Treating Non-Violent Juvenile Offenders with Mental Illnesses: Community-Based Diversion Programs vs. Traditional Residential Placement Facilities

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Treating Non-Violent Juvenile Offenders with Mental Illnesses: Community-Based Diversion Programs vs. Traditional Residential Placement Facilities

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Abstract

Many of the youth who encounter the juvenile justice system have a mental illness, yet they are unable to get adequate treatment while incarcerated. Diversion programs were created to help reduce delinquency, reduce costs, and reduce the level of involvement in the justice system. Although diversion programs can vary, most divert youth from the justice system before they are formally charged with a crime and link them with appropriate resources in the community, enabling them to remain with their families instead of being sent to a residential placement facility. The treatment available in detention facilities is compared to the treatment services provided by diversion programs to determine if youth experience more positive outcomes from being diverted from the justice system. Research on diversion programs has found that recidivism has reduced, costs have dropped, and youth participating in diversion programming have experienced improvements in adverse mental health symptoms. Recommendations for components to include in an ideal diversion program are included, as the findings from various studies on diversion reveal the importance of providing appropriate mental health treatment to youth; treatment that allows them to remain in their communities and homes and out of the justice system.

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Under the Supervision of Dr. Will LeSuer

I. Introduction

Statement of problem

Estimates suggest that between 13 and 20 percent of children in the United States experience a mental illness in a year; some mental illnesses being so severe that they interfere with normal development and functioning and may cause some level of impairment (Centers for Disease Control and Prevention, 2013). Although many children are affected by mental illness, not every child has the opportunity to receive mental health treatment. Research shows that approximately 75% of youth in need of mental health services do not receive them (Kataoka, Zhang, & Wells, 2002). The mental illnesses that youth experience become more complicated when viewed in conjunction with the juvenile justice system (Nicholls, 2009). Studies reveal that mental health and substance abuse issues are overrepresented in the juvenile justice population (Burke, Mulvey, &, Schubert, 2015). About 50-75% of the 2 million youth arrested each year in the United States have a mental illness (Hammond, 2007). Approximately one in five is affected by a mental illness so severe it impairs their ability to grow into a typically functioning adult (Hammond, 2007). Underwood and Washington (2016) suggest that approximately 40 to 80% of incarcerated juveniles have at least one mental illness. Additionally, over 60% of youth with a mental illness also have a substance use disorder (Hammond, 2007). Considering mental illness may contribute to delinquency and given the number of juveniles with mental illnesses, there is a concern that without proper treatment, upon release these

juveniles will have higher rates of recidivism (Mallett, 2014). Interventions for juvenile delinquents which address mental health, including alcohol and other drug abuse issues, are vital to help reduce reoffending and to end the cycle of delinquent behavior which could eventually lead to adult criminality.

Treating juvenile delinquents is important, but the treatment offered to detained juveniles may be insufficient. Research shows that jails are often not prepared to effectively screen and assess youth for mental health problems or provide appropriate treatment (Kretschmar, Butcher, Kanary, & Devens, 2015). Investigations by the U.S. Department of Justice revealed that mental health services are often insufficient or unavailable for youth in the juvenile justice system (National Center for Health and Juvenile Justice, 2015). In addition to being inadequate, White and Aalsma (2013) state that "mental healthcare services within the juvenile justice system are limited and hampered by disparities across race, ethnicity, and gender" (p. 11). Evidence suggests that mental illnesses can be directly and indirectly linked to delinquency (Heilbrun, Lee, & Cottle, 2005). Without properly treating juveniles affected with a variety of mental illnesses, delinquent behavior may persist. Instead of arresting and detaining certain non-violent juvenile offenders, focus should be on treating individuals with mental illnesses and utilizing effective alternatives, such as diversion programs that incorporate a variety of treatment methods.

Significance and Purpose of Study

The cost of juvenile detention is expensive, costing the justice system over $1 billion a year, according to some estimates (Kretschmar et al., 2015). Reducing the number of youth who are incarcerated could drastically reduce the cost taxpayers bear to support the level of services needed to house juveniles, and diverting juveniles from detention centers and jails could reduce the overall cost incurred by the juvenile justice system (Kretschmar et al., 2015). Since the

1990s, the costs of juvenile crime have risen considerably even though juvenile crime has declined significantly (Scott & Steinberg, 2010). A cost/benefit analysis regarding the response to juvenile crime shows that serious juvenile crime declined by 50% between 1994 and 2001, while expenses in the juvenile justice system during the same time increased by 43% (Scott & Steinberg, 2010). In addition to decreasing/reducing costs, if diversion and other community-based treatment programs are more effective at treating mental illnesses and reducing delinquency, juvenile offenders will benefit from these types of programs that concurrently help to treat their mental health issues and keep them out of jail.

In this research, I aim to provide a summary of effective measures to address the insufficiencies in mental health treatment in the juvenile justice system. I will compare mental health services provided to detained juveniles with mental health services provided through programs that divert juveniles from detention centers and jails to community and other evidence-based treatment alternatives to uncover methods that have been found to most effectively reduce future delinquency. By comparing these different programs, I plan to determine if research finds diversion programs to be more beneficial for juveniles affected with mental illness and more successful at reducing delinquency than treatment offered to detained juveniles. The information could be used to establish new programs or change existing programs by providing recommendations for effective components to include in an ideal juvenile mental health program that diverts non-violent offenders from the justice system.

Methods of Approach

I will assess and qualitatively compare the mental health programs and treatment provided to detained juveniles with the alternative programs which divert juveniles from the justice system to uncover the most effective methods. Information for this study will come from

a review of secondary sources, such as articles from peer-reviewed academic journals, state and federal government websites, and government reports. I will utilize the information, statistics, and data found in these secondary sources to support the argument that diverting non-violent juvenile offenders from detention centers and jails to community-based alternatives to treat their mental illnesses will more effectively reduce future crime.

