

**PLACEMENT OPTIONS FOR AGGRESSIVE JUVENILE JUSTICE
YOUTH WITH SEVERE MENTAL ILLNESS:
COUNTY CHALLENGES**

By The Multi-Association Joint Committee
March 2007

FINAL

The Multi-Association Joint Committee (MAJC) is a committee of organizations and agencies that are committed to addressing the needs of youth in the juvenile justice system who have mental illness and/or substance abuse problems. This is accomplished through collaboration at the policy, advocacy, legislative, and programmatic arenas. The membership of MAJC includes the California Mental Health Directors Association, the Chief Probation Officers of California, United Advocates for Children of California, and representatives from various county human service agencies.

The purpose of this paper is to (1) inform policy-makers and other key stakeholders about the challenges counties face in their efforts to adequately serve these youth and to (2) help inform any new efforts on either the state or county levels designed to meet the needs of these aggressive youth with severe mental illness in the juvenile justice system.

The placement of youth of the juvenile justice system, who have severe mental illness and who are also very aggressive, in appropriate settings poses extremely problematic challenges for counties in terms of their appropriate placement. Dwindling resources for confined youth with severe mental illness has significantly jeopardized the mental health care of these minors. The past decade has been witness to closure of numerous acute inpatient settings in communities, a decrease of state hospital beds for children and youth, a decreased average length of stay in hospitals, and a general lack of appropriate community resources for these youth.

Many confined youth with mental illness who become very agitated and aggressive are often served with limited, thus inadequate resources in detention facilities. Such youth may be transferred to a local intra-county hospital or a hospital in a nearby county that serves adolescents for acute care where he/she receives brief treatment during the course of a few days. The aggressive and violent behavior may or may not temporarily abate. Upon return to the detention facility, the youth's condition may again deteriorate to the previous state for which he/she was initially sent to the hospital; it is not uncommon for the hospital to reject a subsequent admission for reasons of safety of other inpatients and staff. The youth then languishes in the detention facility in isolation in a special handling unit since most detention facilities do not have a unit designed to serve such youth. The detention facility is not intended for intensive clinical treatment purposes; however, there

is often no other viable placement alternative. The protection of such youth and the safety of agency staff and other youth becomes the primary concern of all responsible agencies; this priority will then dictate the services for the youth despite the fact that the youth has a condition that is amenable to treatment. Juvenile detention settings, ranging from ranch/camps to juvenile halls, generally do not have sufficient mental health treatment staffing who are available on a 24-hour basis to allow for the successful management of these youth. The supervision of a constantly changing population, coupled with the issues of directing appropriate institutional behavior with the reality of multiple gangs, physical confrontations among others, makes the challenge of successful management of this high need subset of youth very difficult.

These challenging youth often exhibit behaviors that include suicide gestures, self-mutilation, physical assaults of youth and staff, and ingestion of foreign objects and dangerous substances. Other problematic behaviors include pushing staples into veins, biting self or others without warning, writing on walls with various bodily fluids, wrapping self with urine soaked sheets, diving from bed headfirst onto the floor, unresponsive to the use or application of pepper spray, ingestion of cleaning solutions/chemicals or objects, and non-responsiveness to staff. Additional staff and other resources are often mobilized from other areas in repeated, failed attempts to manage such youth thereby leaving the other areas of the facilities inappropriately staffed.

These youth, in general, are inadequately served in confinement, camps or ranches, in a hospital, or in other settings such as group homes with specialized mental health services (RCL 13-14).

Parents often identify additional concerns. They are fearful that their child in residential placement will be bullied, sexually assaulted, and/or learn aggressive behaviors; the child may then return home with more inappropriate and potentially dangerous behaviors. Younger siblings, among other household members, are often victimized by the aggressive youth with severe mental illness upon the youth's return home. Parents/caregivers may feel blamed by the system, which leads to feelings of disempowerment, confusion and frustration. The youth may, again, act out, in violation of his/her probation, thereby triggering another incarceration and thereby continuing the pattern of recycling the youth from home to institutions.

The California legislature recognized the challenges faced by counties in serving this population and attempted a legislative remedy through the passage of AB 1288 (W&I Code Sec 5695 – 5697.5) in 1991. This law provides the authority to establish regional centers “to provide both intensive mental health treatment and behavior control to this population of wards in a secure setting”. It further describes these youth as “frequent failures in open residential care and when confined to traditional juvenile justice system facilities, disrupt programming, endanger themselves and others, and require intensive supervision including occasional isolation and provision of a one-to-one supervision ratio.” The bill, however, did not include any funding.

