

Minnesota Juvenile Justice and Mental Health Initiative

Findings and Recommendations



Final Report

August 2008

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Executive Summary

Identifying and responding to the mental health needs of youth in contact with the juvenile justice system is recognized as a critical issue at the national, state, and local levels (Cocozza & Skowrya, 2000). Based on 2005 mental health screening data, it appears that approximately 70 percent of justice-involved youth in Minnesota have mental health disorders.

In 2007 the Minnesota Department of Corrections (DOC), in partnership with state and local agencies and organizations, established the Juvenile Justice & Mental Health Initiative to improve outcomes through systems change for youth in the justice system with mental health or co-occurring disorders. A 44-member interagency advisory task force, formed as part of the initiative, met throughout 2007 and 2008 to address issues impacting this group of youth and make recommendations for systems change.

The issues are myriad and complex. The task force used multiple approaches to conduct a statewide “strength and gaps” analysis including the use of the “Blueprint for Change” model to help frame the issues; the compilation of a “Data Book” of all national and local work already undertaken in this area; and focus group information collected throughout the state.

Four themes repeatedly emerged from the focus group data and from the review of the literature. These four themes became the first round of initiative issues to be tackled and generated a series of recommendations for change.

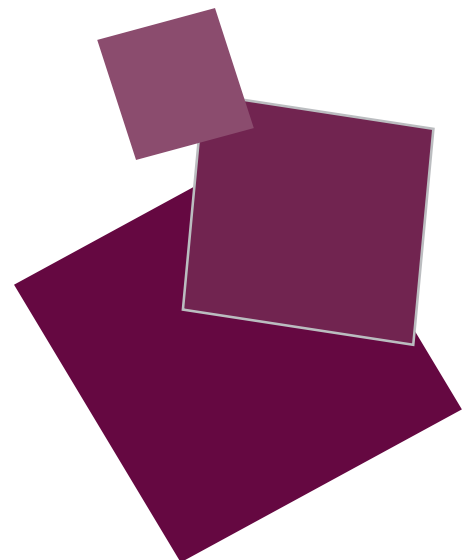
The need to collect data that better informs the process and to share data without jeopardizing the legal interests of youth as defendants

- Initiate a legal review of federal and state data privacy and data-sharing statutes related to juvenile justice and mental health – *existing statutes are not uniformly understood.*

- Clarify definitions for data collection related to the mental health screen and, if feasible, establish an electronic system for collecting the data in the Court Services Tracking System (CSTS) throughout the state – *reporting is not uniform.*
- Add existing data collection requirements that will provide aggregate outcome data – *outcomes are not currently tracked.*
- Address system-wide disparity issues by assembling and publicizing existing data related to disproportionality in each of the systems – *currently such information is not shared.*

The need for post-screening coordination

- Develop a model for post-screening coordination that includes a series of best practice elements – *post-screening procedures are inconsistent across the state.*
- Provide statewide comprehensive training on mental health and juvenile justice to professionals involved in the juvenile justice system, children’s mental health, social services, and school personnel including School Resource Officers – *ongoing training is needed to promote interagency collaboration.*



- Provide web-based education and training materials for use with youth, parents, and community-based and government agencies – *materials that have been developed are not shared across the state.*

The need to better engage families and caregivers as partners

- Develop a System Navigator function within counties or regions to provide parents with information and assistance concerning the screening process, assisting parents in linking their child to services and to track outcomes that ensure youth are being screened and receiving appropriate follow-up services – *better communication with parents is needed.*
- Require juvenile probation officers to receive training in mental health and family engagement strategies as a part of their annual mandatory training hours.
- Provide an advantage in the hiring process to applicants for juvenile probation positions by adding experience and training in mental health and family skill-building as “desirable job qualifications.”

The need for evidence-based, community-based mental health interventions that are effective with justice-involved youth

- Collect sufficient data to inform this effort – *outcomes are not shared statewide when evidence-based interventions have been implemented.*
- Apply for grant funding to pilot the use of evidence-based interventions – *start-up costs are often expensive.*
- Assess the potential for redeploying existing resources through a financial mapping process that identifies the federal and state public funds expended on a yearly basis to fund juvenile justice, mental health, child welfare and special education services.
- Work with the Office of the Legislative Auditor to implement cost-benefit studies.

Introduction

Identifying and responding to the mental health needs of youth in contact with the juvenile justice system is recognized as a critical issue at the national, state, and local levels (Cocozza & Skowrya, 2000). These youth cycle in and out of state and local juvenile justice systems. They are seen in probation offices, detention centers, courts, and correctional facilities.

Often, a youth's disruptive or inappropriate behavior is the result of a symptom of a mental health disorder that has gone undetected and untreated. Based on mental health screening data and several well-constructed studies, we now know that up to 70 percent suffer from mental health disorders, many with multiple and severe disorders including co-occurring disorders of substance use and mental health. More than half (55.6%) of youth met criteria for at least two diagnoses. About 27 percent experience disorders so severe that their ability to function is significantly impaired (Cocozza, 2007).

For some youth, contact with the juvenile justice system is often the first and only chance to get help. For others, it is the last resort after being bounced from one system to another. Both locally and nationally, correctional systems are becoming default mental health providers (State Mental Health Commissions in 2002).

In February of 2002, the Minnesota Department of Human Services (DHS) convened a task force to create "a blueprint to repair and rebuild the Minnesota children's mental health system of care" (Blueprint for a Children's Mental Health System of Care, 2002). One recommendation from the Blueprint task force was to create and/or expand targeted venues for mental health screening and to establish regular screening schedules in juvenile corrections.

