THINKING OUTSIDE THE CELL:
Alternatives to Incarceration for Youth with Mental Illness

Disability Rights Texas
National Center for Youth Law
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EXECUTIVE SUMMARY

Youth with mental illness can suffer devastating consequences from commitment to juvenile justice facilities, where specialized treatment and supports are often insufficient to meet their rehabilitative needs. Given the prevalence of youth with mental health needs in the Texas juvenile justice system, there is a pressing need for the state to develop appropriate and cost-effective alternatives to incarceration for this population. Texas has already started to shift its focus and funding in the right direction — toward community-based supports and services. During the 2009 legislative session, state leadership showed visionary support for community-based programming by reducing funding for the Texas Youth Commission (TYC) by $100 million and providing $45.7 million in new funding to juvenile probation departments for Commitment Reduction Programs intended to divert youth from TYC facilities. Many probation departments across the state used these funds to develop mental health resources, and preliminary data show an excellent return on investment.

THINKING OUTSIDE THE CELL: ALTERNATIVES TO INCARCERATION FOR YOUTH WITH MENTAL ILLNESS features three case studies of youth placed in the Corsicana Residential Treatment Center, the TYC facility designated for youth with serious mental illness or emotional disturbance. Their stories highlight the significant challenges youth with mental health needs face before and after commitment to TYC. They also demonstrate that access to appropriate and effective community-based mental health services is key to addressing the underlying sources of many youths' offenses, reducing recidivism, and preventing deeper penetration into the juvenile and criminal justice systems.

This report also features numerous effective community-based intervention strategies currently being implemented in Texas and other jurisdictions to reduce the incidence of youth with mental health needs in the juvenile justice system. As Texas continues to transform its juvenile justice system, such model programs will help ensure better outcomes for youth, families and communities. Finally, the report provides policy recommendations concerning youth with mental illness involved in the juvenile justice system. Specific recommendations include:

Maintain Community Mental Health Services for Children
The single most important policy decision that Texas can make to prevent contact or further involvement of youth with mental health needs in the juvenile justice system is to invest in community mental health services. Increasing access to services for youth not only provides an excellent return on investment in human terms, but it reduces reliance on more costly services in the long run.

Expand Commitment Reduction Program Funding and Expand the Use of Pre-Adjudication Diversion Programs for Youth with Mental Illness
Research and experience tell us that youth with mental health needs who are involved in the juvenile justice system achieve better outcomes when their specialized treatment needs are met with community-based services that keep them at home or closer to their families and support systems. Even during difficult fiscal times for the state, continued investment in diversion funding is imperative, as it will reduce future reliance on costly government-funded institutions, such as juvenile justice facilities, jails and prisons.

Close and Consolidate Texas Youth Commission Facilities and Reinvest the Savings in Community-Based Services

In light of the successful investments aimed at developing services to keep youthful offenders in their communities, the current capacity of TYC's secure facilities far exceeds the rate at which probation departments are committing youth to state custody. As Texas continues to reduce its reliance on secure placements and more youth are served at the county level, the state should close unnecessary secure facilities and redirect the savings realized to probation departments so they can invest in alternatives to secure confinement for all youth, including those with mental health needs.

Ensure Remaining Facilities Provide Appropriate Access to Services for Youth with Specialized Treatment Needs

Understanding that a small number of youth will still require placement in a secure facility, the remaining facilities must be equipped to appropriately serve those youth. Because the remaining youth will have very complex needs, any blueprint for facility closure must first consider where specialized treatment needs can be met, including location of the facility and corresponding access to mental health and other treatment professionals.

Incentivize Research-Based Rehabilitation Models

While local flexibility is important because the availability of community-based services for youth with mental health impairments varies widely across the state, legislators should incentivize the use of research-based programs, that is, programs that have been shown to produce positive outcomes for youth.

ABOUT THE AUTHORS

DISABILITY RIGHTS TEXAS

Disability Rights Texas is the federally mandated protection and advocacy agency for people with disabilities in Texas. The agency provides direct representation to youth with disabilities in Texas Youth Commission secure facilities and halfway houses around the state and engages in systemic and policy advocacy on juvenile justice issues.

NATIONAL CENTER FOR YOUTH LAW

Founded in 1970, the National Center for Youth Law (NCYL) is a national, nonprofit legal center that uses the law to improve the lives of low-income children. NCYL works to ensure that low-income children have the resources, support and opportunities they need for healthy and productive lives. NCYL focuses its work in three areas: safety and well-being of abused and neglected children; access to quality health and mental health care; and juvenile justice reform.

TEXAS APPLESEED

Texas Appleseed is a nonprofit public interest law center that works for greater justice by using the volunteer skills of lawyers and other professionals to find practical solutions to broad-based problems facing the most vulnerable, including at-risk youth.