Placement Options

Out-of-State Placement

The placement of youth in the juvenile justice system in out-of-state facilities, a common pattern in the past, has virtually been eliminated as an option due to the passage of Senate Bill 933, Chapter 311, Statutes of 1998. The State Department of Social Services must certify all out-of-state programs pursuant to SB 933; the number of such youth has diminished dramatically during the past five years. Just before SB 933 was passed, there were 778 youth in the juvenile justice system placed out-of-state. In June of 2006 there were only 150-175 youth similarly placed.

Out-of-state group homes have historically, in general, been more willing to accept minors referred by the Courts than intra-state group homes. Some of these out-of-state programs were considered “CYA alternatives” and used to bridge the gap between County Camps and the Division of Juvenile Justice (DJJ), formerly known as CYA, within the California Department of Corrections and Rehabilitation (CDCR).

One of the benefits of some out-of-state programs is that some are secure facilities that can manage minors who elope from a number of prior intra-state group home placements. They also treat minors who are considered too great a community threat to be housed in open settings such as all California group home placements. Out-of-state placements often include creative components such as wilderness or athletic environments. Most out-of-state placements were much more expensive than California group homes. State regulations of SB 933 now make this practice prohibitive for Probation Departments thereby providing an incentive to counties to be more responsive to some of these youth by way of releasing youth early or developing better alternatives. These new practices, of course, do not apply to the group of youth with severe mental illness who, also, pose a threat to the community.

The problems with out-of-state placements are numerous. Costs associated with transportation, County supervision /monitoring and family visits are substantial. A variety of licensing/certification bodies are involved in program approvals, thereby creating additional confusion. Some severe and well-publicized incidents around health and safety issues (including the death of a minor who was required to continue intensive physical training while ill) triggered SB 933, which was eventually passed in 1998. The passage of the bill resulted in a large group of minors who were placed out-of-state being returned to California. The State Department of Social Services concurrently developed regulations and certified programs of those out-of-state facilities that continue to serve California youth.

Camps/Ranches

Many counties operate juvenile camps or ranches. As in the case of juvenile halls, these facilities are regulated and inspected by the Corrections Standards Authority, a division of CDCR.

County camps and ranches are (with a few exceptions) unlocked, non-secure facilities. Probation minors are sent to camps and ranches by the Juvenile Courts as a dispositional alternative. Camps and ranches are often located in remote/rural areas. Among camp types are “Fire Camps,” “Forestry Camps,” and “Boot Camps”.

A variety of programming exists within the camp and ranch settings. Educational, recreational and vocational offerings are universal. Increasingly, mental health services are incorporated within the programs. However, minors with severe mental health problems, especially those who are known to be aggressive, are generally not considered appropriate for placement in such programs in large part due to the non-secure environment and minimal, if any, mental health staffing.

Ninety percent of camp clientele are males. Most have been adjudicated as felons, although this percentage is decreasing (66% in 2002, 72% in 1999).

Most camps are largely dependent on county general fund dollars. Juvenile Probation Camp Funding (JPCF) is distributed to counties in a “per bed” amount. Some counties closed beds in the early 80’s due to budget constraints and the increasing popularity of group home placements. Camp beds were increased in the mid 1990’s, largely as a response to DJJ “sliding scale” fees. DJJ “sliding scale” fees were established by the legislature in response to a rapidly growing DJJ population, thereby discouraging counties from sending youth to DJJ. Counties were charged a small nominal monthly fee for all youth committed to DJJ. The implementation of “sliding scale” fees included higher rates for youth who had committed less serious offenses. The rates for the more serious offenders did not change with the new implementation. Counties faced a financial disincentive for sending low-level offenders to DJJ, and most developed local programs (including increasing camp beds) to handle this population.

Although many California counties that have camps accept youth who are on psychotropic medications, many counties do not have the necessary resources, i.e., mental health professional staff, to manage this population, and to adequately staff a program. Therefore, camps/ranches are inappropriate for serving youth who are very aggressive and who have a severe mental illness.