In 2003, the Minnesota Legislature required that mental health screening be conducted for child

welfare and juvenile justice populations, effective July 1, 2004. The legislation amended the Minnesota Comprehensive Children's Mental Health Act and the Minnesota Juvenile Code. The legislation: targeted justice-involved youth between 10 and 18 who either had an initial detention hearing, who were found to be delinquent, or who are third or subsequent petty offenders; provided for uniform screening tools and procedures; distributed allocations to counties based on the number of completed screens to be used for follow-up assessment when appropriate; and required that data be tracked and submitted twice annually to the DHS (Appendix A: Governing Statutes). Based on 2005 mental health screening data, about 70 percent of Minnesota's juveniles who were screened were either referred for a diagnostic assessment, were already under the care of a mental health professional, or were already screened and received a diagnostic assessment within the past 180 days (Minnesota DHS, 2005).

The Minnesota Juvenile Justice and Mental Health Initiative

In 2007, under the leadership of Commissioner Joan Fabian, the Minnesota Department of Corrections (DOC), in partnership with the commissioners of DHS, Education, Health, Public Safety, and the State Court Administrator, established the Juvenile Justice & Mental Health Initiative to improve outcomes through systems change for youth in the justice system with mental health or co-occurring disorders. A 44-member interagency advisory task force was formed as part of the initiative. Chaired by Dr. Chris Bray from the DOC and Dr. Glenace Edwall from the DHS, the task force consisted of state and local stakeholders who met throughout 2007 and 2008 to address issues impacting this group of youth and to make recommendations for systems change (Appendix B: Juvenile Justice & Mental Health Initiative Task Force Membership). This report is a summary of the task force's work.

The initiative goal

The initiative goal was to improve outcomes for justice-involved youth with mental health or co-occurring disorders. It is believed that earlier identification and treatment of mental health disorders will lead to lower recidivism.

The Process

The issues are myriad and complex. The task force used multiple approaches to conduct a statewide strength and gaps analysis.

First, the “Blueprint for Change” model was adopted to help frame the issues. The Blueprint is a comprehensive model for the identification and treatment of justice-involved youth researched by the National Center for Mental Health and Juvenile Justice (Skowrya & Coccozza, 2007). According to the research that led to the Blueprint for Change, four issues identify the most critical areas for improving the system. These issues, or cornerstones, include collaboration, identification, diversion, and treatment:

- Improved **collaboration** between the juvenile justice, mental health systems, and other youth-serving agencies;
- Immediate **identification** of justice-involved youth with mental health needs;
- **Diversion** into effective community-based mental health treatment when appropriate; and
- Access to **treatment** for justice-involved youth with mental health disorders that meets their needs.

Second, all previous work done on this topic at the national and local levels as well as all available Minnesota quantitative data was gathered together into a data book. Using this information, and the Blueprint, the task force identified strengths and gaps with possible recommendations for change.

Issues related to collaboration

- Data is needed to better inform the initiative on what is needed and where.
- Data-sharing and joint information systems among agencies are needed to improve communication and case planning when multiple agencies are involved.
- Agency missions are too narrowly defined and result in fragmented delivery of services.
- Lines of responsibility are unclear when several agencies are involved.
- Greater efforts are required to include family and caregivers as partners.
- Cross-training is needed so professionals (corrections, mental health, social services, schools) better understand each other’s systems.

Issues related to identification

- Improve the number of screenings for eligible youth at the county level.
- Ensure that youth receive diagnostic assessments when indicated by the screen.
- Mental health screening and assessment should be performed, in conjunction with risk assessments, to inform referral recommendations that balance public safety with a youth’s need for mental health services.
- Integrate substance abuse assessments with diagnostic assessments.
- Perform screening and assessments routinely as youth move through the juvenile justice system.
- Use individualized case plans to address mental health or co-occurring services.

Issues related to diversion

- Divert youth to evidenced-based, community-based treatment when appropriate.
- Develop written guidelines and provide ongoing training for school resource officers to slow the pipeline from schools to the juvenile justice system when appropriate.
- Incorporate mental health services into correctional facilities.
- More prevention and early intervention services are needed to divert youth with mental health disorders from the justice system.

Issues related to treatment

- Fully involve family as partners.
- Increase access to evidenced-based, community-based mental health services.
- Increase the level of shared responsibility between juvenile justice and mental health systems.
- Improve on the scarcity of mental health professionals who are qualified and experienced to work with justice-involved youth with mental health disorders.
- Increase the prevalence of gender-based, culturally-sensitive mental health services for adolescents.
- Provide consistent, statewide, discharge-planning services when youth are released from placement

From this comprehensive list of issues, the task force narrowed and prioritized recommendations based on focus group data collected throughout the state. Twenty-seven multi-disciplinary team focus groups that included over 220 individuals were convened in:

- 22 counties
- 2 Indian reservations
- 3 organizations

In addition, a survey was sent to all Special Education Directors throughout the state

At a minimum, each focus group consisted of representatives of local corrections, mental health, social services, and school professionals. Often, focus groups included judges, prosecutors, public defenders, and parent advocates (Appendix C: Focus Group Locations).

The Task Force used the following criteria for selecting the first round of initiative recommendations to the corrections commissioner:

- The recommendations of the task force will positively impact outcomes for justice-involved youth with mental health or co-occurring disorders.
- The recommendations require a change in the system response.
- It is realistic to think the recommended changes can be implemented.
- Specific recommendations along with strategies for implementation for this first round can be ready by the summer of 2008.
- The work of the initiative enhances but does not duplicate the work of others.
- The results of the initiative's work can be measured.
- Initiative recommendations will contribute to the reduction of over-representation and disparities in the system.