I. INTRODUCTION

Every day in Texas, hundreds of young people with mental illness languish in juvenile justice facilities in remote parts of the state, warehoused far away from family, community supports and the treatment and services they need to turn their lives around. Their plight illustrates what happens at the back end of a systemic failure to respond to an overwhelming need for increased access to mental health services. Among the nation's children, the prevalence of mental illness and emotional disturbance in children is alarmingly high, with as many as 22 percent of all youth under the age of 18 in need of mental health services.[1] Texas ranks 49th in the nation on per capita spending for mental health care,[2] and only 18 percent of Texas children eligible to receive public mental health services actually receive them.[3]

Children with mental health problems, especially when left untreated, come into contact with the juvenile justice system at disproportionately high rates. Currently, 33 percent of youth who are referred to the Texas Juvenile Probation Commission have a diagnosed mental illness, and the percentage of youth identified as needing mental health treatment in the Texas Youth Commission (TYC) is considerably higher, at 60 percent.[4] Unless more communities pursue model mental health strategies, like the Texas and national models featured in this report, the statistics on the prevalence of mental illness in the state's juvenile justice system will remain discouraging.

This report also highlights three case studies of youth with significant mental health needs who previously resided or currently reside in TYC's Corsicana Residential Treatment Center. Their experiences suggest that mental health issues frequently predate or even lead to youths' commitments to secure detention. In some cases, the juvenile justice system may have been the first to attempt to serve their needs; in others, their problems persisted in spite of attempted, but still inadequate, interventions by their families, schools, mental health systems, child welfare agencies and other child-serving institutions.

Whatever their pathway into the juvenile justice system, youth with mental illness may suffer devastating consequences from commitments to juvenile justice facilities.[5] Removing them from their homes and communities and relocating them to a remote facility where specialized treatment and supports may be insufficient can exacerbate their mental health condition. For those suffering from the effects of trauma, secure detention also can trigger memories and reactions to previous traumatic events. Families suffer as well, as they worry and grow angry

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[1] UCLA Center for Mental Health in Schools, *Current Status of Mental Health in Schools: A Policy and Practice Analysis* 6 (2006).

[2] National Alliance on Mental Illness, *Grading the States 2009: A Report on America's Health Care System for Adults with Serious Mental Illness* 143 (2009), *available at* http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75459.

[3] Texans Care for Children, *Children's Mental Health in Texas: Running a Diagnostic Test*, *available at* http://texanscareforchildren.org/Images/Interior/reports/texas_childrens_mental_health_report.pdf.

[4] Texas Youth Commission & Texas Juvenile Probation Commission, *TYC-TJPC Coordinated Strategic Plan FY 2010* 8-9 (2009).

[5] Karen Mahoney, Julian D. Ford, Susan J. Ko & Christine B. Siegfried, *Trauma-Focused Interventions for Youth in the Juvenile Justice System* (2004).

but feel powerless to address the system's inability to ensure the safety and well-being of their children.

Fortunately, Texas already has started to shift its funding in the right direction — toward community-based supports and services. During the 2009 legislative session, state leadership showed visionary support for community-based programming. The legislature reduced funding for TYC by approximately $100 million and provided $45.7 million in new funding to juvenile probation departments for Commitment Reduction Programs (CRPs) intended to divert youth from TYC commitment and many probation departments across the state have used CRP funds to develop mental health resources. Preliminary data show this decision was fruitful, with the 141 counties that elected to receive diversion funds reducing commitments by 32 percent from 2009 to 2010.[6] In contrast, counties that chose not to receive CRP funding reduced commitments by only 10 percent.[7] Of the almost 4,000 youth served by the programs funded through this initiative during 2010, only 58 were subsequently committed to TYC through the first three quarters of 2010.[8]

At the core of these programmatic shifts is the philosophy that youth should be supported close to their families and home environments and that detention should always be a last resort. As communities in Texas and other states have shown, alternatives to incarceration are possible for many youth with mental health needs. Building and sustaining an array of diversion and alternative community-based mental health services also will help to preserve and support, rather than separate and harm, youth and families.

II. FACES OF CONFINEMENT

Corsicana Residential Treatment Center (Corsicana) is a high-security TYC facility located approximately 55 miles south of Dallas in Navarro County. It is designated solely for committed youth with severe mental health problems. The facility has the capacity to house up to 145 youth, and its daily population usually remains just below capacity at approximately 130 youth. Corsicana is also home to a Crisis Stabilization Unit, where youth system-wide are sent when they present a risk of serious harm to themselves or others. Corsicana's purpose is to address the unique mental health and substance abuse needs of each youth with individualized treatment plans. However, the remote location of the facility makes recruiting and retaining qualified professionals and ensuring the provision of appropriate mental health and other specialized treatment an ongoing challenge.[9]

The stories that follow are of youth who have been or currently are confined to Corsicana. Identified at an early age as having mental health needs, Ben illustrates the struggles that youth with serious mental illness face in secure settings, which often result in extended lengths of stay. Sarah is an example of a youth whose complex mental health needs are not being appropriately addressed by the system's current treatment model. Chris, a boy with both

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[6] Texas Sunset Advisory Commission, *Commission Recommendations: Texas Youth Commission, Texas Juvenile Probation Commission, Office of the Independent Ombudsman* 13 (2011).
[7] *Id.*
[8] Texas Juvenile Probation Commission, *82nd Texas Legislative Session Agency Information Packet* 10 (2011).
[9] Texas Sunset Advisory Commission, *supra* note 6, at 15-16.

mental health and developmental needs, ended up in TYC as a result of a lack of appropriate treatment in the community that may have helped to prevent his involvement with the juvenile justice system altogether. Their stories illustrate the complexity of trying to serve juveniles with serious mental illness in secure facilities and how the setting itself and the practices within the current system fail to help, or worse, even harm youth.