Locked Facilities (Mental Health)

State hospitals and community psychiatric hospitals are locked/secured; these are the most restrictive levels of mental health care. Youth can be held voluntarily or involuntarily in an inpatient hospital when they meet criteria of being suicidal, homicidal, or gravely disabled as a result of a mental disorder; more than 90% of such youth are held involuntarily. Lengths of stay may range from a few hours to weeks, depending on the acuity and whether or not the youth’s condition meets the state inpatient criteria (or standard) of “medical necessity” for those youth who are indigent or are a Medi-Cal beneficiary. However, it is uncommon for youth to remain in private community psychiatric hospitals for more than a few days in large part because youth do not meet these criteria after a few days. In the perception of the attending clinician and/or

individual attending the court process (for conservatorship), it is too cumbersome and they are not reimbursed for the lengthy periods spent in court that are required under the Lanterman Petris Short (LPS) Act. Private insurance plans implement utilization reviews that strongly discourage lengths of stays beyond a few days. These facilities do not have the regulatory authority or appropriate staffing to serve these aggressive mentally disordered youth.

State hospital capacity for youth has diminished during the past five years. State hospitals have generally served the population of youth that are chronically mentally disordered, and for whom multiple placements have been unsuccessful. Treatment is almost always provided outside of the youth's community. Similar to private community hospitals, state hospitals do not have the regulatory authority or appropriate staffing to manage these youth with severe mental illness who are, also, aggressive.

Locked Facilities (Probation)

Most counties in California operate at least one juvenile hall. Juvenile halls are secure, locked facilities for the detention of minors described in section 602 of the Welfare & Institutions Code. Minors are detained both before and after adjudication of their case by the juvenile court. The majority of minors detained in California have been charged with felony offenses. Full service juvenile halls incorporate education, recreation and medical programs within their facilities. Increasingly, mental health evaluation and services are included in juvenile hall programming.

“Special Purpose” juvenile halls are small facilities primarily found in northern, rural counties. Special purpose juvenile halls are limited to detention periods up to 96 hours. Lack of education and medical services (together with their small capacity) set the special purpose juvenile halls apart from their full service counterparts.

Since 1995, CSA has been responsible for standards and inspections of county juvenile facilities (DJJ provided that service prior to 1995). CSA rated capacity for juvenile halls in California at 7,095. Juvenile hall populations are (generally) 80-85% male, ages 15-17 (about 80%) and about evenly split between pre and post-disposition.

Post-disposition minors include those awaiting placement with relatives, in group homes or camps and ranches. Some await commitments to DJJ. A small percentage are completing “Ricardo M.” commitments (by the court) as a dispositional alternative. These commitments vary in length, usually from 15 to 365 days.

It is estimated that as many as 50% to 60% of the minors in juvenile halls at any given time have mental health needs that require some kind of intervention services. Minors who are severely aggressive and have a mental illness are often detained in juvenile halls as a “last resort,” not necessarily due to their criminality. An increasing percentage of youth detained in juvenile hall are prescribed psychotropic medications. Juvenile halls, however, generally do not have the necessary staffing (mental health, medical, or probation) and they do not provide an appropriate setting to adequately and comprehensively serve these youth.

As part of a massive reorganization of the state correctional system 2005, the California Youth Authority (CYA) became the Division of Juvenile Justice (DJJ) under the California Department of Corrections and Rehabilitation (CDCR). The DJJ provides a secure locked environment for very difficult, troubled and challenging youthful offenders committed to the custody of the DJJ by Superior Courts throughout the state. Youthful offenders committed to DJJ have exhausted all local resources, or have committed serious, violent acts that require secure custody as a matter of public safety.

DJJ has recently been sued as a result of a number of issues, including lack of appropriate mental health services. Reform efforts are under way, and remedial plans have been developed. The outcomes of those reform efforts have yet to be realized.

Community Treatment Facilities (CTFs)

The development of the Community Treatment Facility (CTF) category of residential care was enacted in 1985 with the passage of Senate Bill 876. These facilities are less restrictive environments than hospitals, and more restrictive than RCL 14 settings. The intent of this legislation was to create a complementary package of mental health treatment services delivered within a licensed community care residential facility serving children and youth. CTFs are specifically designed for youths with chronic and severe mental illness who often exhibited runaway behavior from less restrictive settings, aggressive behaviors, self-destructive behaviors, and/or occasional suicidality. These are children who cannot be treated successfully in a less secure environment, or whose previous placements including state hospitals, juvenile halls and the highest-level group homes have not been successful.

In 1988, additional amendments to the statutes (SB 240) added mental health oversight on the use of restraint, seclusion, and psychotropic medications in CTFs. In addition, these amendments also clarified the roles of the State Departments of Social Services (DSS) and Mental Health (DMH). DMH's role is to provide oversight of the treatment components, with a particular attention to restraint, seclusion and medication issues. DSS's role is to oversee the physical facilities and protect the health and safety of the residents.