II. Literature Review

Mental Illness and the Juvenile Justice System

Juveniles are affected by a variety of mental illnesses, most commonly attention deficit hyperactivity disorder (ADHD), behavioral disorders, mood disorders, anxiety disorders, and substance use disorders (CDC, 2013). Research suggests that youth within the juvenile justice system are affected with mental illnesses at higher rates than those within the general population. According to Underwood and Washington (2016), approximately 50-75% of the 2 million youth involved in the juvenile justice system meet the criteria for a mental illness, and approximately 40-80% have at least one mental illness. Whereas, only about 6-10% of youth in the general population are diagnosed with a mental illness (Mallet, 2014). In previous studies of juvenile detention facilities, two-thirds of males and three-quarters of females met the criteria for at least one mental illness; an additional one-tenth were also found to meet the criteria for a substance use disorder (Underwood & Washington, 2016).

Given the amount of detained youth who are affected by a mental illness, the juvenile justice system should provide adequate mental health assessments and treatment. The juvenile justice system was initially both a rehabilitative and preventative approach that emphasized the needs and rights of the youth over punishment (Garascia, 2005). With the goal of diverting

youth from the justice system, community-based programs were utilized, but after a short increase in violent delinquency in the 1980s and 1990s, protecting the community became the primary goal and rehabilitating youth was less of a priority (Underwood & Washington, 2016). Juveniles were being punished more harshly and waived into adult court more often (Cocozza & Skowyra, 2001). Even though juvenile crime rates for violent and nonviolent crimes have decreased across the nation, the number of youth processed through the juvenile justice system continues to be high (Fritz, 2015). Between 1985 and 2013, delinquency cases for drug offenses, person offenses, and public order offenses increased, while property offense cases decreased (Hockenberry & Puzzanchera, 2013). While a small number of convicted, juvenile offenders may actually require incarceration, long-term confinement often leads to recidivism, whereas evidence suggests that community-based alternatives can decrease recidivism, even for youth who commit serious offenses (Underwood & Washington, 2016).

Common Disorders

Several mental illnesses are common among youth offenders, some of which can cause symptoms that increase their risk of engaging in aggressive behaviors (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). The common mental illnesses found in youth offenders, include major depression and manic episodes, psychotic disorders, anxiety disorders (e.g., panic, separation anxiety, generalized anxiety, obsessive-compulsive disorder (OCD), and post-traumatic stress disorder (PTSD)), disruptive behavior disorders (e.g., conduct disorder and oppositional defiant disorder and ADHD), and substance use disorders (Underwood & Washington, 2016). Estimates suggest that 13-40% of youth involved with the juvenile justice system have a depressive disorder, up to 25% have an anxiety disorder, 13-30% have ADHD, and 11- 32% have been diagnosed with PTSD (Abram et al., 2004; Weiss & Garber, 2003;

Goldstein, Olubadewo, Redding, & Lexcen, 2005; Mallett, 2014). Additionally, there is a high prevalence of conduct disorder and substance use disorders, both affecting between 30 and 80 percent of youth in the juvenile justice system (Grisso, 2008; Mallett, 2014).

Much of the evidence on mental health disorders reveals that they are directly and indirectly linked to delinquency (Heilbrun et al., 2005). Stoddard-Dare et al., (2011) state that the risk for aggression is increased for many disorders because the emotional symptoms, such as anger, and the self-regulatory symptoms, like impulsivity, often increase the risk. In addition, attention problems and hyperactivity were found to be linked to later risk taking and offending behavior (Stoddard-Dare et al., 2011). Mood disorders, which affect about 10-25% of youth in the juvenile justice system, are likely to cause anger, irritability, and increase their risk of becoming aggressive (Underwood & Washington, 2016). Youth with oppositional defiant disorder have trouble controlling their temper, display defiant behavior and commonly have an angry or irritable mood (Riley, Ahmed, & Locke, 2016). Without proper treatment, oppositional defiant disorder can lead to conduct disorder, substance abuse, and delinquency (Riley et al., 2016). Conduct disorder, which is classified as a pattern of antisocial behavior, including aggressive acts and other behaviors that meet the specified criteria in the DSM-IV, is the most common mental health disorder in children and adolescents (National Collaborating Center for Mental Health, 2013). Youth with disruptive behaviors, such as conduct disorder and oppositional defiant disorder, can behave more physically aggressive, which can increase their likelihood of being arrested (National Collaborating Center for Mental Health, 2013). According to Mallett (2014) childhood depression and ADHD are linked to delinquency, primarily due to aggressive tendencies and poor impulse controls and the combination of ADHD and conduct disorder greatly increase the likelihood of a youth becoming a serious and chronic offender. In

addition, Mallett (2014) found that depression and anxiety are linked to maltreatment and victimization in juvenile delinquents, and repeated maltreatment has an impact on youths offending behavior. Underwood and Washington (2016) indicate that children with one of these disorders are much more likely to have a combination of these disorders, multiplying the symptoms and associated behavior and increasing their likelihood of engaging in delinquent behavior.