EXTENDED LENGTHS OF STAY FOR YOUTH WITH DISABILITIES

Ben is a 14-year-old boy who was identified as having mental health issues at an early age. He was committed to TYC for a minimum length of two years in October 2008. At the time of his commitment, doctors diagnosed Ben with attention deficit hyperactivity disorder, a learning disability and conduct and impulse control disorders. Based on these diagnoses, TYC placed Ben at Corsicana.

Ben's time at Corsicana can best be defined as unstable and lacking adequate supports. He has seen at least five caseworkers assigned to him come and go and, for a period of time, Ben was without a caseworker entirely. Various multi-disciplinary team meetings to manage his progress have consisted only of Ben, his current caseworker and a note taker.[10] Without consistent supports and services, he has had immense difficulty advancing through the program. In addition, Ben's medication regimen is frequently interrupted or changed, causing him to become more disruptive and setting back any progress he has made through the TYC stages.[11] After more than two years in TYC, Ben is still at stage one of his five-stage release program.

Ben's school life before and after his commitment has not been any more stable. Even though he dropped out of school in the sixth grade, TYC placed Ben in the eighth grade. Still, he feels the work at this higher grade level is too easy and that he learns nothing in school. As a result, Ben acts out during class and has difficulty finishing his work. During his time at Corsicana, Ben has had little consistency in teachers and staff, who do not fully understand Ben's learning disabilities and unique needs in the classroom. In March 2010, Ben's special education services team developed a behavior intervention plan to address his loss of behavioral control and

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[10] A youth's multi-disciplinary team (MDT) consists of staff responsible for partnering with the youth to facilitate the youth's progress in the rehabilitation program. In high restriction facilities like Corsicana, the MDT should, at a minimum, consist of the youth's assigned educator, case manager and a juvenile correctional officer familiar with the youth. The youth's family and other relevant staff members (psychologists, program staff, medical staff, etc.) involved in the youth's treatment and rehabilitation also are encouraged to attend. *See* TYC General Administrative Policy Manual 85.1(18).

[11] All youth committed to TYC have to participate in the *CoNEXTions*© Program, with the goal of progressing through five "stages" of achievement to the highest stage, Youth Empowerment Status (YES). Youth who achieve YES and have met other objective release criteria are considered to have successfully completed the program and are released from TYC. The Release Review Panel also may release those youth who are committed to TYC on a determinate sentence, complete their minimum length of stay and do not achieve YES. If the panel determines the youth no longer needs rehabilitative services from TYC, the panel may authorize the youth's release to parole or discharge the youth from TYC supervision. *See* TEXAS YOUTH COMMISSION, CONEXTIONS© PROGRAM BROCHURE (2009), *available at* http://www.tyc.state.tx.us/programs/conextions_bro/index.html.

problems with boundaries while in school. However, due to the lack of instructor continuity, the school's staff has failed to implement the plan, and Ben continues to struggle in school.

While Ben has failed to make any progress in Corsicana, even more troubling is evidence that he is regressing significantly. Facility staff members have documented multiple incidents of Ben injuring and threatening to injure himself, as well as a growing propensity for cutting himself. Ben says he cuts himself when he gets frustrated — with staff, his failures in school and his inability to progress through the system.

Ben hopes to become a doctor one day, but that dream seems far off. Having completed his two year minimum length of stay, Ben first came in front of TYC's Release Review Panel in October 2010. The panel determined that since Ben had not progressed within the stages, his stay in a high restriction facility should be extended for four more months. In February 2011, Ben again came before the panel. The panel once again extended Ben's stay in residential placement for four more months. As Ben's release date from TYC continues to be pushed back, his frustration with the system grows, and his struggles with rehabilitation continue. Had Ben received adequate supports and services during his first two years in TYC, he could have been released from a secure facility months ago. Instead, he continues to struggle, and his future is uncertain.

SECURE FACILITIES — A FAILED TREATMENT MODEL

In early 2009, at age 15, Sarah had her first encounter with the law. While her extended family had a history of mental illness, Sarah's parents were stunned by the offense, unaware that their daughter had serious mental health needs. It was not until after her offense that Sarah revealed that she had been hearing voices and having suicidal thoughts since around age 13.

While awaiting disposition of her case in a juvenile detention center, Sarah was hospitalized in a residential treatment center for mood swings, severe depression and numerous suicide attempts. During her six month stay, Sarah was first diagnosed with bipolar disorder with psychotic features and a conduct disorder.

In May 2009, Sarah was committed to TYC for a minimum of 36 months. Sarah was first sent to the Ron Jackson I facility in Brownwood, Texas. While there, Sarah revealed for the first time that she was sexually abused by a teacher at her high school during her freshman year. Embarrassed and ashamed, she told no one about the incident when it happened. Instead, she grew increasingly angry, as well as suicidal, eventually leading to her offense.

Within months of being confined at Ron Jackson, Sarah's mental health declined significantly. During a psychiatric evaluation in September 2009, Sarah revealed that she had begun imagining that she lived in a fantasy world about three years prior to her arrest. As her condition continued to deteriorate, Sarah's intent to harm herself grew. During a one-week period in December 2009, she tried to kill herself on at least four occasions. TYC doctors changed the dosages of medications from week to week, trying to find the right combination to treat Sarah's depression and self-harming behavior. However, Sarah continued to suffer serious symptoms of depression and suicidal ideation, and she was consistently noted as being self-isolating, aggressive, impulsive and restless.