First-Round Initiative Issues to be Tackled

Four themes repeatedly emerged from the focus group data and from the review of the literature. These four themes became the first round of initiative issues to be tackled.

The need to collect data that better informs the process and to share data without jeopardizing the legal interests of youth as defendants

Several data collection and data-sharing issues emerged based on quantitative state-level data and focus group data:

- The need for a comprehensive review of relevant federal and state data privacy statutes;
- The need to collect outcome-related data that sheds light on the extent to which screening and post-screening coordination occurs; and
- The need to better understand the extent of disproportionality throughout each of the systems.

The current statutes that govern the use of mental health screening in the juvenile justice system restrict the collection of individual-level mental health screen data. This limitation is designed to protect the rights of youth as defendants. Clarification is needed to help practitioners and policy-makers better understand the type and level of information that can be shared, when information can be shared, and with whom information can be shared.

When a mental health screen reaches a certain threshold, diagnostic assessments (DAs) are needed to further identify the extent of the mental health disorder and the need for appropriate treatment services. Currently, counties are reimbursed for completing screens so that they have funds for DAs when insurance reimbursement is not available. Counties are currently required to report information, but the information is limited and the data elements collected are not clearly defined. Further

aggregate outcome data is needed to shed light on the extent to which eligible youth are screened, the extent to which screening information leads to DAs, and the extent to which DAs drive treatment plans.

As the task force reviewed available state-level data, it appeared that disproportionate minority contact exists in several systems. For example, the Department of Public Safety collects data that shows the degree of disproportionate minority contact within the juvenile justice system. This data makes clear that, as minority youth move through the justice system, their prevalence increases disproportionate to their prevalence in the general population. In particular, African American and American Indian youth are over-represented:

- At arrest,
- At the point of petition,
- At adjudication,
- When placed in confinement, and
- When certified as adults.

The reasons for disproportionality are not clearly identified. What is clearly identified is that disproportionality exists within several systems.

The need for post-screening coordination

Minnesota mental health screening data from 2005 indicate that most counties are complying with screening requirements to a greater or lesser degree. Focus group data revealed that the events that occur once the screen is completed vary widely from county to county. Some counties have excellent policies and procedures in place to ensure appropriate follow-up to the screen. Other counties do very little once the screen is completed. Most counties fall somewhere in between so that practice throughout the state is inconsistent. According to focus group data, there are a variety of reasons for this inconsistency:

- Preconceived notions by juvenile justice professionals that discount the need for mental health screening and evaluation with justice-involved youth;

- Differing priorities;
- Inadequate funding for follow-up services; and
- Lack of appropriate treatment resources including a need for more mental health practitioners skilled in working with adolescents.
- System professionals who define their job narrowly to exclude working with parents and caregivers; and
- A shortage of parent liaison and parent advocate positions.

The need to better engage families and caregivers as partners

“Family involvement is a cornerstone for the children’s mental health system of care,” (DHS, 2002). The juvenile justice system, on the other hand, is very youth-focused in that adolescents, not families, are the subject of most court orders. In 2004, PACER Center commissioned a Family Needs Research Project. The goal of the project was to better understand what parents and families need from the mental health system. Parents expressed concerns in three areas: the need for easier access and for information; the need for trained, culturally-competent service providers; and the need to simplify funding and clarify responsibility of insurers and providers.

Focus group data was unequivocal. Every professional from every discipline, including parents and parent advocates, acknowledged the need to better engage parents and caregivers as partners when planning for and providing services to youth in the justice system with mental health or co-occurring disorders. Professionals identified that, without family engagement, many of their efforts with justice-involved youth were destined for failure – if not in the short-term, then at least in the long term. Barriers identified in the focus groups included:

- Parental mistrust of system professionals;
- A lack of culturally-competent system professionals able to engage families;
- System professionals who are not trained to engage families;

The need for evidence-based, community-based mental health interventions that are effective with justice-involved youth

One common theme that emerged from focus groups in many counties was, “Once we’ve identified the problems, we don’t always have the resources to deal with the problems that we’ve identified.” Included in this discussion was the lack of access to: evidence-based, community-based therapeutic interventions such as Multi Systemic Therapy (MST) and Functional Family Therapy (FFT); adequate in-home resources; case management services; and transportation. Also included in the discussion was the scarcity of knowledgeable diagnosticians and clinicians within the service area and the reduction in collaborative services, a result of reduced collaborative funding.

While pockets of promising and evidence-based, community-based services exist in a small number of counties, they are not available on a statewide basis, raising the issue of equal justice and opportunities for treatment that are not widespread. MST and FFT are two examples of strength and family-based interventions that have been shown to reduce recidivism if implemented with fidelity. These types of programs have proven to be expensive to implement but are cost-effective in the long run. As an example, Washington State was able to implement FFT on a statewide basis by providing data to their legislature showing the relationship between the reduction of recidivism in their juvenile justice population and the reduction of prison expansion (Aos, Miller & Drake, 2006). The Washington State Institute of Public Policy has done ground-breaking work, not only in demonstrating the impact between juvenile offenders and prison

but also in demonstrating the cost-benefit ratio of programs like MST and FFT. Though evidence-based interventions are available in several Minnesota counties and some of these counties are collecting outcome data, statewide implementation and statewide data do not exist to demonstrate similar cost-benefit relationships nor does Minnesota have a research arm similar to the Institute of Public Policy with expertise in conducting cost-benefit studies.

Summary of Task Force Recommendations

The following is a summary of the task force’s proposed strategies for addressing the themes that emerged from the focus groups and for prioritizing the myriad of issues facing justice-involved youth with mental health or co-occurring disorders and their families. The recommendations reflect this first round of work needed to be done immediately and within the constraints of current budgets. In order to provide a comprehensive strategy for addressing all issues related to justice-involved youth with mental health or co-occurring disorders, more data is needed (Appendix D: A Comprehensive List of Recommendations Considered by the Initiative).