Substance Abuse

In an effort to lessen the symptoms caused by these disorders, juveniles often turn to substance use (Underwood & Washington, 2016). Past research has shown that juveniles with substance use issues are more likely to behave inappropriately at home, with peers, and in school. There is considerable evidence which suggests there is a relationship between substance abuse, delinquency and continued aggression into adulthood (Huizinga, Loeber, Thornberry, & Cothern, 2000). Being involved with drugs and alcohol increases the probability that a juvenile will have continued contact with the justice system (National Center on Addiction and Substance Abuse, 2002). Data from the Denver Youth Study, the Pittsburgh Youth Study, and the Rochester Youth Development Study found a statistically significant relationship between persistent delinquency and drug use for both males and females (Huizinga et al., 2000). High risk behavior, such as alcohol and drug abuse and delinquency, tend to occur simultaneously (Dembo & Schmeidler, 2002). According to the National Center on Addiction and Substance Abuse (2002), 25% of juvenile delinquents reported using alcohol, 70% reported drug use, and 75% reported either alcohol or drug use. These percentages indicate the need for substance abuse treatment for juveniles in an effort to reduce or even prevent delinquency.

PTSD, Trauma, and Abuse

The DSM-5 lists four major symptoms occurring in individuals experiencing PTSD, including re-experiencing the traumatic event, heightened arousal, avoidance, and negative thoughts and moods or feelings (American Psychological Association, 2013). PTSD, which was first associated with Vietnam veterans in the 1970s, has now been well-documented in the general population at an estimated rate of 7.8%, including high-risk children such as delinquents (Amatya & Barzman, 2012). Some studies have found that 25% of juvenile delinquents met PTSD criteria and 42% fulfilled partial PTSD criteria, indicating that the percentage of juveniles with PTSD even exceeds the percentage of cases found in the population of Vietnam veterans (Amatya & Barzman, 2012). Trauma can impact children in significant ways, causing developmental delays, social, behavioral, and academic difficulties, somatic complaints, lower self-esteem, and attachment issues (Amatya & Barzman, 2012).

Mallett (2014) suggests that between 26 and 60% of youth involved with the juvenile justice system have maltreatment histories, meaning they are past victims of physical, psychological, sexual abuse, or neglect. Researchers have found that the violent and traumatic situations experienced by victims of trauma may manifest as outward acts of aggression, delinquency, and conduct disorder. According to Ryan and Testa (2005), victims of maltreatment averaged 47% higher delinquency rates than non-abused children. In addition, 31.7% of severely delinquent juvenile offenders meet the criteria for PTSD and 20% meet partial criteria (Amatya & Barzman, 2012). Research has also found that certain environmental factors such as parental psychopathology, drug use and criminal activity, which likely contribute to delinquency, are also factors contributive to trauma. Once trauma has occurred, PTSD, even without these other factors, can lead to juvenile delinquency, but children who experience these

adverse environmental factors who have also experienced trauma are at greatest risk of juvenile offending (Amatya & Barzman, 2012).

Various studies discovered a high prevalence of interpersonal violence victimization, such as sexual assault, physical assault/abuse, and witnessing domestic or community violence, among adolescents frequently involved in high-risk behaviors (Begle et al., 2011). There are gender differences in regards to exposure to violence, with male adolescents more likely to experience physical assault and witness community violence and females more likely to be victims of sexual abuse or assault (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009). Victimization is related to substance use and delinquency in males and females (Finkelhor et al., 2009).

Trauma, delinquency, and substance abuse among girls. Most studies about juvenile delinquency focus on the delinquency of only male offenders, yet they are used to describe female delinquency as well when males and females actually exhibit different paths for involvement in delinquent activity (Foy, Ritchie, & Conway, 2012). Mental health problems are significantly higher in female youth than in male youth, with 73.8% of females in detention meeting the criteria for a mental health diagnoses compared to 66.3% of male youth (Cruise, Marsee, Dandreaux, & DePrato, 2007; Teplin et al., 2002). Females have higher rates of mood disorders, substance use, sexual abuse, and physical abuse, but their treatment needs are often minimized or overlooked completely (Underwood, Phillips, von Dresner, & Knight, 2006). Research shows that girls in the juvenile justice system are known to have rates of co-occurring childhood abuse, trauma, and substance abuse. Higher rates of family trauma and childhood trauma experiences in girls increases the risk for development of trauma-related mental health problems and delinquency (Smith, Leve, & Chamberlain, 2006). Co-occurring delinquency,

childhood abuse, trauma, and substance use in girls can cause serious adverse outcomes, including worsening criminal behavior and drug abuse (Smith & Saldana, 2013).

Research suggests that delinquent girls with conduct problems have rates of trauma as high as 80% and high rates of substance use (Goodkind, Ng, & Sarri, 2006). A study by Cruise et al (2007), found that 46.8% of female offenders had a substance use disorder. Studies show that 54% of youths in inpatient substance abuse settings have PTSD (Stevens, Murphy, & McKnight, 2003). Results of a study by Smith and Saldan (2013), found a significant relationship between trauma, specifically sexual abuse, and the use of tobacco, alcohol, and drugs, including hard drugs such as crack, cocaine, opiates, hallucinogens, and depressants. Results from studies trying to uncover links between childhood abuse and trauma and co-occurring problems for girls suggest that they might benefit from prevention and intervention services that include comprehensive assessment and treatment of childhood sexual and substance abuse (Smith & Saldana, 2013).

III. Current Treatment for Detained Youth

Often there is a struggle to balance the social need for safety with the needs of the individual when discussing mental health treatment of juvenile offenders. A six-month study in 2003 found that almost fifteen thousand juveniles were incarcerated because there was no access to mental health treatment in their communities (Hicks, 2011). In a separate national survey, 36% of families with children affected by severe mental illnesses reported that their children were in the juvenile justice system because they had no other way to access mental health services (Shelton, 2002). Shelton (2002) states that nearly a quarter of families had to surrender custody of their children to authorities in order for their children to receive treatment, and the

17% who did surrender custody were concerned their children would not get adequate treatment for their mental health needs and would potentially become violent. Because juveniles with mental health needs are overrepresented in the juvenile justice system, juvenile corrections play a significant role in coordinating the care to provide treatment services to these juveniles (Hicks, 2011). If they are to address these urgent needs, these facilities must develop the ability to provide effective mental health care.