By April 2010, Sarah's condition had deteriorated even further. She complained of depression, loss of appetite, insomnia and nightmares. When she tried talking to staff about her problems, she felt as though they did not believe her. Over the next few months, Sarah's pattern of self-harming behavior persisted, even while on suicide watch.

In August 2010, Sarah's mental health status deteriorated to the point that she had to be transferred to the Crisis Stabilization Unit at Corsicana. She continued to believe that she was living in a fantasy world, and staff psychiatrists observed symptoms of severe psychotic and affective disorders. Staff heard Sarah talking aloud to the characters in her fantasy world and declaring that these characters were the only people who understood her.

Despite being transferred to a more restrictive setting, Sarah's attempts to harm herself continued, and after three weeks at Corsicana, she was transferred to Terrell State Hospital (TSH), an inpatient psychiatric facility, for treatment on an emergency 90-day commitment. She responded positively to the treatment provided by TSH, which included a period of one-on-one supervision and a reevaluation of the proper balance of medications for her conditions.

The most helpful treatment Sarah received at TSH appears to have been group therapy sessions. Her TSH doctor felt strongly that she would be more responsive to psychotherapeutic interventions, such as therapy, than to pharmacologic ones. This strategy paid off. When Sarah was first admitted, doctors noted that she was quiet and uncommunicative. Over time in the therapy sessions, Sarah grew more comfortable participating and sharing her feelings with the group. Through these sessions, she learned to recognize her mood swings and identify calming measures that she can use in response, including drawing and writing, instead of resorting to self-harm.

In November 2010, Sarah's hospital commitment expired, and she was transferred back to TYC. She is now finishing her sentence in the Ron Jackson I facility in Brownwood with a projected release date of January 2012.[12] Her family is hopeful that her time at TSH will allow her to safely complete her sentence. Sarah cannot wait to start her life over and go to college.

MISSED OPPORTUNITIES FOR COMMUNITY-BASED INTERVENTIONS

Chris is a 17-year-old who has been in the custody of TYC since September 2009 serving a five-year determinate sentence. Chris was transferred to Corsicana after only a few weeks at another facility, where he struggled with psychosis, depression and trauma.

The path that led to Chris' eventual placement in Corsicana is a long one. He was diagnosed with a learning disability before kindergarten, and he began receiving special education services at that time. When Chris was 7, his cousins began molesting him. The abuse continued for two years until Child Protective Services (CPS) was notified and stepped in. CPS took statements from Chris, but failed to provide any counseling or other services. Growing up, Chris had no opportunity to discuss the trauma he suffered and the emotional consequences he

[12] Beginning in October 2010, females committed to TYC are placed solely at the Ron Jackson I facility in Brownwood. All female youth who had been placed at the Corsicana facility for their severe mental health needs were transferred to Ron Jackson.

felt from the abuse. Only recently has he begun to explore the abuse with his psychologist.

When Chris was 11, his environment became especially chaotic. His father left the family, his grandmother died and their home was repossessed. At the same time, Chris' school switched him to a general education classroom without providing the special assistance his disabilities required. His teachers soon reported that Chris was shutting down — resting his head on his desk, refusing to comply with teachers and talking about death. Chris went to counseling for a few months, which he liked and found helpful, but his mother's long work hours to support the family soon made those sessions impractical.

Not until the age of 13 was Chris referred by his school to the local Mental Health Mental Retardation Center (MHMR) due to signs of depression. At that time, Chris reported hearing voices, feeling restless and having trouble sleeping, making decisions, concentrating and remembering things. By the time he was 14, Chris had become anxious and angry, and he continued to think about suicide and self-harm. His high school gave him one-on-one supervision and noted that Chris was aggressive, hyperactive, inattentive and "oppositional." Around this time, he started skipping school, spending time with more dominant older boys and cutting himself. Through MHMR, Chris received a combination of therapy and medication. He was particularly open to therapy because "he wouldn't get in trouble for how he felt." In January 2008, Chris' mother brought him to MHMR again because her son was experiencing fits of rage and wanting to be alone or hurt himself. Chris was again diagnosed with depression and once again treated with medication and therapy.

In March 2008, at age 14, Chris was arrested and placed in a county detention facility. The six-month detention worsened his mental health condition. Chris' mother recalls that she could not recognize her son's voice or personality and that he looked "drugged up" while in detention. While awaiting disposition of his case, Chris became suicidal; he once tried to hang himself at the instruction of voices, and another time he attempted to overdose on his medications.

A psychological evaluation in June 2008 concluded that Chris' impaired intellectual ability limited his capacity to find appropriate solutions to his problems. Chris was diagnosed with schizoaffective disorder, mild intellectual disability and polysubstance abuse. For the first time, Chris also was diagnosed with post-traumatic stress disorder as a result of childhood sexual abuse and other victimization at the hand of peers and adults.

Though finally released from detention near the end of 2008, Chris continued to struggle prior to his adjudication and commitment to TYC. He was hospitalized nine times in 2009 for being a danger to himself. Doctors prescribed him various medications during each hospitalization, but his mother often could not afford to buy them. At best, he complied inconsistently with his drug treatment plan.