In 1993, Senate Bill 282 (Chapter 1245, Statutes of 1993) amended the CTF statutory language to allow a locked perimeter for CTFs, as many of these youth with serious problems could not be treated in an open setting. Secure containment (restraint) and seclusion became part of the treatment continuum within a CTF.

In June of 1998, regulations required that the CTFs employ licensed mental health professionals, including a psychiatrist, registered nurses, licensed vocational nurses and licensed mental health therapists. These regulations also addressed the nature of the treatment environment, due process concerns, personal rights, treatment intervention protections, documentation and appropriate levels of on-site supervision and staff training.

The regulations also set a statutory 400-bed limit on the number of CTFs to be implemented statewide. State DMH, in concert with the California Mental Health Directors Association, (CMHDA) and other stakeholders, allocated the 400 beds on a regional basis (see map in appendix).

Although CTFs as a category of facilities were created in 1985, the first CTF did not open until 2001.

The current statutes governing CTFs, amended in 2000 by the passage of Assembly Bill 2877 (Chapter 93, Statutes of 2000), authorize the Department of Social Services (DSS) to modify certain regulatory requirements for CTFs for one year. AB 2877 authorized DMH and DSS to adopt and implement specific CTF provisions, including emergency regulations, to jointly develop protocols for the oversight of community treatment facilities. It required that these departments undertake specified actions with respect to training and education of facility management and staff, facility inspections and reporting requirements during FY 2000-01, and provided funding requirements for CTFs, including the establishment of a system of supplemental reimbursements. This bill also exempts DSS from reporting the use of restraints unless they resulted in death, injury, unconsciousness or other medical conditions.

Although CTFs have a secure perimeter, these facilities are not as restrictive as an inpatient unit. Residents in CTFs are placed there on a voluntary basis, unlike most inpatient settings.

These facilities are very useful for intensive treatment of mentally disordered youth in the juvenile justice system, provided that the youth are not severely aggressive or severely agitated. CTFs do not have the regulatory authority or the staffing found in county juvenile halls or acute psychiatric hospitals to manage the behavior of youth with severe aggressive or severe agitation behavior, and to provide the necessary structure and psychiatric care.

Group Homes or Residential Treatment Centers (RTCs)/Other Models

Group home placement of juvenile justice youth began (on a widespread basis) in the late 1970's. The "group home" category of care includes a wide range of facilities and programs, ranging from single six-bed facilities in the community to large campus-style programs. The services provided to a child or youth in placement and his or her family, can vary from basic board, care and supervision, to an intensive treatment program following any of a variety of therapeutic models.

Group homes are licensed and regulated by CDSS, Community Care Licensing Branch. Rate care levels (RCL 14 being the highest level) and rate setting is also a CDSS responsibility. Group homes can be differentiated by the wide variety of needs of the children and youth served – from the impact of severe abuse and neglect, to the emergence of serious emotional, developmental and behavioral disorders, to dangerous misconduct such as physical and sexual aggressiveness, to problems caused by substance

abuse and addiction. However, all group homes operate under the same licensing provisions.

Unlike most states, California has no category of facility or program called “residential treatment center.” Group homes often utilize various funding streams, including Medi-Cal EPSDT and education, to provide services to children in their group homes. These often include mental health services and nonpublic school services. When those services are provided under one program, they are often referred to as residential treatment because virtually all higher RCL group homes offer mental health services, and both the California Department of Mental Health and CDSS certify level 13 and 14 group homes.

Group Homes are unlocked facilities located throughout the state. As the name implies, most of these facilities resemble typical homes within a neighborhood. While group homes may be of any capacity, the average group home contains six beds. Many agencies operate more than one group home. Group homes provide 24- hour care and supervision to children in a structured environment. Group homes provide social, psychological and behavioral programs.

Most group homes that accept juvenile justice clients, that is wards of the court adjudicated under Section 602 of the W&I Code, specialize in serving that population (as opposed to non-delinquent W&I Code Section 300 youth, adjudicated as dependents). There are also group homes that sub-specialize in the treatment of adjudicated juvenile sex offenders and wards with significant substance abuse problems.

Youths’ individual histories of offenses and psychological needs have become more complex in recent years. These problems often are exacerbated by poor “matching” of a minor’s needs and strengths with a group home’s programmatic capacity and the services provided. This problem is exacerbated by recent voluntary closures of an increasing number of higher level group home programs.