Data collection

- Initiate a legal review of federal and state data privacy and data-sharing statutes related to juvenile justice, mental health, and child welfare – *existing statutes are not uniformly understood.*
- Clarify definitions for data collection related to the mental health screen and, if feasible, establish an electronic system for collecting the data in CSTS throughout the state – *reporting is not uniform.*
- Add existing data collection requirements that will provide aggregate outcome data – *outcomes are not currently tracked.*

- Address system-wide disparity issues by assembling and publicizing existing data related to disproportionality in each of the systems – *such information is currently not shared.*

Post-screening coordination

- Develop a model for post-screening coordination that includes the following components (Appendices E: Model Post-Screening Protocol for Youth Entering Detention and F: Model Post-Screening Protocol for Youth Found to be Delinquent):
 - A template court order at the Finding of Delinquency hearing that orders the screen and diagnostic assessment if the youth meets the threshold on the screen. This language prevails unless the judge checks a box allowing the youth to opt out of the screening and a follow-up DA if needed.
 - A System Navigator function that is responsible for:
 - 1) providing parents with information concerning the screening process;
 - 2) providing parents and youth with the results of the screen and information on accessing a DA when their child meets the threshold;
 - 3) assisting parents to link their child to services;
 - 4) assisting parents to navigate county and community-based agencies; and
 - 5) tracking outcomes.
 - An integrated system of mental health screening and assessment performed in conjunction with a “risk to re-offend” assessment to inform referral recommendations that balance public safety with the youth’s need for mental health services.
 - A multi-disciplinary team that develops a case plan and identifies existing funding streams for services.

- A predisposition report and disposition hearing for those families who will not voluntarily follow through to get needed mental health services.
- Methods for tracking to ensure that youth are screened and assessed when appropriate.
- Provide statewide comprehensive training on mental health and juvenile justice to professionals involved in the juvenile justice system, children’s mental health, social services, and school personnel including School Resource Officers.
- Provide web-based education and training materials for use with youth, parents, and community-based and government agencies.

Engaging parents as partners

- As a critical element of post-screening coordination, develop a System Navigator function that is responsible for:
 - providing parents with information concerning the screening process;
 - providing parents and youth with the results of the screen and information on accessing a diagnostic assessment when their child meets the threshold;
 - assisting parents to link their child to services;
 - assisting parents to navigate county and community-based agencies; and
 - tracking outcomes to ensure youth are being screened and receiving appropriate follow-up services.
- Require juvenile probation officers to receive training in mental health and family engagement strategies as a part of their annual mandatory training hours.

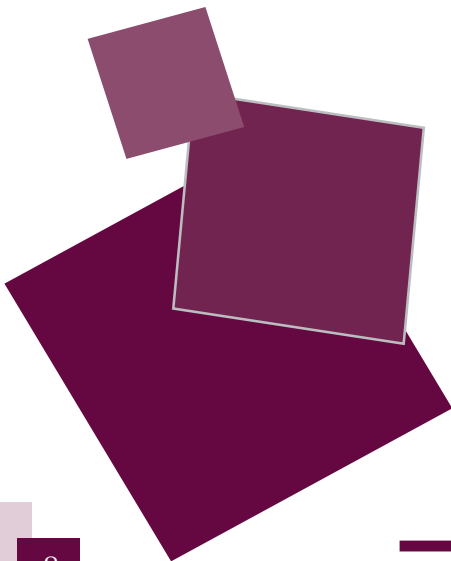
- Provide an advantage in the hiring process to applicants for juvenile probation positions by adding experience and training in mental health and family skill-building as “desirable job qualifications.”

Evidence-based, community-based interventions

The initiative is committed to increasing the availability of evidence-based, community-based interventions that are proven to reduce recidivism among justice-involved youth with mental health disorders.

- Collect outcome data from those counties and regions where evidence-based interventions are being used and when data is available.
- Use grant funding to pilot the use of best practices for post-screening coordination and to develop evidence-based interventions. For example, the Initiative applied for a Bureau of Justice Corrections and Mental Health Collaboration Project grant to pilot the model for post-screening coordination and to fund evidence-based, community-based mental health services for justice-involved youth in Becker, Mahanomen, and Clearwater Counties and the White Earth Indian Reservation.
- As an outgrowth of the focus groups conducted on the White Earth and Leech Lake Indian Reservations, the initiative provided a grant writer to the White Earth Reservation so they could apply for a federal Substance Abuse and Mental Health Services Administration grant (SAMHSA) to assess and program for fetal alcohol spectrum disorders. The application was successful.
- Assess the potential for redeploying existing resources through a financial-mapping process that identifies the federal and state public funds expended on a yearly basis to fund juvenile

justice, mental health, child welfare and special education services. Participation could include state agencies such as the DOC, DHS (including Children’s Mental Health, Child Permanency and Planning and Chemical Health), Public Safety (Office of Justice Programs), Education, Housing, and Workforce Development. Financial mapping provides decision-makers with an x-ray of relevant funding streams for youth.