Chris continued to receive special education services for his academic, emotional and behavioral needs during this time, but lacked other services to address his mental health needs. Chris' parents expressed interest in respite care, behavioral specialist assistance and anger management training for their child through MHMR. The center agreed, recommending parenting skills training and family counseling and placing him on the waiting lists for Medicaid waiver services. MHMR secured a case manager and a mentor for Chris, but six

months later, at the time of his commitment to TYC in the fall of 2009, he and his family were still waiting for the other suggested services to be provided.

Throughout the hospitalizations, MHMR referred Chris to residential treatment centers numerous times, believing he could benefit from increased structure and supervision since, despite his parents' best efforts, his home living situation was not meeting his complex needs. An appropriate placement was never found. As a result, the hospital recommended the only other option for Chris after discharge — commitment to TYC.

Chris deteriorated even further after being committed to TYC. After more than a year of secure confinement, Chris showed signs of disorganized thinking, instability and "racing, ruminative and obsessive thoughts," and he frequently expressed the desire to kill himself. Chris also has developed pronounced facial-motor tics, and he now rarely makes eye contact or smiles. To cope with the stress of incarceration, Chris paces the floor and visualizes scenarios of retribution against "those who have betrayed him in the past." He is also cutting himself with increasing frequency and severity.

Chris has been unable to advance in the TYC program and has been at stage one of his five-stage release program since he arrived. He misses his family and wants to go home, hoping to someday work in maintenance with his father. His parents remain wholly supportive of their son and hope that one day he will receive the services he desperately needs.

III. KEEPING YOUTH WITH MENTAL HEALTH NEEDS IN THE COMMUNITY

Ben, Sarah and Chris' stories illustrate that the current treatment models used in TYC secure facilities fail to appropriately serve youth with complex mental health needs. Not only do youth lack adequate access to mental health care in these facilities, the secure institutional setting by itself has prevented their progress or led to their deterioration. Their stories also reveal gaps in the children's mental health system, which should have identified and treated the needs of these youth to avoid juvenile justice involvement in the first place.

Access to appropriate and effective mental health services is key to addressing the underlying sources of these youths' offenses, reducing recidivism and preventing deeper penetration into the system. Within the juvenile justice system, opportunities for intervention and positive development of youth with mental health needs exist at many key points — from initial contact and referral by law enforcement to post-adjudication and post-disposition decisions by judges. In light of the destructive effects of secure confinement, this section focuses on effective interventions at early stages of juvenile justice processing. The goal of each of these models is to keep youth safely and appropriately in their communities. Reducing commitments to secure facilities and instead shifting monies toward effective community-based alternatives also may present significant cost savings for Texas.

As described below, some parts of Texas are already practicing innovative ways of curbing the flow of youth with serious mental health issues into the juvenile justice system on the front end by working with schools, law enforcement and probation departments to divert them to community-based alternatives to incarceration. Other jurisdictions around the country also are

developing continuums of community-based services and supports that serve youth with serious mental health needs before they come in contact with the juvenile justice system. Toward this end, the Substance Abuse and Mental Health Services Administration has funded "systems of care" — multi-agency partnerships to provide services in a more efficient and cost-effective way.[13] Meaningful partnerships between the juvenile justice system and mental health system, as well as other relevant agencies, have emerged to address the needs of youth who are involved, or are at risk of involvement, in the juvenile justice system.

The common emphases of all these community-based approaches to serving youth with significant mental health needs include:

- The use of well-developed mental health screening and assessment tools and processes;
- Consideration of the multiple needs of youth and their families;
- Intensive case management;
- Use of individualized wraparound services that include therapeutic interventions;
- A strength-based approach based on principles of positive youth development;
- Involvement and support of the entire family in addition to the youth; and
- Specialized planning and coordination of care by various systems and stakeholders.[14]

TEXAS MODELS

System of Care — The Children's Partnership, Travis County

Developed in 2000, the Travis County collaborative system of care meets the complex needs of children and youth with serious emotional disturbances. The Children's Partnership manages the system of care, coordinating services and funding from four school districts, the child welfare system, the local mental health authority, the Texas Health and Human Services Commission, the juvenile justice system and Casey Family Programs. Focusing on the strengths of the youth and the unique values and culture of each family, the partnership provides a full range of services in or near a youth's home. Partnership staff members pride themselves on being partners with families, listening to their needs, treating them with dignity and providing encouragement.

Under this model, a multi-agency team develops and tailors a service plan to meet the needs of youth and their families, with the ultimate goal of avoiding out-of-home placement. Youth receive wraparound services, and families may access a network of more than 100 service providers. Nontraditional services are available through faith-based, community-based and neighborhood organizations, as well as school and after-school programs. Support provided through the partnership can be as basic as transportation and can also include parent-to-parent support, after school care, mentoring and respite care. To receive services through the

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[13] Technical Assistance Partnership for Child and Family Mental Health, *Addressing the Mental Health Needs of Youth in Contact with the Juvenile Justice System in System of Care* (2010).
[14] Beth A. Stroul, *Promising Approaches for Behavioral Health Services to Children and Adolescents and Their Families in Managed Care Systems: Serving Youth with Serious and Complex Behavioral Health Needs in Managed Care Systems* 15 (2003).

partnership, youth must be currently, or be at risk for, placement outside of the home due to a mental health need.