According to Hicks (2011), most juvenile detention centers lack the resources to properly screen or treat individuals with mental illnesses. For example, 75% of juvenile detention centers in the United States fail to follow standard suicide prevention procedures (Hicks, 2011). Considering that youth in juvenile detention centers are four times more likely to commit suicide than the general population, following a standard procedure may help reduce that increased likelihood (Hicks, 2011). In addition, one-quarter of juvenile detention centers provide poor quality mental health services or none at all, and when treatment is available, often the staff are not trained well enough to handle individuals affected with mental health issues (Hick, 2011).

Although studies on mental health services in juvenile detention centers are limited, the most recent suggest that detained youth do not receive appropriate treatment services (Aalsma, Schwartz, & Perkins, 2014). In many facilities, when mental health treatment is available, it primarily consists of medication administration and management, and only 68% of facilities surveyed offered counseling services, most of which were not provided by licensed mental health care professionals (Aalsma et al., 2014). A report, which assessed the mental health care in Illinois' juvenile prisons, revealed that these prisons were not adequately screening and treating mentally ill youths (Mills, 2010). The facilities are commonly underfunded, understaffed and their mental health providers are not always trained in modern methods (Mills, 2010). The

primary goal of the juvenile justice system should be to rehabilitate young offenders. Many juveniles enter the justice system with serious mental health problems, therefore, it is important that juvenile facilities that detain these juveniles are able to meet their individual mental health needs to help in preventing the future costs of untreated mental health problems and worsening criminal behavior (Cooper, 2009).

Effective rehabilitation of detained youth begins with optimal screening of all juveniles as close to entry into the juvenile system as possible, including an assessment for mental health, emotional, developmental, and social challenges (Soulier & McBride, 2016). Screening and assessment help to identify youth who may be at increased risk of having mental health issues, substance abuse, and other delinquency needs that require immediate attention (Underwood et al., 2006). Past research shows that the most used and empirically proven tool to screen juveniles is the Massachusetts Youth Screening Instrument, which can be used at entry and transitional placement points in the juvenile system. The Massachusetts Youth Screening Instrument does not generate psychiatric diagnoses but instead identifies warning signs for further assessment (Soulier & McBride, 2016). This instrument includes seven scales that screen for a combination of externalizing and internalizing mental health problems, such as drug/alcohol use, depression/anxiety, suicide ideation, anger/irritability, and traumatic experiences (Cruse et al., 2007). More than 30 states routinely administer the Massachusetts Youth Screening Instrument in an effort to provide comprehensive mental health care for detained juveniles (Cruse et al., 2007). All states should utilize this screening instrument to standardize the screening process and initiate further assessment for youth needing treatment.

Treatment Disparities and Barriers to Mental Health Treatment

Limited access to mental health services may be most pronounced for minority juveniles, who are disproportionately represented at every stage of the juvenile justice system (Aalsma et al., 2014). On a given day, over 60% of the juveniles held in juvenile detention facilities are racial/ethnic minorities (Teplin, Abram, McClelland, Washburn, & Pikus, 2005). Evidence suggests that youth of color are increasingly at risk for entry into the juvenile justice system and are often treated differently within the mental health and juvenile justice system (Underwood et al., 2006). Minorities are disproportionately represented among youth with mental health issues, but despite this overrepresentation, research shows that White youths are more likely to be referred to mental health services (Dalton, Evans, Cruise, Feinstein, & Kendrick, 2009). Minorities in juvenile detention centers are less likely to undergo screening for mental illnesses, and Black males are usually underdiagnosed because untrained staff perceive these individuals as violent instead of mentally ill (Hicks, 2011). Teplin et al (2005) found that for youth who needed mental health treatment, White youths were almost two times more likely than Black youths to be perceived as needing treatment services. Although there is a minority overrepresentation in the juvenile justice system, there is an under-utilization of mental health service identification and implementation for this group of offenders (Underwood et al., 2006). Similar results were observed in outpatient settings, with one study finding that 57% of Black and 74% of White youths utilize outpatient mental health and substance abuse services (Dalton et al., 2009). Research by White, McGrew, and Aalsma (2016) found that Black youths were less likely to receive mental and behavioral health services; only 36.7% received treatment services after detention, even though 72.6% met the criteria for a mental and/or substance abuse disorder.

Dalton et al. (2009) conducted a study to investigate the relationship between race and mental health services for male adolescents. Standard mental health screening and assessment

measures were administered to all juveniles to identify those with serious mental illnesses (SMI) who needed specialized mental health services. Results indicated that race was a significant factor in SMI assignment even when controlling for possible race group differences, showing that White youths were four times more likely than Black youths to be designated with a SMI (Dalton et al., 2009).

Although other factors beyond race may influence the treatment referral of juvenile offenders, these disparities are still evident and should be addressed as limited access to mental health care can have a serious impact on rehabilitation and a juvenile's overall behavior upon release and re-entry into the community. Cultural competence training for law enforcement officials and mental health professionals may help to address these disparities in mental health care and improve systems of care (Primm, Osher, & Gomez, 2005).

IV. Diversion Programs

Although appropriate and effective mental health treatment should be provided to juvenile delinquents affected with mental illnesses, emphasizing the mental health treatment services in juvenile justice may not be the best approach. Increasing mental health services in juvenile justice could mean that youth would need to be arrested, charged, and incarcerated to get these services (Grisso, 2008). In a study that assesses the inappropriate incarceration of youth with mental illness, Erickson (2012) states that "incarceration is relatively ineffective at remediating behaviors associated with untreated serious mental illness and may worsen some youths' symptoms and long-term prognoses". Furthermore, many juveniles with serious mental illness do not receive sufficient, or any, mental health treatment, and many do not even receive a diagnosis while in custody, despite the juvenile justice systems' responsibility to provide mental

health treatment under the Civil Rights of Institutionalized Persons Act of 1980 (Erickson, 2012). Incarceration can be much more expensive than treatment, produce less positive health outcomes and even be destructive to the health and well-being of youth with mental illness (Erickson, 2012). Research has found that many successful treatment approaches work best when applied in the community, while youth remain with their families instead of being apart from them (Grisso, 2008).