Foster Care/Foster Family Agencies

Under current law, county placing agencies, child protective services (CPS) and juvenile probation, are required to place children in the least restrictive, most family-like setting possible. Depending on individual needs, a child may be placed in the home of a relative (kinship care), a county licensed foster family home, a foster home certified by a foster family agency, or a group home. Increasingly, foster care children in California are placed in the homes of relatives. A grandparent, aunt, uncle or sibling is given preferential consideration in the placement of a child. Foster family homes provide 24-hour care and supervision in family residences for no more than six children.

Foster Family Agencies (FFAs) are private, non-profit children’s services agencies that recruit, certify and train foster parents. The agencies find homes for children referred from county placing agencies and provide professional support to foster children and foster parents. The California Department of Social Services (CDSS), under the California Code of Regulations, licenses FFAs to certify homes for their exclusive use, using the CDSS-promulgated small family home regulations.

Each county has unique needs and uses available FFA resources to meet the diverse challenges of the county's children and families. Most often, FFAs work with children and youth whose individual or familial needs require a higher level of care and supervision than can be provided in county licensed foster family homes. In almost all cases, children placed in FFAs would otherwise be placed in shelters, group homes or other institutional settings.

Home Supervision

Most counties operate home-based programs for minors as an alternative to juvenile hall detention. These programs can be voluntary or court-ordered, and may include home detention (or home supervision) and/or electronic monitoring. They generally require the cooperation and participation of the minor and parent(s)/guardian(s). There are conditions that apply which can include school attendance, restrictive curfews and other limitations of the minor's liberty. Minors who remain very aggressive and have mental health problems are unlikely to benefit from these less restrictive alternatives due to perceived threats to themselves or others, and/or parents/guardians who are unable to control the youth's behavior at home. On any given day, 2,000 to 2,500 minors may be serving home detention (with or without electronic monitoring) statewide.

Other Treatment or Service Options

Wraparound and System of Care Programs

Wraparound is a family-centered, strengths-based, needs-driven planning process for creating individualized services and supports for children, youth and their families that facilitate access to normalized and inclusive community options, activities and opportunities. While in wraparound, children usually reside with their families, in foster family homes, or in relative placements, but may also reside in group homes. Depending on family strengths and needs, wraparound may include home schooling, frequent home health worker visitation, and intensive case management.

Wraparound is currently funded through SB 163 (Chapter 795, Statutes of 1997). Wraparound serves youth who are currently residing or at risk of placement in a RCL level 10-14 group home. CDSS assigns participating counties a number of Wraparound slots to provide an individualized and intensive planning process in order to keep these children in their homes, or allow them to be returned to their families, or transferred to a lower level of placement.

SB 163 allows the state share of foster care maintenance payment funds that would otherwise be used to support a child in an RCL 10 or 14 group home placement to be used flexibly to help meet family needs. The service model employs a specific set of practice principles and an intervention methodology that facilitates partnering of families with formal and informal service and support providers to customize responses, and to adapt and modify those responses over time. It also includes an assessment of child, family and community strengths from which to develop service planning. A broad range of community-based services can be incorporated into a service package. Further, this

model assists families to become the architects of their own service plans, which increases family independence with natural support systems and minimizes formal service system involvement over time as favorable outcomes are achieved.

Youth involved in the juvenile justice system who have significant behavioral or mental health needs have been a particular focus of wraparound. Recent research suggests that youth in juvenile halls, shelters and group homes may benefit from wraparound to the extent that reunification and other positive outcomes may be achieved, such as improved school performance, decreased juvenile justice involvement, improved psychological functioning, an increase in pro-social behaviors, and increased family involvement, functioning and satisfaction. This service requires a moderate level of cooperation by a youth, and therefore may not be appropriate for aggressive, mentally disordered youth who require intensive behavioral management and structure.

Children's System of Care Program

The Children's System of Care (CSOC) program consists of interagency services, blended programs and program standards that are intended to serve and support clients in the least restrictive environments. CSOC was an ongoing state-funded initiative for severely emotionally disturbed (SED) youth and their families until FY 2004-05. When state funding was eliminated for this program, some counties decided to continue their original program with other funding resources.

CSOC has been successful in providing services to juvenile justice youth assessed as having severe emotional and behavior problems, often among the most challenging clients supervised by probation. These minors are at risk for further violation of probation, and further violations of the law that result in more severe sanctions in the juvenile justice system. Typically, the minors and their families have been served by more than one agency.

CSOC services are child centered and family focused, with parent participation at all levels. An inter-agency policy council and case management team are required. Designed to treat minors at risk of out-of-home placement, CSOC services may be utilized to treat minors in their homes and avoid placement.

