drug or alcohol abuse and dependence; and post-traumatic stress disorder (PTSD) in the year prior to the baseline interview. Also, a portion of the follow-up interview used a life calendar approach[4] to capture the nature, number, and timing of important changes in the life circumstances of these youth (including periods of employment and academic success).

Getting an accurate reflection of changes in employment and education over this follow-up period required a few important data manipulations. First, we asked the adolescents about formal ("legal work") and informal ("under-the-table") employment situations and converted information about number of jobs, hours worked, wages earned, and job interruptions into a monthly amount of money earned. Second, we recognized that school attendance would be expected to decrease over the time period of the study, and employment would be expected to increase, possibly dependent on different factors in the youth's life. Thus, a focus on either school attendance or employment alone does not sufficiently reflect positive adjustment.[5] So, we consolidated school attendance and employment information into a single construct ("gainful activity") intended to indicate the youth's involvement in age-appropriate social roles over the recall period. Finally, we also recognized that both education and employment participation are affected when youth are removed from the community as part of legal sanctions (i.e., sent to an institution). To account for this, the time spent in out-of-community placement was controlled for at each assessment wave.

TWO FINDINGS

We are still running analyses of the data to determine how education and employment experiences differ in juvenile offenders with and without mental health problems and the factors related to marked increases in earning power or stability of employment. So far, though, we have seen several consistent patterns in the data in our preliminary analyses.

1. The overall histories of employment and education appear the same in the adolescent offenders with and without mental health diagnoses.

Evidence from prior studies indicates that adolescent offenders are not a homogenous group doomed to uniformly poor education and employment outcomes. Thus, one of our initial goals was to examine variation in patterns of education and employment for youth over the 7 years of follow-up, and to see if these patterns looked different for the adolescents with mental health problems. We used a statistical technique called trajectory analysis to find distinct groups of individuals who follow the same pattern of change over the whole follow-up period on a particular outcome of interest.

We analyzed the group with a mental health diagnosis and the group without a mental health diagnosis separately on the outcome of "gainful activity" (i.e., how much they either went to school if they were supposed to be in school, or worked if they were out of school) to see how many distinct trajectories might emerge and what the shapes of these trajectories might be in each group. We found that each group (i.e., those with a

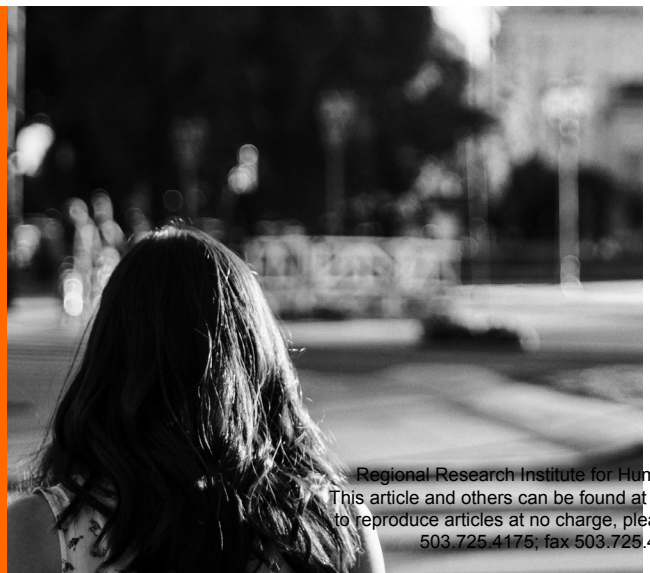
mental health diagnosis and those without a diagnosis) produced essentially identical solutions. Each one had four distinct patterns with about the same proportions of the group in each one: one staying rather consistently high in gainful activity, one dropping off dramatically, one increasing slightly, and one staying consistently low.

To us, this indicates juvenile offenders with and without mental health disorders do not look very different as their educational and employment histories unfold. Having a diagnosable mental health problem might not be a very determinative factor in how these patterns of adjustment emerge. Factors other than mental health status may be more important in determining which juvenile offenders have the highest chances for success or frustration in education and employment.

2. *Getting a high school diploma or technical certification does make a difference in earning power, whether you have a mental health disorder or not.*

There were differences among those juvenile offenders with a mental health disorder and those without a disorder in their overall level of educational attainment. The juvenile offenders with a mental health disorder were more likely to obtain a GED rather than a high school diploma or technical certification. Further analyses then indicated that obtaining the high school diploma or technical certification was related to higher earnings in the periods after the attainment of the diploma or certification, even when controlling for a large number of background characteristics related to whether an adolescent was likely to achieve the diploma or certification. In addition, the benefit of having the diploma or certification had an equivalent positive effect in the group with a mental health disorder and in the group without one. Getting a GED did not increase the earning power of either group. In short, the adolescent offenders with mental health disorders were less likely to get a diploma or certification (more likely to get a GED), and not having the diploma and certification appears to hold them back in their earning power. The lesson here seems to be that promoting educational degree attainment in adolescent offenders with mental health problems is likely to pay off for them in the long run, but they currently are not getting this advantage.

These two findings just reflect our initial analyses of how having a mental health disorder might or might not affect the adjustment of juvenile offenders in the community during early adulthood. So far, it does not appear that sorting juvenile offenders by the presence or absence of a diagnosable disorder has much predictive value. How the presence of a disorder interacts with opportunities or risk factors over time might be much more important. We are currently examining how shifts in mental health symptoms and involvement in treatment are related to employment patterns and earnings. We think that this more dynamic picture of the effects of a mental health problem will be more informative for practice and policy for this group of high-risk adolescents.



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