In the U.S., diversion, an alternative to detention for delinquent youth, has become more common (Hamilton, Sullivan, Veysey, & Grillo, 2007). The goals of diversion programs are to reduce delinquency and recidivism, increase system efficiency, reduce costs, and reduce the level of involvement in the juvenile justice system (Cocozza et al., 2005). The labeling theory on which diversion is based suggests that encountering the juvenile justice system may do more harm than good for some youths because of the potential for stigmatization (Bynum & Thompson, 1996). Diversion was designed to address several criticisms of the juvenile justice system, including criminologists challenging the effectiveness of juvenile detention and programming, the lack of constitutional protections given to youth, the increasing effects of alternatives to incarceration, and the inefficiencies in the system and high costs of secure placements (Cocozza, et al., 2005). Diversion programs most often refer youth accused of a crime to a program outside of the justice system before a formal charge is given (Hoge, 2016).

Although juvenile diversion programs vary, several elements are included in most programs (Hamilton et al., 2007). The first component is screening and assessment, which allows staff to identify youth who are appropriate for diversion and recognizes participants' specific needs (Hamilton et al., 2007). After these needs are identified, juveniles can be referred to appropriate treatment and services. Screening and assessing youth help to ensure that services

and resources are directed to youth who are experiencing psychosocial problems (Cocozza et al., 2005). The second component is community-based intervention (Hamilton et al., 2007). Diversion programs most often involve referrals to a variety of agencies, especially when dealing with multi-problem youth with mental health and substance abuse issues (Hamilton et al., 2007). Consequently, diversion programs are most effective when they are able to identify the multitude of problems that a youth is experiencing and provide, or coordinate, appropriate treatments that are responsive to their specific needs (Hamilton et al., 2007).

Various studies have found that youth in community-based treatment have better outcomes than youth whose treatment was provided in detention (Hamilton et al., 2007). There are potential benefits of allowing juveniles to participate in treatment in their communities, including improved health, well-being and family functioning, decreased stigma, and increased overall functioning, which may ultimately prevent future delinquency (Hamilton et al., 2007). Diverting youth from the juvenile justice system helps to avoid some of the negative consequences associated with it, including the effects of labeling a youth as a delinquent, which can have negative effects on how a youth is treated by family and in school (Hoge, 2016). The labeling view suggests that contact with the justice system leads to a delinquent self-image and related behavior (Cocozza et al., 2005).

The most common potential benefits of diversion programs are the reductions in burdens on the juvenile justice system (Hoge, 2016). Services provided by criminal justice personnel, including police officers and judges and the resources spent on building and staffing correctional facilities, is generally more than the cost of community-based services (Hoge, 2016). Research has found that community-based alternatives cost much less than the costs of incarcerating juveniles. The yearly cost of juvenile detention in 2012 was over $1 billion nationally and it can

cost between $150 and $300 per day for each bed that is occupied in a detention center (Kretschmar et al., 2015). The cost of incarcerating a youth for a year in the juvenile justice system varies in different states but costs range from approximately $45,000 in Washington to $215,000 in New York (Scott & Steinberg, 2010). Reducing the number of youth who are incarcerated could not only reduce the burden on the juvenile justice system, but it could reduce the amount that taxpayers need to contribute to support all the services needed by detained juveniles.

According to Cocozza and colleagues (2005), there are four critical elements of effective diversion programs. Effective diversion programs include systematic and standardized screening and assessment of youth, reduce the depth of entry into the juvenile justice system, utilize holistic, family-centered interventions, and develop and use a wide network of community-based providers (Cocozza et al., 2005). Most juveniles who encounter the justice system have a multitude of problems, including substance use and mental health issues, poor academic performance, and they often come from violent homes and neighborhoods, so a comprehensive network of services must be available within the community to address various issues (Cocozza et al., 2005). Several evaluations of juvenile diversion programs, focusing on recidivism as the main measure of effectiveness, found that participation in diversion programming was associated with lower levels of future delinquency and fewer placements outside of the home (Kretschmar et al., 2015). These and other results are encouraging and support the notion that diversion programming can be applied safely and effectively.

The Miami-Dade Juvenile Assessment Center Post-Arrest Diversion Program

In 1997, the Miami-Dade County Juvenile Assessment Center (JAC) opened to provide a single point-of-entry processing center comprised of a variety of agencies that interface with arrested youth because there was an increasing understanding that these youths often have needs that require the attention of multiple systems, including mental health and alcohol and drug treatment, and social service agencies (Cocozza et al., 2005). JAC can play a role in effectively recognizing and responding to the psychosocial problems and recidivism risk of arrested youths (Dembo, Walters, & Meyers, 2005). The JAC provides immediate and comprehensive assessments of youth needs, manages and monitors youth to ensure that they are provided with appropriate treatment, and provides an integrated case management process that links the results from the assessment to needed services (Cocozza et al., 2005).