This level of care, however, is inadequate for aggressive, mentally disordered youth who require more intensive structure and behavioral management.

Therapeutic Behavioral Services (TBS)

TBS is a mental health service that is an option for youth who have full scope Medi-Cal. TBS is not a stand-alone service; it complements other mental health services. Intended as a "short term" intervention, TBS involves a behavioral aide who may spend up to 24 hours a day with the youth in a variety of settings (home, community, etc.) to assist the youth with adaptation to his or her environment. It is intended to address specific behaviors (that are not expected to respond to other mental health services alone) for a youth who meets the following criteria: currently placed in an RCL 12-14 or CTF facility; risk of placement in RCL 12-14, CTF; history of a psychiatric hospitalization in

the last 24 months, or previous recipient of TBS as a member of the class identified in the *Emily Q.* class-action lawsuit against the State.

Day Treatment

There are two types of Day Treatment: 1) Day Treatment Intensive is a half-day or full-day service in which the youth may receive a range of services provided by designated mental health staff including, but not limited to, group and individual therapies, and collateral and psychiatric services. Mental health staff must be immediately accessible to the youth during Intensive program hours. Day Treatment Intensive may be part of a school program, in which a portion of the day is academic and a portion is therapeutic intervention. 2) Day Rehabilitation Services are provided to youth during a block of time, in a designated area with mental health intervention consisting of a broad range of services. A qualified mental health staff has to be accessible (not immediately) and the staff to youth ratio is less than that for Day Treatment Intensive. Both of these services are provided in an unsecured setting and therefore not appropriate for youth with severe mental illness who are very aggressive.

Psychotropic Medication

Many of the youth are administered psychotropic medication for their emotional and behavioral problems. Although psychotropic medication may provide some benefit to some of these youth, virtually all youth have the right to refuse medication, whether the youth is in a hospital (unless there is a life-threatening emergency), in a juvenile hall/camp or in a residential setting. Psychotropic medication is generally used to complement other mental health services.

Salient Issues

In addition to limitation of resources, there are other issues that effect availability of effective treatment programs, such as different agendas among associations and conflicting mandates among state agencies.

Other important considerations include:

Shared Mission/Values

The care and protection of children and youth living in high risk situations is a core mandate for multiple local and State agencies. Clearly, there is national recognition regarding the extreme vulnerability of children and youth with severe mental illnesses and emotional disturbances and who have come under the jurisdiction of the juvenile courts. All agencies, including mental health, child welfare, juvenile probation, education or substance abuse, share common missions and values, such as “least restrictive environment” for care, culturally appropriate services, and assisting youth in becoming productive citizens as adults. The uniqueness of each agency’s mandates, community role (public safety, symptom management, education, addiction management), and community expectations of the “mission” also help to shape institutional philosophies and approaches that may differ from that of sister agencies serving that same child. Probation must ensure public safety and therefore is faced with balancing the needs of the individual while fulfilling the mandate to ensure public safety;

the other agencies do not share this priority to the degree that Probation Departments do. Severe mentally disordered children who commit minor offenses are at times incarcerated for lack of a more appropriate disposition.

Societal Impact of Not Serving These Youth

Youth, who have severe mental illness and who, also, have severe behavioral problems, in the juvenile justice system generally do not “self correct.” Oftentimes, earlier, yet, ineffective interventions are later followed by more offenses and continued suffering from mental illness. Opportunities to resume a more normal life diminish as a child matures. Scarce resources also diminish more hopeful opportunities. It is especially important during times of budgetary crisis that informed policy makers examine the costs of failed interventions, in both dollars and lives.

Education/Alternatives/Assessment

Youth in the juvenile justice system are entitled to the same educational services as those youth who have no involvement in the juvenile justice system. A youth with an educational disability including an “emotional disturbance” (ED) may be entitled to various types of mental health services pursuant to the federal Individuals with Disabilities Education Act (IDEA). In California, county mental health departments are mandated by the State to provide mental health services in order that students who are identified have ED as identified by schools may benefit from their “free and appropriate public education (FAPE)”.

The range of mental health services that may be provided to a ward of the court with an educational disability pursuant to an Individualized Educational Plan (IEP) includes individual, group, and family therapies, day treatment intensive, day treatment rehabilitation, medication support and case management. Wards of the court who remain in the care, custody, and control of their parents, or who are placed on a “home of parent” order by the court may, in some instances, be considered for residential placement when it is determined by the IEP team that residential placement is the least restrictive, most appropriate setting in which the ward may benefit from special education programming.