Appendix A: Governing Statutes

- Laws of 2003, 1st special session, chapter 14, article 4, sections 2, 14, 15, 16, 17, and 18
- Minnesota Statutes sections:
 - 245.4874 (14)
 - 260B.157, subdivision 1
 - 260B.176, subdivision 2
 - 260B.178, subdivision 1
 - 260B.193, subdivision 2
 - 260B.235, subdivision 6
- Minnesota Comprehensive Children’s Mental Health Act, sections 245.487 to 245.4888



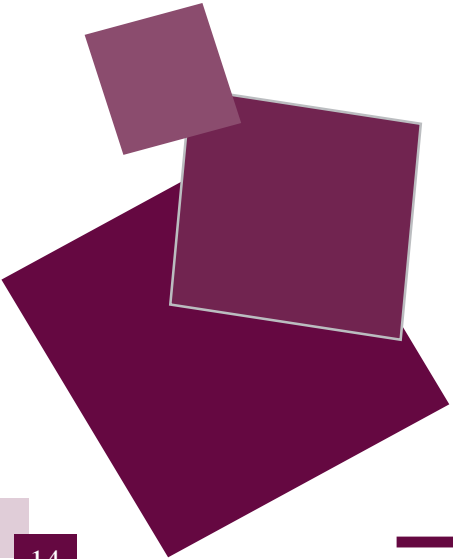
Appendix B: Juvenile Justice & Mental Health Initiative Task Force Membership

Minnesota (MN) Department of Corrections (DOC)	Chris Bray, Director, Juvenile Services Kyiunga Olson, Associate Warden, Minnesota Correctional Facility-Red Wing
MN Department of Human Services (DHS), Children's Mental Health Division	Glenace Edwall, Co-Chair and Director, Children's Mental Health Division Bill Wyss, Supervisor Kathy Jefferson, Coordinator, Northwest Region
MN Department of Human Services, Child Safety and Permanency Division	Erin Sullivan Sutton, Director Ed McBryer, Permanency Manager
MN Department of Human Services, Chemical Health Unit	Jeffrey Hunsberger, Acting Operations Manager
MN Department of Human Services, Chemical and Mental Health Administration	Don Eubanks, Director, Multicultural Affairs
MN Department of Education	Barbara Troolin, Director, Special Education Policy
MN Department of Health	John Hurley, Manager, MN Children with Special Needs
MN Department of Public Safety	Jeri Boisvert, Executive Director, Office of Justice Programs Dana Swayze, Management Analyst
State Courts	Gregg Johnson, Chief Judge, Second Judicial District Lawrence Panciera, Chief of Psychological Services, Fourth Judicial District
Association of Minnesota Counties	Toni Carter, Ramsey County Commissioner
MN Association of Community Corrections Act Counties	Therese McCoy, Director, Scott County Community Corrections
Ramsey County Human Services	Linda Hall, Manager, Mental Health and Status Offender Programs
MN Association of County Probation Officers	Steve King, Director, Mower County Court Services
MN Department of Corrections Field Services	Dayna Burmeister, Chaska District Supervisor
MN Association of County Social Services Administrators	Dave Rooney, Director, Dakota County Community Services
MN Council of Child-Caring Agencies	Mary Regan, Executive Director
MN Association of Community Mental Health Programs	Mark Kuppe, CEO, Human Services Inc.
MN Association for Children's Mental Health	Deb Saxhaug, Executive Director, OPTIONS Family & Behavior Services

Minnesota Family-Based Services Association	Janee Anez, Program Director, OPTIONS Family & Behavior Services
MN Association of Resource for Recovery and Chemical Health	Deb Wamsley, Program Director, Haven Chemical Health Systems
Public Defenders	Jodie Carlson, Assistant State Public Defender, Appellate Court
County Attorney's Association	Patty Moses, Managing Attorney Hennepin County Juvenile Prosecution Division
MN Corrections Association	Shelley McBride, Program Manager, Juvenile Corrections Dodge/Fillmore/Olmsted Community Corrections
Tribal Affairs - DOC	Joe Day, Indian Affairs Liaison
Tribal Affairs - DHS	Karen Smith, American Indian Mental Health Program Consultant
American Indian Mental Health Advisory Council	Jessica Gourneau, American Indian Family Center
MN Psychological Association	Willie Garrett, Former Chief Professional Officer
Hamline University	Mary K Boyd, Former Acting Director Admissions Graduate School of Education
University of Minnesota	Joel Hetler, Director, Center for Excellence in Children's Mental Health
Metropolitan State University	Robert O'Connor, Assistant Professor, Social Work Department
Healing Bonds	William Allen, Therapist
Wilder Southeast Asian Services	Tony Yang, Director
Centro Cultural Chicano	Mary Jo Avendano, Director of Mental Health Programs
Juvenile Justice Coalition of Minnesota	Curt Peterson, Director
Governor's Juvenile Justice & Children's Mental Health Subcommittee	Steven Allen, Committee Chair
National Alliance on Mental Illness-Minnesota Parent Advocate	Sue Abderholden, Executive Director Suzette Scheele, Parent Support Coordinator
Parent Advocacy Coalition for Educational Rights	Lili Garfinkel, Juvenile Justice Project Coordinator

Appendix C: Focus Group Locations

- Norman, Red Lake, Polk
- Ottertail
- Mahnomen/Becker
- White Earth
- 6 W (Yellow Medicine, Chippewa, La Qui Parle)
- Minnesota Council of Child-Caring Agencies Treatment Providers
- Washington County
- Juvenile Justice Advisory Committee
- Scott County
- Leech Lake Reservation
- Juvenile Justice Coalition
- Dakota County
- Olmsted County
- Anoka County
- Blue Earth County
- Ramsey County
- Stearns County
- Goodhue County
- Beltrami County
- Rice County
- Hearthstone
- Mower County
- Individual parent interviews



Appendix D: A Comprehensive List of Recommendations Considered by the Initiative

Earlier identification and intervention

The most common definition from focus groups across the state was, “It’s too late once youth get into the justice system. We need to intervene before they get there.” These are youth who are in the pipeline to the justice system because their behavior is disruptive and they have experienced some significant risk factors that will, without further intervention, inevitably result in placement in the justice system. Often mentioned in this category are youth served by collaboratives, youth who are truant from school, youth under age 10 who are being arrested, youth in federal setting IV education programs who exhibit disruptive behavior in school, and youth who are frequently referred to school police liaison officers for possible arrest.