The JAC created a Post-Arrest Diversion (PAD) program for first time, nonviolent misdemeanor offenders, which has dual goals of identifying risk factors and treatment needs and reducing the depth of involvement in the juvenile justice system (Cocozza et al., 2005). After the diversion alternatives are described to the youth and their family members and they agree to the terms of the diversion, PAD staff conduct a thorough evaluation and develop a treatment and supervision plan (Cocozza et al., 2005). Incorporating effective screening and assessment instruments into new procedures to identify the specific needs of each youth is a vital component of JAC (Dembo et al., 2005). In addition to providing case management and on-site follow up throughout this diversion program, which lasts approximately 60 days, PAD staff has access to over 200 providers in the community. Diversion youth also receive a justice sanction, which involves a form of restitution and community service (Cocozza et al., 2005).

Since the implementation of this post-arrest diversion program, it has undergone significant improvements. The program has enhanced its screening and assessment instruments

and staff are regularly trained on the new instruments, procedures, and other topics, such as motivational interviewing approaches, youth and family engagement, family communication skills development, and cultural and gender sensitivity (Cocozza et al., 2005). The programs assessment techniques, case planning and support from community-based services have helped to create positive outcomes for youth and their families (Cocozza et. al., 2005).

Eastern Michigan University Adolescent Diversion Program

The Eastern Michigan University Adolescent Diversion Program (ADP) began in 2011 as a collaborative project between the juvenile court and the university's School of Social Work (Fritz, 2015). The primary goals of the program were to reduce the number of youth who enter the juvenile justice system or become victims of the school-to-prison pipeline and to create safer communities (Fritz, 2015). The school-to-prison pipeline is a "systematic socio-political process that pushes selected youth out of school and on to the streets to be targeted by law enforcement, where they end up in juvenile detention" (Nocella, Ducre, & Lupinacci, 2016, p. 1). There are generally five common elements of the school-to-prison pipeline: criminalization, policing, punitive discipline, oppressive/rigid education, and cultural incompetent personnel (Nocella, Ducre, & Lupinacci, 2016). A school-to prison pipeline has resulted from the failure of schools to identify and properly treat mental health issues in their students (Hicks, 2011). In service of its mission to prevent youth from becoming victims of the school-to-prison pipeline, undergrad social work student interns serve as mentors and link troubled youth with educational, mental health, and social service resources (Fritz, 2015). Youth receive an average of 12 hours of mentorship per week for 13 weeks each year. Mentors for this diversion program, which goes beyond focusing on the youth's criminal offense, are trained to understand the various issues that play a role in youths first offenses, and they use these factors to develop individualized action

plans (Fritz, 2015). 93% of youth who participated in this program have avoided further contact with police (Fritz, 2015).

Ohio's Behavioral Health/Juvenile Justice Initiative

Due to an overwhelming number of juveniles appearing in court demonstrating serious behavioral health problems, and to judges lacking the resources and knowledge to identify, assess, and serve these youth, the Behavioral Health Juvenile Justice (BHJJ) project was created (Kretschmar et al., 2015). The goal of this 3-year pilot program was to divert youth who demonstrated a need for mental health treatment from juvenile detention facilities into community-based treatment (Kretschmar et al., 2015). Youth who have been charged with a crime are screened for behavioral/mental health issues, and if they meet the eligibility criteria and agree to participate they are enrolled in the BHJJ program and referred to the treatment agency responsible for providing diagnostic assessment and treatment services (Kretschmar et al., 2015). The youth and the family participate in treatment and other services, such as mentoring and tutoring, and when they complete the goals in the treatment plan, the therapist begins the termination process (Kretschmar et al., 2015).

A mission of BHJJ is to provide treatment in the least restrictive setting possible, so most treatment is provided in-home or in outpatient settings (Kretschmar et al., 2015). The counties that utilize this program must use evidence-based or evidence-informed treatment models, such as Multisystemic Therapy, Functional Family Therapy, Integrated Co-occurring Treatment, Trauma-Focused Cognitive Behavioral Therapy, and Multidimensional Family Therapy (Kretschmar et al., 2015).

Most juvenile diversion programs focus on recidivism rates to determine the success of the program, but BHJJ assesses both behavioral health and juvenile justice outcomes of the program (Kretschmar et al., 2015). Longitudinal data on mental health symptoms, substance use, trauma, and criminal justice involvement are collected on every juvenile in the program. The results indicated that over 72% of the juveniles successfully completed their treatment and demonstrated statistically significant improvements in trauma symptoms, day-to-day functioning, and problem severity from intake to termination of the program (Kretschmar et al., 2015). Youth showed a 50% reduction in the risk of out-of-home placement; only 7% who successfully completed the program were still judged to be at risk for this type of placement. BHJJ youth demonstrated reduced future delinquency, and youth who successfully completed treatment received fewer subsequent charges. In fact, over 70% had no additional felony charges in the year after completing the program. Only 82 out of 2,336 who participated in the program were sent to state-run detention facilities at any time after their enrollment (Kretschmar et al., 2015).

Not only were their significant benefits to the juveniles in the BHJJ program, but there were significant financial savings. In 2014, the cost per day to house a juvenile in one of Ohio's juvenile facilities was $561, which is approximately $187,000 for just one youth per year (Kretschmar et al., 2015). The $12.6 million that Ohio contributed to the BHJJ program through 2013, which equates to around $5,000 per youth, is significantly less than the amount it costs to house a juvenile in a detention center each year (Kretschmar et al., 2015). The savings achieved by the state by diverting youth away from detention facilities has allowed money to be reinvested back into community diversion programming like BHJJ, which have produced significant, positive behavioral results, reduced delinquency, and are proven to be extremely cost-effective (Kretschmar et al., 2015).

Wraparound Milwaukee

The Wraparound approach promotes integrated services across the mental health, juvenile justice, child welfare, and education systems for youth with serious emotional problems (Kamradt, 2000). There are many components to the Wraparound model, but Kamradt (2000) lists these elements as particularly important to assist children in the juvenile justice system: family involvement during treatment, needs-based service planning and delivery, and individualized service plans. The structure of Wraparound uses juvenile-guided, family-driven policy and a care team to empower mentally ill juveniles and those with serious behavioral concerns and helps prevent further involvement in the juvenile justice system (McGinty et al., 2013).