Although this program is a state mandate, for which counties are entitled to receive full reimbursement from the state pursuant to the Commission on State Mandates, the state has recently failed to adequately pay counties for their costs. This has led to serious cash flow issues for most counties, and four counties actually sued the state and won. The court determined that those counties were relieved of the mandate if the state failed to provide adequate reimbursement. Since then, Proposition 1A was passed by the voters, which requires the state to either fully pay counties for the costs of complying with mandates, or suspend the mandate. Therefore, as long as the mandate on counties remains for this program, counties can expect to be fully paid for their costs.

Safety of Staff/Youth/Institutions/General Public

Young people with mental health issues present numerous safety problems in the community as well as in custody. There are serious concerns for the safety of the youth themselves, as they place themselves in potentially dangerous situations. Although a

youth can be ordered to a treatment facility or to receive mental health services, the youth will have to meet an eligibility standard generally codified in state regulations in order to receive treatment. In addition, a youth always retains the right to refuse psychotropic medication except in medical emergencies. Therefore, many of these youth return to community settings where they are not receiving appropriate treatment for their mental illness. Subsequent recycling through the juvenile court, detention facilities, and community is not uncommon for some of these youth.

The California Association of Probation Institutions Administrators (CAPIA) in 2002 identified the following as key concerns related to youth with mental health issues in juvenile halls throughout the State of California: youth with unpredictable behavior often resulting in chaos on units; mentally ill youth being very fearful of being assaulted by other youth; limited staffing resources; redeployment of staff resulting in inadequate staffing in other areas; frequent one-to-one staffing required; longer detention periods for mentally ill youth; problematic medication side effects; refusal by youth to take prescribed medication; self-mutilation; grossly inappropriate behaviors by youth involving bodily fluids; increased stress levels among custodial staff; limited interagency planning and service provision; and excessive transportation needs which impact other facility areas.

Communication Among Responsible State Agencies/Local Government

The opportunities to improve the outcomes for these youth are many, although not likely, on any given day. The long standing pattern of categorical management of separate programs and services dedicated to children and youth are the catalysts of failed outcomes, as each agency or department manages to their agency's directives and mandates. The recognition of the benefits of integrated services across all children service agencies is acknowledged in various state circles. This integration of services, however, has not yet been institutionalized at the state level. As a result, single actions taken to address specific concerns within one "silo" continues unabated despite unintended negative consequences for other systems and, of course, most importantly to the children and families who are supposed to be benefiting from these services.

The broad purpose for the Multi-Association Joint Committee (MAJC) is to create an arena for county/state level planning, training and technical assistance development, and other collaborative activities in order to meet the mental health and alcohol and other drug (AOD) service needs of youth in the juvenile justice system; and to promote fair and equal justice for all children and youth.

The Multi-Association Joint Committee (MAJC) was formed in 2000 in an attempt to establish a statewide focus on youth in the juvenile justice system who have mental illness and substance abuse problems, and their families. It is a committee of associations that have overlapping agendas. With the convening of MAJC, the issues facing the juvenile probation departments have been highlighted and the importance of shared responsibility among agencies and the development of better solutions has been underscored.

Conclusion

With the enormous complexity of current state and federal statutes and regulations, a diverse composition of multiple stakeholders, as well as overlapping agendas, it is critically important that the appropriate expertise be sought when crafting legislation or drafting public policy initiatives that will impact the delivery of services to these youth.

One of the core challenges is the thoughtful development of pragmatic solutions that will actually resolve some of the issues outlined in this issue paper. It is often assumed that solutions are easily identifiable. However, due to the complexity of the multiple systems involved, the solutions need to address the complexity as well as those systems responsible for the program implementation and oversight.

The California Mental Health Directors Association, the Chief Probation Officers of California and the United Advocates for Children of California are available to assist legislators and public policy makers on the development of legislative solutions and encourage them to use these organizations as a resource.

ensure progressive and appropriate operations. As a part of the inspection cycle, the CSA provides notification on areas of noncompliance to the Chief Probation Officer, Presiding Juvenile Court Judge, County Chief Administrative Officer, County Board of Supervisors, Chair of the Juvenile Justice and Delinquency Prevention Commission, and Facility Superintendent. The CSA also assists local agencies in developing a corrective action plan that addresses areas of noncompliance. The CSA examines data collected from this inspection process to identify emerging trends and critical policy issues and includes the findings of this process in a biennial report to the Legislature.