Law Enforcement Intervention — Crisis Intervention Training, Bexar County

Bexar County has created the Children's Crisis Intervention Training (CCIT) for school police officers to address upfront the volume of youth in the juvenile system for school-based behavior directly related to their unmet mental health needs.[15] The focus of CCIT is to divert juveniles with mental health needs into treatment, rather than referring them to the juvenile justice system. The CCIT course consists of 40 hours of training and covers such topics as:

- Officer tactics and safety in a school campus environment;
- Active listening and de-escalation techniques;
- Mental, learning and developmental disorders and substance abuse in children and youth;
- Psychotropic medications;
- Family perspective and community resources;
- Legal issues relating to school environment and minors and emergency detention; and
- Role-play scenarios that allow officers to gain practical experience in active listening and de-escalation techniques specific to students experiencing a mental health crisis.

The training is also available for other school staff, including administrators. To date, Bexar County has trained 77 school district police officers.

Post-Adjudication Probation Services — Commitment Reduction Programs, Bexar County

Bexar County created several programs using the CRP funds appropriated by the Texas Legislature in 2009, including:

- **Home-Based Substance Abuse Treatment**: a three- to six-month program providing treatment and counseling in the youth's home.[16] Its goals and intervention strategies are tailored to meet the specific needs of the individual youth and his or her family.[17]
- **Parent Project**: a 10-week program for parents to learn prevention and intervention strategies for their child's challenging behaviors. Parents may be self-referred or referred through probation officers or the court. The classes take place in conjunction with classes for the youth under supervision. Meals and childcare are provided.
- **Weekend Program**: a four-consecutive weekend program at the detention facility. Each weekend is comprised of 37 hours of program modules with parents participating before and after each weekend. Program modules include: an initial assessment to determine the youth's needs; training on social skills, character development, anger management,

[15] Texas Appleseed, *Texas' School to Prison Pipeline: Ticketing, Arrest & Use of Force in Schools* 61 (2010), *available at* http://www.texasappleseed.net/images/stories/reports/Ticketing_Booklet_web.pdf.
[16] Texas Juvenile Probation Commission, House Committee on Corrections Information Packet 20 (2010).
[17] *Id*.

gang awareness and victim empathy; support groups; substance abuse intervention; therapeutic services; and physical recreation.[18]

As of January 2010, Bexar County had served 323 youth through these programs. The typical participant had at least one felony referral to the juvenile system and multiple misdemeanor and Child in Need of Supervision (CINS) referrals.[19] Thirty-eight percent of the youth served have been in at least one residential placement and 54 percent had been detained three or more times.[20] Despite these potential barriers to success, of the 323 youth enrolled in one of these programs, only seven were subsequently committed to TYC.[21] Of youth in the Weekend Program, 81 percent successfully completed its requirements, and only 13 youth recidivated.

The success of these programs goes beyond what is reflected in the data. Interviews with youth and parents underscore their enthusiasm toward the services they receive. One parent says that she was initially angry when the judge "punished" her with parenting classes as part of the disposition in her son's case. After attending the classes, however, she enthusiastically recommended them, as did other parents. Many parents even say they wish they had had earlier access to such classes, which helped them to better understand, communicate and forge stronger relationships with their children — in some cases, after they had abandoned hope of ever doing so.

Youth also have been enthusiastic about participating in the programs. They describe staff as being available at all times of the day and coming to their homes to meet not just with them but with their family as well. Youth also feel that their counselors' genuine concern has made a big difference in their success in the program. They also have noted that staff members often help families with problems unrelated to the youth's adjudication by connecting them with services broader than those meant solely for them. For example, one youth says that his counselor helped his mother find financial support and food bank assistance after she lost her job.

The CRPs in Bexar County provide mental health supports and services, though not as their primary focus. A significant percentage of the youth served have experienced a history of mental health problems and/or treatment. Twenty-three percent of the 92 youth served in the home-based substance abuse treatment program had a current mental health diagnosis, as did 50 percent of youth in the weekend program. These programs are good examples of how communities and probation departments can take advantage of local resources and tailor services to meet the needs of all youth, including those who have a mental health diagnosis.

Deferred Prosecution Juvenile Mental Health Court, Travis County

The Travis County Juvenile Mental Health Court is a specialty court for youth ages 10 to 17 whose mental health condition has contributed to their involvement in the juvenile justice system. Created by Travis County Juvenile Court and Juvenile Probation Department, the court

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[18] *Id*.
[19] E-mail from Jeannine Von Stultz, Director of Mental Health Services, Bexar County Juvenile Probation Department, to Deborah Fowler, Legal Director, Texas Appleseed (January 3, 2011) (on file with author).
[20] *Id*.
[21] *Id*.

runs a deferred prosecution program called Collaborative Opportunities for Positive Experiences (COPE), the first of its kind in Texas to serve pre-adjudicated youth. COPE diverts youth from formal processing by addressing the emotional, behavioral and academic needs underlying their offenses. Youth and families participate in the program for six months to one year. Upon successful completion of COPE, a youth's charge is dismissed, and his or her juvenile record is cleared.

To provide access to improved treatment for youth and their families, COPE facilitates collaboration among the juvenile justice, educational and mental health treatment systems; assists with obtaining Medicaid/CHIP insurance; and provides consistent comprehensive, individualized services, including aftercare. It also provides training to judges, educators, law enforcement and treatment professionals in crisis intervention, brain disorders, trauma and other relevant topics.