A program that adopted the Wraparound approach, Wraparound Milwaukee, initially targeted 25 youth in residential treatment centers. Its goal was to demonstrate that, through the Wraparound model, these youths could be returned home or to community-based foster care for less than it would cost for them to remain in residential treatment centers (Kamradt, 2000). The key components which help to guide the success of the project are care coordination, the Child and Family Team, the Mobile Crisis Team, and a provider network (Kamradt, 2000). The care coordinators perform assessments, assemble the Child and Family Team, conduct plan-of-care meetings, and help determine the specific needs of each youth and family and the resources they will utilize. The care coordinators also develop individualized service plans, crisis plans, and promote collaboration of services among different providers (McGinty et al., 2013). Because Wraparound Milwaukee is family-driven, the care coordinator assembles family members and friends, in addition to others who may provide support to the family and juvenile, to form the support system for the child and family (Kamradt, 2000). This project has a variety of services

and resources to respond to the multiple needs identified by different families, and has extended its array of services from 20 to 60 and includes more than 170 agencies (Kamradt, 2000). One of these services is a 24-hour crisis intervention service, consisting of psychologists and social workers, who intervene in family crisis situations and work with the care coordinator to return the child to the community (Kamradt, 2000). The variety of services increases the choices families have when selecting agencies and providers that will offer them the best resources to suit their needs. Some of the services offered by Wraparound Milwaukee include alcohol/substance abuse counseling, mental health assessment/evaluation, mentoring, tutors, recreation/child-oriented activities, supervision/observation in home, independent living support, day treatment/alternative school, and parent aides (Kamradt, 2000).

Since Wraparound Milwaukee began, the use of residential treatment has decreased 60%, inpatient psychiatric hospitalization has dropped 80%, and recidivism rates have reduced significantly for a variety of offenses for the youth participating in this program (Kamradt, 2000; McGinty et al., 2013). In addition to these decreases in residential treatment, inpatient hospitalizations and recidivism rates, the average overall cost per child has dropped from more than $5,000 per month to less than $3,300 per month (Kamradt, 2000). Like BHJJ, which reinvests the money it saves diverting youth from detention back into diversion programing, the savings received by Wraparound Milwaukee have been reinvested into serving more youth, allowing the project the ability to serve 650 youth for the same amount that would have served only 360 youth in detention (Kamradt, 2000). These results help support Wraparound Milwaukee as an effective diversion method which not only reduces youths contact with the justice system, but helps to provide a variety of resources to youths and their families.

The Connecticut School-Based Diversion Initiative

Through the perspective that many youths who are arrested have unmet mental health needs, the Connecticut School-Based Diversion Initiative (SBDI) was designed with the goal of reducing discretionary in-school arrests and expulsions and linking youth with behavioral and mental health needs to appropriate community-based services (Bracey et al., 2013). To achieve this, SBDI engages directly with school administration, staff, and school resource officers, in addition to key community-based resources (Bracey et al., 2013). Students of color, particularly Black and Latino males, are arrested and expelled more often than other students, and reactions to their behaviors by school staff are more severe, even when the behaviors are the same as other students (Richetelli, Hartstone, & Murphy, 2009). SBDI helps to reduce this disproportionality in arrests and expulsions, which, in turn, may also reduce the disproportionate numbers of youth of color involved in the juvenile justice system. SBDI works to reduce the use of restrictive forms of care including incarceration, inpatient hospitalizations and residential treatment (Bracey et al., 2013).

According to Petteruti (2011), schools often need better connections to crisis response, mental health services and other resources in the community, which can be effective alternatives to law enforcement involvement. SBDI works with schools to ensure that students, even those who are not arrested for school incidents, receive the services, support, and alternative disciplinary action they need (Bracey et al., 2013). SBDI engages in training and professional development for key school professionals (e.g., administrators, teachers, school social workers and psychologists), coordination and collaboration with existing community-based services, school disciplinary policy consultation and data collection. Some of the training topics include: understanding normal adolescent development; recognizing mental health symptoms; accessing

community-based behavioral health resources; and understanding the juvenile justice system (Bracey et al., 2013).

Youth who experience a mental health crisis in school are especially susceptible to unnecessary police contact, and they may require supportive services that are not available through their school (Bracey et al., 2013). SBDI facilitates a stronger connection between schools and their local Emergency Mobile Psychiatric Services Crisis Intervention Team (EMPS), which responds quickly to support students experiencing behavioral health problems (Bracey et al., 2013). SBDI and Wraparound Milwaukee are similar in this aspect, as they both utilize a crisis intervention service which provides support in times of crisis and helps to reduce the chances of a youth being removed from their home, school, or community (Kamradt, 2000; Bracey et al., 2013).

In 2010-2011, in communities that adopted SBDI, in-school arrests dropped 50-59%, out-of-school and in-school suspensions dropped 8 and 9%, respectively, and EMPS Crisis Intervention utilization tripled, while ambulance calls decreased by 22% (Bracey et al., 2013). In an analysis that compared data on initial and subsequent court referrals between similar communities with and without SBDI, the results indicated that youth first served by EMPS had fewer referrals to court (47%) compared to those initially referred to court (66%) (Bracey et al., 2013. Additionally, rates of juvenile justice referrals were significantly lower in SBDI communities compared to non-SBDI-communities, even after controlling for race, age, gender, and previous delinquency (Bracey et al., 2013). These results support this initiatives goals and approach to school-based arrest diversion and can help divert youth from the justice system before an official arrest is made.