The minimum standards for local juvenile detention facilities include provisions relating to policies and procedures for the appropriate screening, processing, treatment, supervision and care of all detained youth. As outlined below, many of the regulations have particular significance or are specific to mentally ill or disturbed youth, who represent a sizeable – and growing – number of juveniles in custody. During the third quarter of 2001, for example, counties reported that the average daily number of juveniles who had been identified as needing mental health services was 2,161 – an increase of more than 27 percent in one year. For this same time period, the number of juveniles receiving psychotropic medication while in local detention facilities jumped 30 percent. The following Title 15 regulations impact this population.

Section 1350. Admittance Procedures and **Section 1430. Intake Health Screening** address the critical initial phase of confinement where a process of screening and identification of medical/mental health concerns is conducted.

Section 1351. Release Procedures requires notification to the facility medical provider for coordination with outside agencies and when transferring a juvenile to another facility.

Section 1352. Classification stipulates that assignment to housing or program settings may include such factors as emotional stability or medical/mental health considerations.

Section 1355. Assessment and Plan requires a complete assessment of a minor's problems and implementation of a plan addressing those needs within 30 days of admission.

Section 1356. Counseling and Casework Services provides for the availability of counseling and casework for all detained minors. Services specifically included are substance abuse, family crisis, counseling, and mental health.

Section 1358. Use of Physical Restraints emphasizes procedures recognizing that prolonged restraint, applied because behavior cannot be controlled through less restrictive means, may be symptomatic of underlying psychological or medical

problems requiring specific interventions and monitoring, including medical and mental health consultation.

Section 1370. Education Program prescribes compliance with the State Education Code and County Board of Education policies to provide a quality educational program that includes instructional strategies designed to respond to the different learning styles and abilities of students. It includes provisions for individuals with special needs, as well as programs designed to promote social awareness, i.e. conflict resolution, anger management, effective decision making skills, etc.

Section 1400. Responsibility for Health Care Services entrusts the facility administrator with the ultimate responsibility for assuring that health care is provided to all minors.

Section 1401. Patient Treatment Decisions provides that clinical decisions are the sole province of health care professionals.

Section 1402. Scope of Health Care defines services within the facility and by community resources.

Section 1411. Access to Treatment assures unimpeded access to health care.

Section 1413. Individualized Treatment Plans addresses the management of minors who have health conditions that may impact their ability to function within the established facility routine or to participate in programs for which they are being considered.

Section 1415. Health Education requires facilities to develop a program of regular health education that includes mental health and suicide prevention.

Section 1430. Intake Health Screening assures coordination between custody staff and mental health services in cases of substance abusing minors with known or suspected mental illness.

Section 1431. Intoxicated and Substance Abusing Minors addresses the identification and management of alcohol and other drug intoxication.

Section 1432. Health Appraisals/Medical Examinations requires a health appraisal/medical evaluation to be completed within 96 hours of admission to a facility. The appraisal/evaluation must include a review of abuse, neglect, history of mental illness, self-injury, and suicidal ideation.

Section 1433. Requests for Health Care Services provides assurances that any minor requesting or needing medical attention will receive such attention as soon as is reasonable and possible.

Section 1437. Mental Health Services and Transfer to a Treatment Facility requires policies and procedures for assuring the provision of specified mental health services and for transferring a minor to a licensed facility when a higher level of care is needed. Services must include screening for mental health problems at intake, crisis intervention and stabilization of acute psychiatric episodes, intervention to prevent avoidable deterioration of a minor's mental health while in custody, and medication support.

Section 1439. Psychotropic Medications requires policies and procedures governing the management and use of psychotropic medications, including such considerations as informed consent, administration of involuntary medications, and arrangements for transferring to another facility.

Section 1450. Suicide Prevention Program requires a written, organized approach to suicide prevention that addresses identification of minors at risk, monitoring and treatment, and staff training.

Resources:

- (1) The Prevalence of Mental Health Disabilities And Youth in the Juvenile Justice System, Peter Leone, Ph.D., University of Maryland, Department of Maryland, U.S. Department of Labor August 13, 2002.
- (2) The National Center on Education, Disability and Juvenile Justice, January, 2002
- (3) Education Code – Part 30, Section 56000 et. seq.
- (4) California Code of Regulations, Title 5. Education. Division 1. State Department of Education. Chapter 3. Handicapped Children
- (5) California Department of Education, Special Education Division, Assessment, Evaluation & Support Unit
- (6) Senate Bill 933, Chapter 311, Statutes of 1998