Recommendation 1.1

Incorporate the early identification of at-risk youth as suggested by school disciplinary issues, truancy, learning difficulties. Once identified, provide integrated services involving parents, schools, social services, mental health, and community agencies.

Recommendation 1.2

Create a family engagement workgroup to identify strategies and implementation plans that engage families in their child’s mental health identification and treatment.

Recommendation 1.3

Encourage voluntary screening and/or evaluation of children of adult clients receiving services in the community mental health and substance abuse systems to promote early intervention and identification of treatment needs.

Recommendation 1.4

Encourage screening and/or evaluation of children of incarcerated adults with mental illnesses, along with the provision of prevention, early intervention, and primary care services as necessary.

Recommendation 1.5

Co-locate probation and mental health workers in targeted schools/school programs where justice-involved youth are referred.

Recommendation 1.6

Develop programs for youth under 10 who are at high-risk to enter the juvenile justice system because of multiple police contacts.

Recommendation 1.7

Increase funding and provide a permanent funding source for mental health and family collaboratives.

Recommendation 1.8

Develop and provide an ongoing, comprehensive training curriculum on crisis intervention and mental health to law enforcement, school personnel, juvenile justice personnel, and courts.

Recommendation 1.9

Examine diverted offenses and the correlation between diverted offenses and race.

Post-screening coordination

Post-screening coordination is a process to ensure that appropriate actions result from positive screens.

Recommendation 2.1

Examine legislation and existing policies to further develop a model mental health screening protocol. Once a protocol is developed, train and develop strategies for embedding the protocol at the local level.

Recommendation 2.2

Develop and promote the use of model post-mental health screening coordination for justice-involved youth that incorporates multi-disciplinary collabora-

tion and funding. The model could contain the following elements:

- Use a template court order that orders the screen and necessary follow-up assessments.
 - Develop screening and assessment procedures that target both mental health and substance abuse needs.
 - Combine risk to re-offend assessment scores with mental health screening information to create a model for structured decision-making.
 - Establish or use existing interagency/multi-disciplinary teams to plan for youth with screens or diagnostic assessments that require further action. For example, county interagency placement case planning teams meet per Minnesota Statutes section 260B. The role of these teams could be expanded to include case planning for mental health screens that require further action.
 - Inform judges by increasing the use of predisposition reports for youth with mental health or co-occurring disorders, particularly if their families are not willing or able to cooperate with voluntary services.
 - In each case, establish a lead agency with clear role definition for the other agencies. For example, screens that fall in warning and/or caution area might go to the social service agency for follow-up with parents and the mental health agency for follow-up assessments, while probation supervises the public safety aspect of the case.
 - Develop clear policies that address responses and interventions once youth are “screened in.” Pennsylvania, Texas, and New Jersey have model protocols in place to guide decision-making (Mental Health Screening within Juvenile Justice: The Next Frontier).
- Develop policies and MOUs for shared cases including: financial responsibility when services are required that are not covered by insurance, keeping cases open in social service agencies when child safety issues are identified, and a thorough review of aftercare plans before discharge from placement.

Recommendation 2.3

Link the results of the risk assessment with the results of a mental health screen and evaluation to help guide decisions about a youth’s suitability and need for service level and programs (Blueprint for Change).

Recommendation 2.4

Develop a model protocol or policies for shared cases. Once policies are developed, train and develop strategies for embedding the protocol at the local level.

Recommendation 2.5

Ensure that juvenile justice employees are appropriately educated and trained in mental health issues and co-occurring disorders:

- Advocate for or require additional agent/employee qualifications that include mental health training and family engagement experience/skills.
- Establish a model curriculum for ongoing education and training related to justice-involved youth with mental health or co-occurring disorders for corrections, mental health, and social service employees and for educating would-be professionals in institutions of higher education.

Recommendation 2.6

Expand the use of specialized corrections caseloads for youth on probation with mental health or co-occurring disorders. Train specialized probation officers as case managers to allow for more funding flexibility.

Recommendation 2.7

Create culturally-specific parent advocate/liaison positions to engage families of justice-involved youth with mental health or co-occurring disorders.

Access to services

One common theme expressed in many counties was, “Once we’ve identified the problems, we don’t always have the resources to deal with the problems that we’ve identified.” Included in this discussion was the lack of access to: evidence-based, community-based therapeutic interventions such as Multi Systemic Therapy and Functional Family Therapy; adequate in-home resources; case management services; and transportation. Also included in the discussion is the scarcity of knowledgeable diagnosticians and clinicians within the service area and the reduction in collaborative services.

Recommendation 3.1

Deploy mobile diagnostic teams throughout the state to provide on-site assessment and crisis intervention to incarcerated youth in correctional/detention facilities.

Recommendation 3.2

Assure that youth in detention and public correctional facilities who are eligible for Children’s Health Insurance or Children’s Medicaid receive health coverage immediately upon release so that they do not experience a delay in accessing community mental health care.

Recommendation 3.3

Link appropriate youth in detention centers to community-based mental health providers who will provide treatment to detained youth once they’ve been identified as needing a mental health intervention. This could be done through detention discharge planners or detention mental health case managers.

Recommendation 3.4

Begin working with families, utilizing funding for aftercare services, prior to release from juvenile detention facilities.