Each case accepted for deferred prosecution comes to a collaborative team comprised of the judge, a casework manager, two "deferred prosecution officers," an assistant district attorney, a juvenile public defender, the Community Resource Coordination Group coordinator, a Travis County Juvenile Probation Department psychologist and the director of Special Services. Operating by consensus, the team decides whether to accept a case. Any youth who has a pending referral for delinquent conduct to the Juvenile Court is eligible if the youth and family agree to participate, supervision through the program is appropriate, and the youth has a diagnosis of or diagnosis comparable to major depression, bipolar disorder or schizophrenia. Other youth may be accepted based on fact-specific circumstances. COPE accepts youth only after performing an appropriate assessment. Before accepting a case, the team also considers whether other, more appropriate interventions are available including, school-based advocacy, mentoring and social skills development. The program mostly involves youth facing misdemeanor charges (68 percent), but also includes youth referred for felonies (32 percent).

Once accepted, a youth and his or her family work with the team to develop an incentive and strengths-based case plan. COPE-designated probation officers supervise youth using an intensive case management framework. Usually within seven to 10 days of acceptance into the program, youth begin treatment that is contracted out to community providers. The services provided include:

- Cognitive behavioral and multi-systemic therapy for youth and families;
- A six-week anger management group using aggression replacement training psychiatric evaluations and medication management;
- Further psychological and neuropsychological testing, if needed;
- Educational assistance and special education services advocacy; and
- Wraparound services through the Children's Partnership.

At the heart of COPE is a philosophy that children are children. As Associate Judge John Hathaway explained, "We believe in looking at the child, not the charge." He emphasizes that COPE is a diversionary program, not a court process. Since its creation, COPE has served 206

youth. In 2009, 82 percent of the 92 youth under its care graduated successfully. In 2008, 69 percent completed the program and 65 percent have not committed another offense.[22]

NATIONAL MODELS

The Dawn Project, Marion County, Indiana

Like the Children's Partnership in Travis County, a collaborative system of care was also formed in Marion County, Indiana. In 1997, a consortium of state and county child and family agencies, family members and other community stakeholders was formed to address soaring out-of-home placement costs for youth with serious mental and behavioral health needs. Called the Dawn Project, the consortium initially served 10 youth who were in or at risk for out-of-home care in its first year.[23] By 2008, it was serving over 400 youth annually.

The Dawn Project is managed by the nonprofit Choices. The project strives to keep youth with serious emotional disorders in their homes and communities by providing and coordinating individualized, community-based services and supports. The project is described as "a one-stop shop for families."[24] Under a managed care system model, youth and their families have access to a diverse provider network, offering individualized wraparound services ranging from therapy to placement to tutoring and mentoring. The model also pools money from different agencies, and this "blended funding" allows for efficient, better coordination of services.

The philosophy of the Dawn Project is to focus on the unique strengths and needs of youth and families and to develop ways for them to become more self-sufficient after the program's conclusion. On average, youth stay with the program for 14 to 15 months. Referrals come from juvenile court, as well as the child welfare system, the Department of Mental Health and the Department of Special Education. When a new case is referred, the project convenes a "Child and Family Team" comprised of the child and family, the service coordinator, the referring worker, current service providers, a therapist, a school representative and other relevant supporters as identified by the family. Together, the team develops a service coordination plan, authorizes services for a 30-day period and revisits the plan at regular intervals.

The Dawn Project has demonstrated considerable success. A September 2005 assessment showed that 65 percent of youth left the program by meeting the goals established by their team and that the youth who were discharged after meeting these targets were 78 percent less likely to return to a child-serving agency than those discharged for other reasons. Of those who successfully completed the program, 83 percent stayed out of the system altogether. Equally important, these positive results have been sustained over time; in 2008, 96 percent of all youth

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[22] *See* Marc Levin, Texas Public Policy Foundation, *Getting More for Less in Juvenile Justice: Innovative and Cost-Effective Approaches to Reduce Crime, Restore Victims, and Preserve Families* 21 (2010), *available at* http://www.texaspolicy.com/pdf/2010-03-RR01-JuvenileJustice-ml.pdf.
[23] Beth A. Stroul, *Promising Approaches for Behavioral Health Services to Children and Adolescents and Their Families in Managed Care Systems: Serving Youth with Serious and Complex Behavioral Health Needs in Managed Care Systems* 32 (2003).
[24] Choice Stream, "Dawn Project", http://www.choicesteam.org/dawn.html (last visited March 10, 2011).

serviced through the project had not run away, engaged in delinquent behavior or engaged in behaviors that threatened the community at the time of their most recent assessment.[25]

Law Enforcement Interventions

Law enforcement is often the first to encounter or respond to youth with serious mental health needs underlying their misbehaviors. Recognizing the unique opportunity that law enforcement officers have in connecting such youth to screening and evaluation and other services, as appropriate, many jurisdictions across the country have implemented "Crisis Intervention Teams" (CITs).[26] Similar to the school-based CCIT in Bexar County, CITs consist of law enforcement officers who are specialized and trained in responding to calls involving people with possible mental health needs. Partnering with the mental health system, CITs help people access needed resources as part of their response to a mental health crisis. In 2010, the Mental Health and Juvenile Justice Action Network worked with the National Center for Mental Health and Juvenile Justice to develop and pilot a new version of CIT tailored to youth with mental health needs, known as Crisis Intervention Teams for Youth (CIT-Y).[27]