V. Recommendations

There are many different types of diversion programs and many diversionary practices, that, like the ones mentioned above, have proven to be successful at preventing juveniles from entering the juvenile justice system and reducing recidivism. Ideally, diversion should take place before a juvenile has been arrested, or at least prior to being charged, to minimize contact with the justice system. As Cocozza and colleagues (2005) stated, four critical elements should be implemented in an effective diversion program: systematic and standardized screening and assessment, reducing involvement in the justice system, utilizing family-centered approaches, and developing and using a wide array of community-based services and providers. In addition, diversion programs should consist of evidence-based treatment. Numerous studies, including a study by Timmons-Mitchell, Bender, Kishna, and Mitchell (2006), have found that juveniles undergoing evidence-based therapy, such as multisystemic therapy, experience significant reductions in rearrests and improvements in many areas of functioning.

Effective screening and assessment, which enables staff to identify youth with specific mental health needs, is critical for diversion programs (Hamilton et al., 2007). Properly screening and assessing youth helps to ensure that youth who are experiencing mental health issues are directed to appropriate treatment services that fit their needs (Cocozza et al., 2005). Proper treatment of mental illnesses is imperative for rehabilitation. The Massachusetts Youth Screening Instrument, which is the most common tool to screen juveniles, should be administered to juveniles in detention prior to diversion and at various points during treatment (Soulier & McBride, 2016). This will ensure that juveniles are referred to services that target their specific needs.

Diversion programs should utilize community-based interventions and alternatives that assist in addressing underlying issues, including mental illness and substance abuse. As Bracey et al. (2013) indicated, the majority of juvenile arrests occur due to behaviors in schools. Hicks (2011) suggests that mental health issues be addressed early on in school, instead of waiting until it is too late and youth are already caught up in the justice system. Because of this, I believe more programs like SBDI, which seek to reduce in-school arrests and expulsions and link youth who have mental health needs to community-based services, should be implemented and utilized. It is recommended that rather than immediately instituting police contact and referring the juvenile for criminal charges, schools using diversionary response plans should initially ensure that juveniles receive appropriate care for their behavioral and mental health issues. Petteruti (2011) suggests that crisis response and mental health services are effective alternatives to law enforcement involvement, and schools should have access to these types of resources to help intervene when a child is experiencing a behavioral or mental health crisis to lessen contact with law enforcement. School-based diversion programs should coordinate care with outside agencies and have relationships with a variety of alternatives to refer juveniles to appropriate services, especially when dealing with multi-problem youth with mental health and substance abuse issues (Hamilton et al., 2007). It is also recommended that school professionals undergo regular professional development and training on recognizing mental health symptoms, cultural and gender sensitivity, and various other types of training that will assist them in understanding and working with youth from a variety of backgrounds affected with mental illness. Cultural and gender sensitivity and cultural competence training may also be effective in lessoning the disparities in mental health care.

Substance abuse has been linked to inappropriate behavior in school, at home, and in the community and there is a relationship between substance abuse and delinquency (Huizinga et al., 2000). Therefore, diversion programs should incorporate substance abuse treatment, which if effective may assist in reducing delinquency and juveniles' contact with the justice system. Given there are also links between trauma/abuse and substance abuse and delinquency, especially for girls, diversion programs should provide training to staff to help in understanding these co-occurring issues and provide comprehensive assessment and treatment for childhood trauma, abuse, and substance abuse.

Another recommendation for an element to include in diversion programs is family involvement, which is a component found in many diversion programs including Wraparound approaches. Family involvement is recognized as a critical element of service planning for children's mental health, welfare, and education (Walker, Bishop, Pullmann, & Bauer, 2015). Literature on family involvement in mental health supports the general conclusion that family-centered policies have positive impacts on youths' behavior (Kutash, Duchnowski, Green, & Ferron, 2011).

For youth who are not diverted out of the juvenile justice system, effective rehabilitation begins with properly screening and assessing youth for mental health, emotional, developmental, and social challenges (Soulier & McBride, 2016). Research suggests that screening should take place as close to entry as possible. Juvenile corrections must coordinate care to provide treatment services to these juveniles and develop effective treatment programs that focus on mental health, substance abuse, emotional, developmental, and social challenges that may lead to criminal behavior in an effort to help prevent future delinquency. Additionally, law enforcement personnel should receive specialty training to identify and effectively assist children with

psychological issues requiring intervention and proactively divert those individuals to appropriate services.

VI. Summary and Conclusion

Considering that over 50% of the youth who come in contact with the juvenile justice system have a mental illness and many disorders common in juvenile offenders are likely linked to delinquency, it is imperative that effective treatment is provided to these individuals. Effective treatment could concurrently lessen the symptoms of a youth's mental illness and help reduce recidivism. Although mental health treatment is important for juveniles they may not be provided with adequate treatment while in detention. Diversion programs are a good alternative to detention and have been found to produce positive outcomes for many youth, including reduced recidivism. In addition, diversion programs ordinarily provide a variety of treatment services, which may include family involvement, counseling, mentoring, crisis intervention, and community resources. School diversionary programs may be helpful in limiting the school-to-prison pipeline, which, like the juvenile justice system, seems to disproportionately target certain groups of individuals. The services included in diversion programs are found to more effectively treat youth affected by mental illness than the treatment offered to youth in detention and other residential placement facilities. With effective screening and assessment of youth, a variety of community-based and evidence-based treatment services, individualized care, and proper training to juvenile justice staff, diversion programs may effectively help to reduce recidivism and the overwhelming cost of incarceration while also producing positive health outcomes for many youths and their families. Diversion programming could ultimately help to better our communities by rehabilitating juveniles and reducing their contact with the juvenile justice system.

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