Recommendation 3.5

Shift funding to implement evidence-based, community-based interventions such as Multi-Systemic Therapy, Functional Family Therapy, Aggression Replacement Training, Multidimensional Therapeutic Foster Care, and Brief Strategic Family Therapy:

- Build capacity at the local level
- Strengthen community bonds
- Keep families involved
- Shift funding to proven community-based programs

Recommendation 3.6

Create wrap-around teams for youth at risk of out-of-placement and/or Seriously Emotionally Disturbed (SED) youth and for their families.

Recommendation 3.7

Provide strength-based, non-traditional interventions; i.e., restorative services in appropriate settings.

Recommendation 3.8

Develop, fund, and use appropriate alternatives to out-of-home placement including problem-solving courts (mental health courts, drug courts, co-occurring courts).

Recommendation 3.9

Develop formal relationships with psychiatric units so hospital beds and hospital interventions are available for youth at risk of going into detention or remaining in detention because of mental illness.

System management issues

Recommendation 4.1

Address system-wide disparity issues by assembling and publicizing existing data related to disproportionality in each of the systems.

Recommendation 4.2

Strengthen the ability to share mental health information between county agencies and schools.

Recommendation 4.3

Develop or locate a central database to track dual jurisdiction youth – youth who are or were in the social service system and the juvenile justice system.

Recommendation 4.4

Broaden mental health screening tracking requirements to include race, gender, and outcomes by changing legislation and/or creating interagency MOUs.

Recommendation 4.5

Train county employees to maximize the use of Community Alternatives for Disabled Individuals waivers (CADI) and Medical Assistance (MA) waivers for justice-involved youth with mental health or co-occurring disorders.

Recommendation 4.6

Develop state policies and procedures to suspend rather than terminate Medicaid benefits upon placement in public correctional facilities.

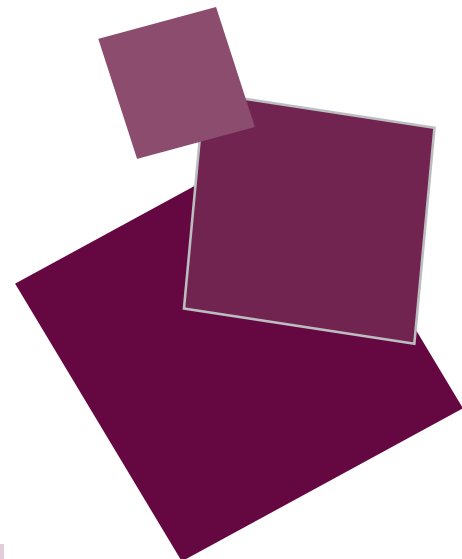
Recommendation 4.7

Create a Medicaid presumptive eligibility status for youth reentering the community.