The Baltimore County Crisis Response System is an example of another approach to involving law enforcement in diverting people with mental health needs. In Baltimore, police have partnered with the local mental health agency and a community-based nonprofit to create "Behavioral Assessment Teams." In contrast to CITs, this approach involves integrating mental health professionals into police departments themselves. These professionals assist law enforcement officers in various ways, including: phone-based assessments, referrals and interventions; in-home intervention teams that accompany police officers called to situations involving mental health crises; and Mobile Crisis Teams, which pair licensed clinicians with police officers to provide immediate on-site responses to people in crisis. The Baltimore project has successfully diverted individuals with mental health needs from the criminal justice system by linking them with mental health services, emergency interventions and long-term mental health services. Like CITs, these Behavioral Assessment Teams were designed for adults, but they could be carefully tailored to meet youths' needs as well.

IV. CONCLUSION AND POLICY RECOMMENDATIONS

Building on system reform efforts to date, Texas should continue to prioritize community-based programs and services over institutional placements for youth involved in the juvenile justice system. Effective model programs exist in Texas and other jurisdictions that better serve youth with mental health needs through community-based services, both as an alternative to secure confinement and as a measure to prevent contact with the juvenile justice system in the first place. When secure confinement is necessary, youth should receive appropriate specialized

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[25] Dawn Project Outcomes Report (2008), *available at* http://www.choicesteam.org/documents/reports/2008dawnreport.pdf.
[26] National Center for Mental Health and Juvenile Justice, *Advances and Innovations Emerging from the Mental Health/Juvenile Justice Action Network: 2009 Update* (2009), *available at* http://www.ncmhjj.com/pdfs/publications/Advances_Innovations.pdf.
[27] Kathleen Skowyra, *Law Enforcement-Based Diversion: Helping Youth at a Critical Stage* (2010), http://www.modelsforchange.net/reform-progress/75 (last visited March 10, 2011).

treatment to ensure their safety and well-being and increase the chances of their success when they return to the community.

The following policy recommendations will help ensure that best practices are more widely implemented so that Texas youth, families and communities benefit as the state continues to transform the juvenile justice service delivery system.

Maintain Community Mental Health Services for Children

In the Legislative Budget Board report on Adult and Juvenile Correctional Population Projections for Fiscal Years 2011–2016, juvenile justice practitioners from across the state recommended prioritizing mental health resources for youth to keep correctional populations down.[28] Even in difficult budgetary times, the single most important policy decision that Texas can make to prevent contact or further involvement of youth with mental health issues with the juvenile justice system is to invest in community mental health services. Increasing access to community mental health services for youth provides an excellent return on investment in human terms and reduces reliance on more costly services in the long run.

Expand Commitment Reduction Program Funding and the Use of Pre-adjudication Diversion Programs for Youth with Mental Illness

Research and experience tell us that youth with mental health problems who are involved in the juvenile justice system achieve better outcomes when their specialized treatment needs are met with community-based services that keep them at home or closer to their families and support systems. Since 2006, the Texas Legislature has appropriated approximately $100 million to strengthen community-based diversion programs for youth who previously would have been sent to TYC with very promising results. Even during difficult fiscal times for the state, continued investment in this funding is imperative, as it will reduce future reliance on costly government-funded institutions, such as juvenile justice facilities, jails and prisons.

Using Commitment Reduction Program funding allocations to partner with local or regional mental health resources, probation departments across the state have developed innovative and cost-effective approaches to serving system-involved youth with mental health impairments while maintaining public safety. Probation departments also should receive sufficient resources so they can provide intensive treatment services for youth with serious mental health disorders who cannot be served at the local level.

Close and Consolidate Texas Youth Commission Facilities and Reinvest the Savings in Community-Based Services

In light of the successful investments aimed at developing services to keep youthful offenders in their communities, the current capacity of TYC's secure facilities far exceeds the rate at which probation departments are committing youth to state custody. Realignment of the entire system through thoughtful closure and consolidation of certain secure facilities is therefore necessary to

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[28] Legislative Budget Board, Adult and Juvenile Correctional Population Projections Fiscal Years 2011-2016 25 (2011).

reflect this downsize. Community-based programs and services are a cost-effective alternative to placements in secure facilities. As Texas continues to reduce its reliance on secure placements and more youth are served at the county level, the state should redirect the savings realized to probation departments so they can invest in alternatives to secure confinement for all youth, including those with mental health needs.

Ensure the Remaining Facilities Provide Appropriate Access to Services for Youth with Specialized Treatment Needs

While a community-based rehabilitation model is best for the vast majority of juvenile offenders, it may not be appropriate for all. A small percentage of youth who present a significant public safety risk will require confinement in a secure facility, and a small number of facilities must be maintained for this purpose. Because the remaining youth will have very complex needs, any blueprint for facility closure must first consider where specialized treatment needs can be met, including location of the facility and corresponding access to mental health and other treatment professionals.

Incentivize Research-Based Rehabilitation Models

While local flexibility is important because the availability of community-based services for youth with mental health impairments varies widely across the state, legislators should incentivize the use of research-based programs, that is, programs that have been shown to produce positive outcomes for youth.