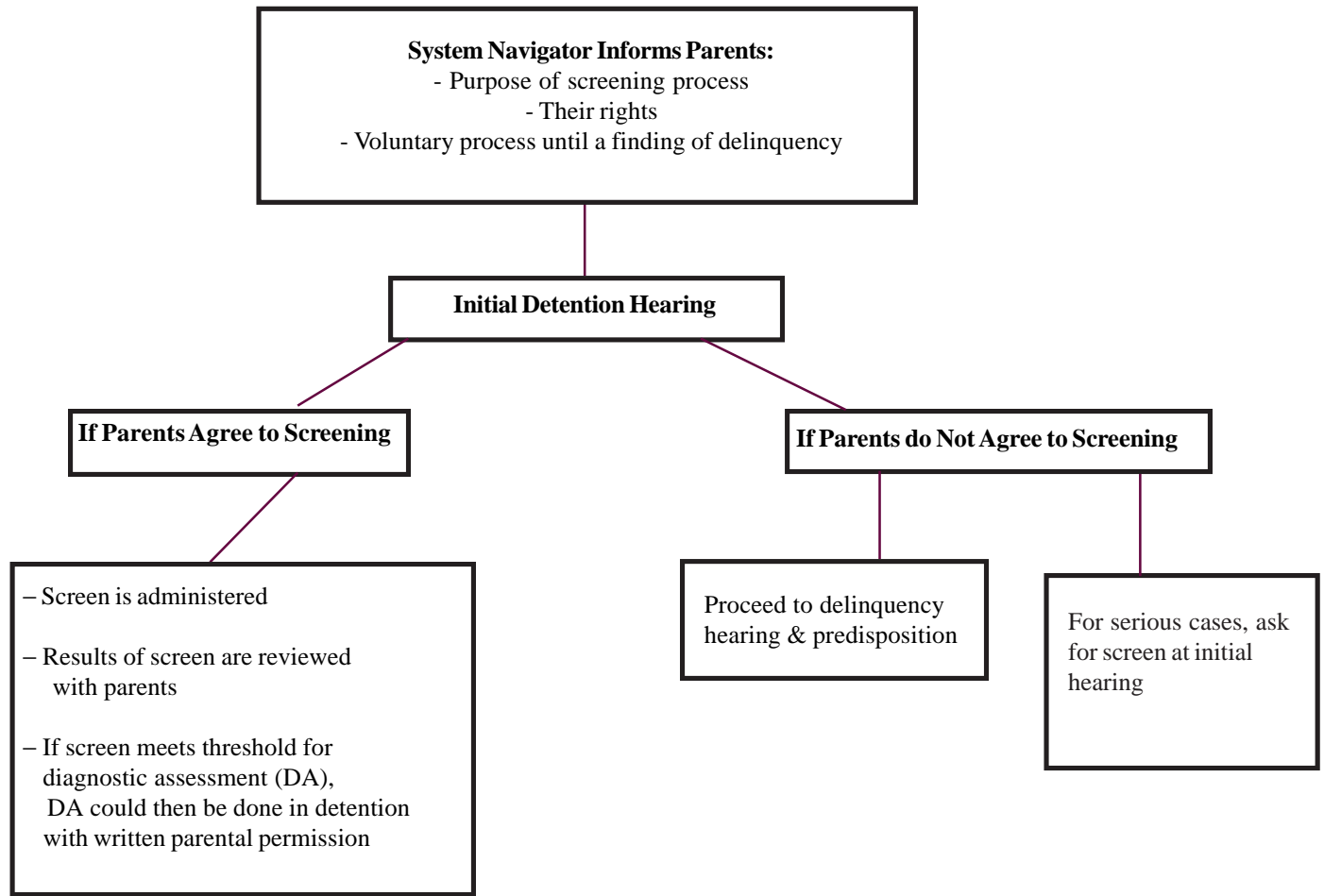
Recommendation 4.8

Investigate blending a variety of funding sources for the above recommendations including:

- Federal sources including Title IV-E, TANF, Medicaid Title XIX, and Medicaid Targeted Case Management
- Federal Funds from Department of Justice (OJJDP formula grants)
- JJDP reauthorization funds for screening, assessment, and treatment
- Department of Education Title I, Title I Part D, Special Education
- Early and Periodic Screening Diagnosis and Treatment (EPSDT)
- Foundation and private donors
- General revenue



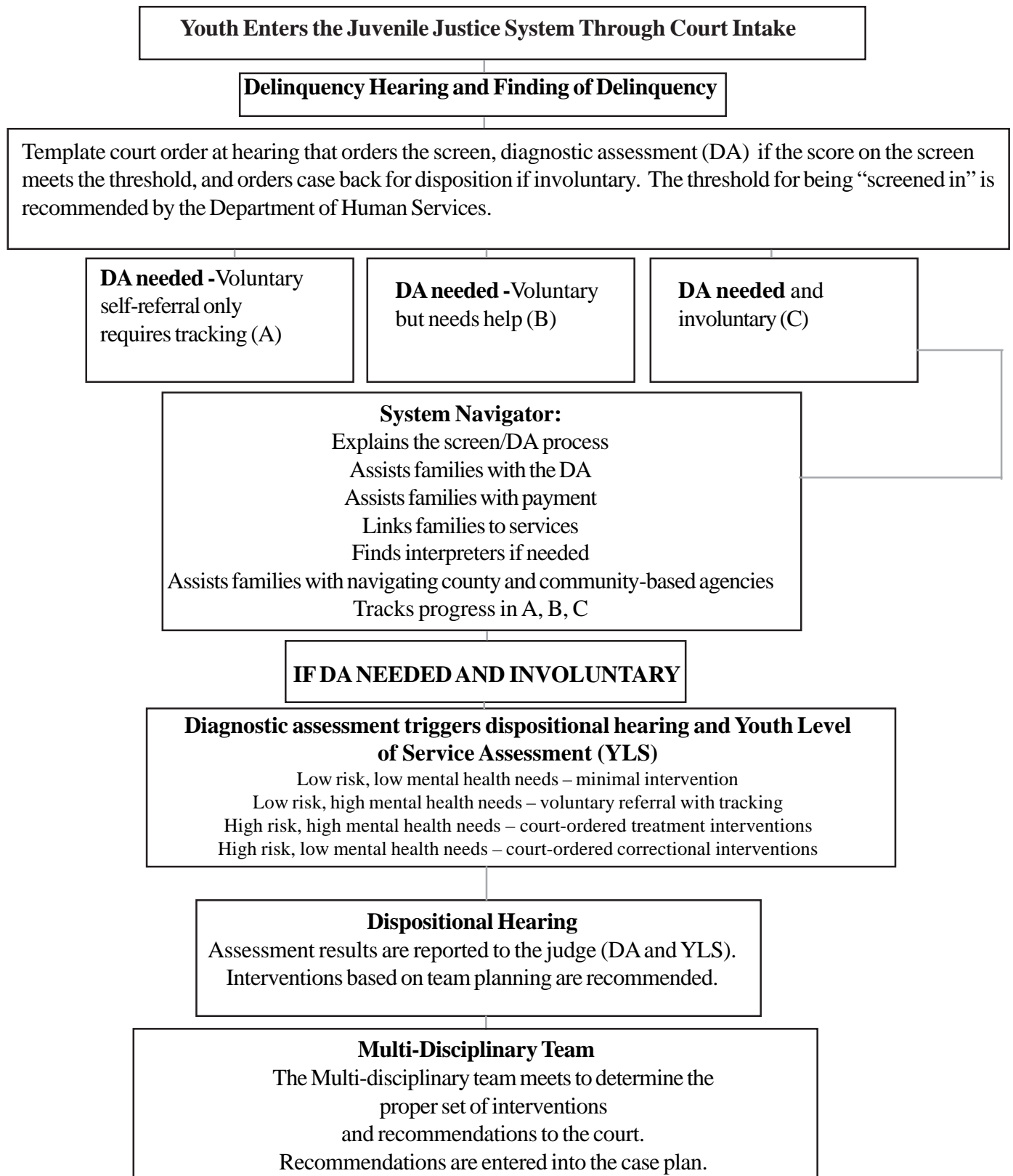
Appendix E: Model Post-Screening Protocol for Youth Entering Detention



If the parents refuse the DA, the results of the screen are not shared with or shown to the judge prior to a finding of delinquency unless the youth appears to be in serious distress. If that is the case, the judge can be asked to order the screen at the initial hearing. Once there is a finding of delinquency, broad statements can be made to the judge; i.e., “The mental health screen indicates a need for further diagnostic assessment.”



Appendix F: Model Post-Screening Protocol for Youth Found to be Delinquent





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